ACGME BULLETIN October 1999

Accreditation Council for Graduate Medical Education

Executive Director's Column:

David C. Leach, M.D.

Preparing for the ACGME Accreditation Site Visit

How does one prepare for an ACGME site visit? What characteristics mark those site visits that go well and what predicts disaster? Each year about 2,000 program directors receive a letter announcing an ACGME site visit. This column is addressed to them.

Stephen Covey says "Begin with the end in mind." Imagine a notification has letter arrived, copied to your dean and CEO. It informs you that your program has been fully accredited and been granted a five-year interval until the next site visit. Imagine this information being shared with colleagues on the Graduate Medical Education Committee, department chairs, faculty councils, trustees, resident applicants, and others. Imagine further that you know that the letter reflects a wonderful program and was written because you presented your program in a way that permitted it to be accurately judged by your peers on the Residency Review Committee (RRC). What will it take to get from here to there?

One program director recently wrote me and suggested that divine intervention would be needed. He has a good program, but none of us like to be audited (this includes the RRCs, whose efforts are reviewed by the ACGME's Monitoring Committee). Nonetheless, the peer review process is a fundamental part of medicine's and medical education's social contract, the part that lets us regulate ourselves, and that safeguards the quality of physician education. The question is not whether it should be done, but how to do it effectively.

"The average RRC member spends forty hours before each RRC meeting reviewing programs for the meeting."

Key aspects of the preparation effort that result in a good site visit include an early start; a thorough review of the program requirements; an in-depth reading of the most recent notification letter; ongoing efforts to identify and realize improvement opportunities; good communication with residents and faculty; and conveying the relevant attributes of program in a clear and accurate way to the site visitor and, through the Program Information Form (PIF), to the RRC.

The site visit process really begins immediately after the last RRC review. If you were not part of the last visit (there are about 1,500 new program directors each year), and you cannot find a copy of the most recent notification letter, contact the ACGME and we will be happy to send a copy to you. Look at citations and concerns identified in the last accreditation action, and review what your program has done to address them. If the answer is "nothing" or "not much," change your strategy quickly. Repetitive patterns of noncompliance are not tolerated well by the RRCs. Ideally, midway between the last site visit, and the tentative next site visit date, there should be an internal review of the program to assess progress in areas of concern and explore the program's strengths and areas needing improvement.

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The start of the preparations for the site visit may be a good time to call the Executive Director of your RRC (identified on our web site: www.acgme.org). He or she will give you accurate and helpful information based on a wealth of experience with the RRC and with other programs in similar situations. In my former life as a program director I never called them. However, now that I have seen this side of the fence, I have come to appreciate how talented they are and how helpful they can be.

The RRC will judge your program against the standards published in the requirements, which can be downloaded from the ACGME web site. Start with a thorough reading. You may find that you disagree with some of the requirements. Make a note to contribute actively to the development of the next generation of requirements (proposed requirements are also on the web site with an invitation for the GME community to comment on them). At the same time, don't expect that because you do not agree with a particular requirement your program will not be held accountable for complying with it.

The next step involves downloading the PIF from the web site. Remember that the site visitor's role is to clarify and verify the information you have put in the PIF. Answer all the questions. The most common reason for an adverse action that is subsequently reversed is an incomplete or poorly prepared PIF. Keep your audience in mind. The average RRC member spends forty hours before each RRC meeting reviewing programs for the meeting. These are busy physicians, committed to their work, but not appreciative of a sloppily presented program. One program director sent in a poorly prepared PIF, and later a one-thousand-page document that requested reconsideration of a proposed adverse action. It can be deduced that it is preferable to do it right the first time.

Don't prepare for the site visit alone. Engage help from others - a coordinator, other faculty, the residents, institutional officials, whoever has the information needed to complete the PIF. Parcel out pieces of the PIF to be completed. Make the PIF comprehensive, succinct, clear and accurate. Your site visitor and RRC will appreciate it.

A timetable should be established to keep this project on track. Although you will need a team to get the information together, the program director should thoroughly review the finished product and be very familiar with it. It may have been written by a committee but it should not read like it. On the day of the site visit, the program director will be expected to answer questions about the source of the information on the PIF. Ask other program directors to read the PIF and to point out areas of discrepancy or sections that are not clear. Proofing for content and for discrepancies is very important. ***Table 1*** provides some of the frequently found discrepancies in PIFs. If these or similar ones are allowed to remain in the document, correcting them will take up valuable time on the day of the site visit. If they cannot be corrected, they will present a less than optimal picture of your program to the RRC.

Two other groups who should review the document are your residents and faculty. They will be able to point out discrepancies and factual errors, but an added, potentially more significant, benefit of their having read the narrative is that they will be familiar with the description of the program on the day of the visit, and should not be stymied when the site visitor asks for the educational justification for a particular rotation.

The approximate date of the site visit is indicated in the most recent notification letter. Although it may take a year or more to do all the preparations for a site visit, program directors are notified about three months in advance of the specific date and who the site visitor will be. The time you receive the notification letter might be a good time to look up the site visitor on the web site. All but specialist site visitors are on there, and this begins to humanize the process. About 45 days before the appointed date, the site visitor will contact you with specific requests for documentation and the schedule on the day of the visit.

On the day of the visit you can anticipate that you will be asked to show certain things to the site visitor- affiliation agreements, a sample resident contract, and resident and institutional policies; written goals and objectives; sample evaluation forms, and completed evaluations for both residents and faculty; resident files; due process policies; curricula, conference schedules and attendance records; and data specific to your discipline and the supporting information for the data, among others. Have this information easily accessible.

Of the 100,000 residents in the United States, I would be

Table 1

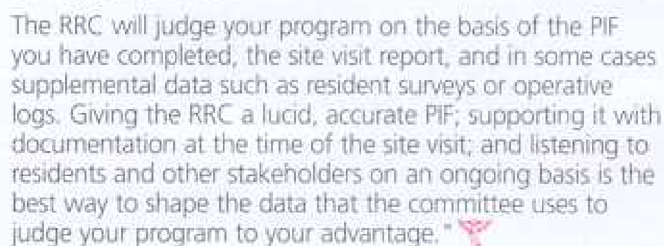
Selected Frequently Found Inconsistencies in the PIF

- Number of residents in program - *number of names on resident list*
- Months/FTEs at each institution/or specific rotation - *number of months on block diagram*
- Number of resident evaluations - *frequency of resident reviews*
- Institution referenced in narrative or block diagram but not mentioned anywhere else
- Faculty list/faculty credentials - *Faculty CVs attached to PIF*

ACGME, 1999

surprised if one-tenth knows who the ACGME is. Residents are too busy to worry about accreditation. Yet the interviews between them and the site visitor (for some specialties supplemented with a written resident survey) is a rich source of material to illuminate the program. Virtually all questions asked stem directly from the requirements. The answers are not shared with the program unless an adverse action is taken. The members of the ACGME field staff are old hands at resident interviews. Their report will reflect the consensus of what is said. If a minority of residents feel strongly about something, it will be reflected as a minority opinion. The best way to prepare your residents and yourself for the interview is to have an ongoing pattern of communication, evaluation and responsiveness.

The RRC will judge your program on the basis of the PIF you have completed, the site visit report, and in some cases supplemental data such as resident surveys or operative logs. Giving the RRC a lucid, accurate PIF; supporting it with documentation at the time of the site visit; and listening to residents and other stakeholders on an ongoing basis is the best way to shape the data that the committee uses to judge your program to your advantage."



What Happens During an ACGME Resident Interview

Ingrid Philibert

The preceding article discusses the preparations for and what transpires during an ACGME site visit. New program directors, and many seasoned ones, are curious about what happens during the ACGME resident interview. This short piece, written to complement Dr. Leach's article, offers some insight.

Any discussion of what transpires in the resident interview that is part of the ACGME site visit needs to be prefaced with two fundamental statements about the ACGME's accreditation process. First, the accreditation process assesses whether the residency education program meets the ACGME/RRC requirements. Thus, virtually all questions asked during the resident interview have their foundation directly in the requirements are in essence a translation of the requirements into a question format. Second, the role of the ACGME site surveyor is to clarify and verify the information the program has provided in the Program Information Form (PIF), and a significant portion of this corroboration occurs in the interview with the residents. Questions the site visitor asks the residents will focus on two areas: (1) area where, based on the review of the PIF, the site visitor thinks that the program may not be in compliance with the requirements; and (2) areas where he or she senses a discrepancy between what is reported in the PIF or by the program director and/or faculty, and what may actually occur. This means that beyond a small number of general questions (a limited selection is shown in ***Table 1***), the questions change for each program.

"Virtually all questions asked during the resident interview have their foundation directly in the requirements — are in essence a translation of the requirements into a question format."

At the start of the resident interview, most ACGME surveyors provide a mini-overview of the ACGME and the GME accreditation process, to put the resident interview into perspective. During the interview, the format of the questions comprises a mix of closed questions, such as "Are you aware of resident work hour rules? Does your institution abide by these rules?" and open-ended questions, such as "Please describe how your educational progress is evaluated?"

Two important 'capstone' questions, generally asked at the conclusion of the resident interview, are "What are the strengths of this residency education program?" and "What are the weaknesses of the program?" or "What could be improved about this program?" This offers residents an opportunity to comment on the program from their perspective, and can identify areas where residents have concerns that did not emerge in the review of the PIF.

For internal medicine programs (core and subspecialties),

Table 1

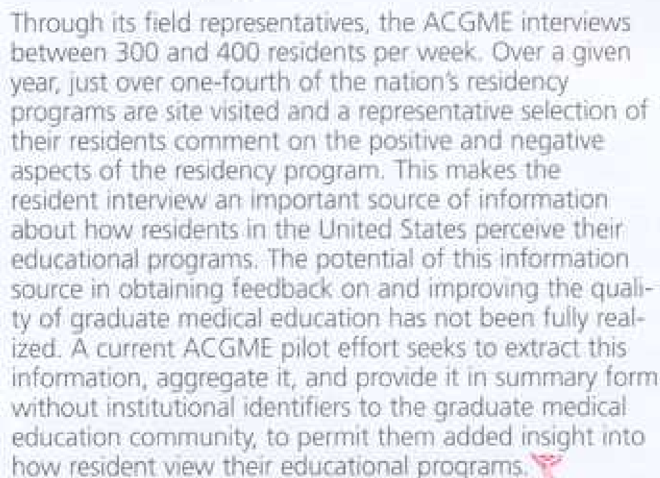
A Sampling of the Questions Posed during the ACGME Site Visit Resident Interview

- Have you seen and did you receive a copy of the program's educational goals and objectives?
- What were the reasons you chose this program?
- Do you evaluate the faculty, your rotations and the educational program? How?
- How and how often are you evaluated?
- How are you supervised? Please describe. Is this too much, too little, just right?
- If you or a colleague had stress or other difficulties, how would you get assistance? Would it be confidential?
- Please explain your call system.
- If you had to use the due process procedure, where would you find it and whom would you contact?
- How did you get selected to meet with me? Were you selected by your peers?

ACGME, 1999

use of the computer-assisted Accreditation Review (CAAR) System causes the questions asked in the interview to be focused on areas identified as potential concerns in the CAAR surveys. CAAR involves the completion of a written survey by the residents approximately 6 - 18 months prior to the actual site visit. The tabulated results are provided to the site surveyor, who uses this information to tailor the questions for the resident group (some of whom may have completed the questionnaire and some of whom may not). In addition, some 'generic' questions and the open-ended questions about programs' strengths and weaknesses are also asked.

The information shared by the residents during the interview remains confidential. The site visit report will never state the residents' names, it merely reports whether residents raised a given issue unanimously, whether a group of residents reported it, or whether a single resident or a minority made a statement. Confidentiality is important, because it enables the residents to comment frankly on their educational program.



Through its field representatives, the ACGME interviews between 300 and 400 residents per week. Over a given year, just over one-fourth of the nation's residency programs are site visited and a representative selection of their residents comment on the positive and negative aspects of the residency program. This makes the resident interview an important source of information about how residents in the United States perceive their educational programs. The potential of this information source in obtaining feedback on and improving the quality of graduate medical education has not been fully realized. A current ACGME pilot effort seeks to extract this information, aggregate it, and provide it in summary form without institutional identifiers to the graduate medical education community, to permit them added insight into how resident view their educational programs.

Creating a Capacity for Positive Change - One Family Practice Residency Program's Use of Appreciate Inquiry

Interview with Diana Whitney, Ph.D. and Richard McClaflin, M.D.

Ingrid Philibert

The University of Wisconsin (Eau Claire) Family Practice residency program is working with Diana Whitney, Ph.D., President of the Corporation for Positive Change, to use Appreciative Inquiry for an in-depth assessment of the program. Richard McClaflin, M.D., the program director, and Dr. Whitney were interviewed for this article. It offers an early view of the use of this technique as a tool for assessing the residency's strengths and areas that need improvement.

How did you decide to use Appreciative Inquiry?

Richard McClaflin, M.D.: When I came to the program a little over a year ago, two things immediately became clear. The program had a wonderfully talented, dedicated faculty and bright, hard-working residents. At the same time, partly due to recent faculty turnover, these individuals had not developed a strong group identity. I felt a need to find the glue that would bring them together with a shared sense of organizational purpose.

Our program's psychologist and dietician were working with a counseling technique called Solution Focused Therapy, to which both patients and residents seemed to relate well. In their readings, they discovered the Organizational Development equivalent to this technique, called Appreciative Inquiry.

What is Appreciative Inquiry and how was it used to assess the Eau Clair Family Practice residency?

Diana Whitney, Ph.D.: Appreciative Inquiry (AI) in an organizational setting starts with the formation of a core team trained in AI, who selects the topics for study and creates an inquiry protocol and strategy. The team may also design the inquiry strategy - who will be interviewed by whom, and over what period of time.

Our process for AI is called the 4-D Model. It involves Discovery, Dream, Design, and Destiny. They are described in more detail in ***Figure 1***.

Figure 1

The 4-D Model for Appreciative Inquiry

Discovery - the mass mobilization of inquiry to surface stories of positive capacity throughout the system.

Dream - envisioning possible futures, ways in which the organization can better serve its stakeholders and the world.

Design - crafting a desired organization to achieve the most lofty vision imaginable.

Destiny - sustaining a positive, narrative rich culture that supports high performance and maintains organization agility.

Corporation for Positive Change, 1999

What did you expect to achieve through the use of AI?

Dr. McClaflin: The project at the Eau Claire family practice residency started as an initiative to strengthen the orientation process for new residency. But when we introduced the ideas to a group of residents and staff, they unanimously decided to bring it to the entire Eau Claire Family Medicine Clinic. Our primary goals were to learn about more about who we are as a residency program and a group of individuals; to begin a strategic planning process; and to find a way to increase the involvement of all stakeholders in decision-making related to the program.

Secondary goals included our interest in learning a new process for strategic planning and quality improvement. We also wanted to develop an interview guide that would expand the depth and breadth of our resident selection process.

Who was involved and how was this group selected?

Dr. McClaflin: We decided to involve a broad group of individuals to ensure that major stakeholders would be represented, including our patients. Participants included the department chair, the director of the family practice residency, the education coordinator, the business manager and the nursing leadership. The group included representatives for the residents, the faculty, the clinic's clinical and clerical staff, and representatives for the patients and the community. In selecting staff, it was important to have participation from administrative and non-administrative staff, and to include the residents and faculty. At the same time, we needed to keep the group size reasonable, and meetings had to be scheduled in a way to minimize disruption to clinic schedules and resident rotations.

What information resulted from the use of AI?

Dr. McClaflin: Through the use of AI, individuals shared their thoughts and ideas about the residency program. What emerged immediately was the participants' joy in their work, the residents' joy in learning, and the joy that came from everyone's role in caring for people. The results also showed the potential of AI to help people see what they are doing each day in a different light.

We think our initial experience has been a success. Based on this, we have decided to move forward with a broader initiative that will use AI to improve the residency program. It will involve all clinic employees, and comprehensive interviews with community partners and stakeholders. While it is too early to tell how the findings will ultimately change the residency program, there are early, gratifying discoveries. One, which came as a surprise, is how excited participants became when, through AI, they learned new things about individuals they had worked with for years - including their shared commitment to the success of the residency.

What can organizations hope to accomplish by using AI?

Dr. Whitney: AI can be used to facilitate systemic culture change, for resource-based strategic planning, to enhance employee engagement and morale, and to improve customer service. For example, GTE won the American Society for Training and Development Award for the best organization change initiative as a result of its AI efforts. GTE and Hunter Douglas have seen measurable improvement in employee satisfaction and retention as a result of AI.

How does AI effect positive change?

Dr. Whitney: In our experience, human systems - people and organizations - move in the direction of what they study. Most approaches to organizational development are problem-focused. They encourage study and a dialogue about what is not working. Deficit models of change also tend to look backward, they assess blame, and they can be divisive. AI creates a capacity for positive change that involves discovery and a dialogue about what gives life to the organization when it is at its best in economic, ecological and human terms. AI-based organizational change fosters cooperation and understanding, and focuses the entire organization in a common direction.

Will the information gained through the use of AI be used in the program's internal review? Could the AI process be a viable approach to meet the ACGME's internal review requirement?

Dr. McClaflin: We did not have internal review or the GME accreditation process in mind when we decided to use AI. A potential constraint to our use of AI may be our interpretation of the ACGME's internal review process, which we see as primarily focused on program weaknesses. AI is more oriented toward identifying and building on positive aspects of the program. As I think about it further, I can see some applicability, but it would require a more liberal interpretation of the internal review.

What else do you think is noteworthy about the use of AI in this setting? How does the information shared compare with other organizations where you have applied AI?

Dr. McClaflin: AI encourages positive conversations among groups that typically do not directly interact within a residency program. It can be a powerful tool that enables disparate constituencies to see shared aspirations and goals. It can promote real input and understanding at all levels of an organization.

Dr. Whitney: This is my first time working with a residency education program. In general, AI is particularly useful

in situations of high complexity and high uncertainty. Graduate medical education is such a situation. Residents are there to learn; at the same time they must successfully serve the community of patients.

What have you learned about residency education - as an expert on AI, and as a consumer of health care?

Dr. Whitney: I have learned that learning and patient service are inseparable. In addition, the relationships among the university, the community, the medical staff and the administrative staff at times may seem like relationships among foreign nations. AI is a highly participatory process which helps build relationships, goodwill and learning. It enables the whole system - all employees, patients, residents, providers and insurers - to come together and dialogue about images and actualities for a better future.

As a result of my work with this program, I have a strong sense of confidence in the future of family practice. I have met a group of people who successfully balance the need for caring, compassionate service and education with the capacities of advanced technology and medical innovation. They are dedicated to understanding what "good medicine" means from the patients' perspective, while at the same time facilitating learning and applying the best of current medical knowledge.

How can AI assist a residency education program in preparing the next generation of family physicians?

Dr. Whitney: It is my hope that AI will help the graduates of the residency program remember their calling – why they chose family practice. It will assist the program in focusing the positive capacities of its residents, faculty and staff on serving the community of Eau Claire and to attract and develop some of the country's best family practice doctors.

Diana Whitney, Ph.D. *is the President, and one of the two founders of the Corporation for Positive Change She has taught AI and has consulted to organizations in all sectors, including British Airways, GTE, the National Board of Medical Examiners, and Smithkline Beecham. Dr. Whitney lives in Taos, NM. She may be contacted at 505/751-1231 (voice); 505/751-1233 (fax).*

Richard McClaflin, M.D. *is the director of the University of Wisconsin (Eau Claire) Family Practice residency program in Eau Claire, Wisconsin.*

What Does the RRC "Really" Look for When They Review Your Program?

Doris Stoll, Ph.D.

The information for this article was developed from a survey of the RRC Executive Directors on what RRCs consider important in their review of a given residency education program. The concept that emerged was the following: Since many of the key accreditation criteria are similar across Program Requirements in the various specialties, why not build upon the commonalities instead of focusing on the differences? This articles addresses what the author chose to call the "big ticket items" common criteria that all RRCs evaluate as they review a program.

The Educational Program

Questions that concern the educational program include the following: Are good teaching and learning occurring? Are goals and objectives documented and distributed to residents and faculty? Do they reflect what the program expects that residents will learn for all aspects of the program, including each major clinical assignment and each of the years of the program? Has the faculty developed a series of conferences that reflect the breadth of specialty knowledge?

Since residents are adults, it is an expectation that they will devote a part of their learning activities to self-directed study and exploration. At the same time, formal and varied educational sessions planned by the faculty should complement these activities. Do the faculty and residents attend these sessions, actively participate in discussions, and present? When an RRC reviewer evaluates the implementation of a program curriculum, the key elements that he or she will focus on are the following: Are academic conferences scheduled and planned? Does entry-level content precede advanced information? Is academic information sequenced to precede clinical assignments? Are multiple teaching methods available? Are more than a sole faculty member or the residents themselves are responsible for teaching? Is specialty-specific content covered in depth? Finally, a critical element, important to the teaching-learning process, is the expectation that the faculty reinforces academic learning through resident and patient-centered clinical conferences.

Faculty

A series of characteristics that RRCs consider in the review of programs relate to the program's faculty: Are there sufficient and qualified faculty to support the teaching-learning process? Do these faculty members serve as role models for the positive professional attributes of inquiry and zest for learning? To evaluate this important area,

some specialties have stated minimum faculty/resident ratios, while others evaluate sufficiency based upon indirect methods. The number of faculty members is not necessarily a judge of sufficiency if the faculty is not engaged in the educational process. The quality and constancy of the interactions with the faculty is really what is being judged. For example, are residents supervised appropriate to their level in the program and the complexity of the assignment? Do residents actively participate in the care of the faculty members' patients? Does the faculty strike the appropriate balance of being available versus being in attendance? Does the faculty keep current by participating actively in their own continuing education and professional improvement? Are faculty members actively involved in scholarly activities?

There should be not teaching without the patient for a text, and the best teaching is that taught by the patient himself.

Sir William Osler

Educational Resources

All specialties in different ways require accurate documentation that a sufficient volume, variety, and breadth of clinical experiences is available for the education of the residents. In some specialties, this criterion is evaluated by collecting data on the numbers of patients, in others the terms "meaningful, diverse, quality, balance, and experience across the spectrum of the specialty" are used to describe the patient populations necessary for resident learning.

Too much or too little volume of both inpatient and ambulatory clinical experience is always a targeted area for focused evaluation. The capabilities of the sponsoring and participating institutions to provide residents with a variety of clinical experiences and to assign experiences at the appropriate level for individual resident are key elements of the review. Also scrutinized are the spectrum and variety of diagnoses and experiences available for resident assignments. Do residents see too many patients in some categories and too few in other key areas of practice?

Assessment of Educational Quality

Another element of the review assesses the ability of the program's leadership to evaluate the quality of the education the program provides. RRCs require four basic evaluations: the residents' evaluation of the program and the faculty; the faculty's evaluation of the program; the evaluation of the resident's performance and educational progress; and the internal review of the program by the institution at the midpoint of the accreditation cycle. The capability of the program director and faculty to engage in meaningful exchange about the program's strengths and weaknesses, and about areas needing improvement, is central to the evaluation process. Does the faculty meet routinely and at least annually to discuss the program? Has the educational effectiveness of the curriculum and the teaching-learning environment been discussed? Has a mechanism been implemented for residents to evaluate the quality of their program and are they assured of freedom from retribution in this process?

Questions related to the assessment of educational quality include the following: Is each resident evaluated at least semiannually, in writing, and informed of the results of his or her evaluations and is the evaluation discussed with the resident? Is this meeting documented by the resident's signature on this evaluation? Are residents with learning problems monitored, evaluated, and counseled more frequently? Has the Graduate Medical Education Committee reviewed the program? Another important aspect is what the program does with the results of the evaluation. Does the evaluation loop get closed? That is, does the program director act upon the identified areas of concern? Have improvements to the program been made and has the impact of these improvements been documented? The evaluation system implemented by a program does not need to be tedious or overly bureaucratic, but it should reflect the faculty's interest in identifying areas for improvement, and it should help the faculty, residents and program to enhance the quality of education, with the goal of facilitating the education of competent physicians.

The 'Educational Climate' of the Residency Program

To assess this area, the RRC asks: What are the criteria that impact directly on the resident-learners? The first criterion in this area involves resident work hours. Are residents assigned to no more than eighty duty hours per week, take call no more often than every third night in-house, and have an average of at least one day in seven free from hospital duties? Is there evidence that the program strikes a balance between service expected from the residents, and the quantity and quality of time residents are able to devote to their education? Do the residents have back-up support when patient care responsibilities are prolonged or exhausting? Do the clinical assignments progress from the simple to the complex, and are these assignments based upon their educational needs and their experience? Do the residents receive experiences in the breath of patient care experiences so that they can practice competently when they graduate?

When an RRC critically evaluates this area, the review focuses on documentation of fair and appropriate work hours, quality of assignments, the progression of resident experiences, and the continuity of patient care experiences.

In assessing whether the institution provides what is necessary to develop and maintain an educational effort, the issue of institutional support goes beyond the dollars and the associated accoutrements of computers, offices,

> **"For good education to occur, an overall commitment to the educational process must be evident."**

and the like. An overarching expectation for quality education is the "professional feel" or the "milieu" in which the programs exist. While most program directors interpret this area as the basic "what is provided as means of support to their program," this part of the evaluation is aimed at more than tangibles. For good education to occur, an overall commitment to the educational process must be evident. This commitment is superordinate to the age of the physical plant and the need for more library books. We all know that education cannot occur when the basics are not available. These program basics for education do not have the be world-class, but they must be sufficient.

A discussion of the educational climate is a good way to conclude a summary of what RRCs look for when they evaluate a residency education program. When good education is occurring, a feel and an excitement pervade the organization. This is the most accurate reflection of the institutional commitment to education. When an RRC actively discusses what accreditation action should be made in the case of a given residency program, more often than not, a key element to the final decision is just this issue, the educational milieu that has been transmitted through the program information form and the site visit report.

ACGME Takes Part in International GME Quality Assessment Activities and Conferences

Judith Armbruster, Ph.D.

Activities of the Royal College of Physicians of Canada

For the last seven years, the ACGME and The Royal College of Physicians of Canada have enjoyed reciprocal observer status at the regular meetings of the accrediting bodies of both countries. Most recently, ACGME staff attended the annual meeting of the Royal College, held in Montreal in September 1999. Of special interest was a one-day workshop for new program directors that introduced the newcomers to the accreditation process by putting them in the role of an Accreditation Committee member (the Canadian equivalent of a Residency Review Committee). The attendees worked in small groups with a blinded PIF and survey report (not in their own specialty). Using this information, they discussed the program's compliance with the requirements and recommended an accreditation action, to be compared later with the action of record. This hands-on introduction works well for Canada, where the number of programs, and new directors, is so much smaller than in the United States.

Association for Medical Education in Europe (AMEE)

ACGME staff also attended a meeting of the Association for Medical Education in Europe (AMEE), in Linkoping, Sweden. This organization has grown well beyond Europe: the conference was attended by medical educators from 47 countries.

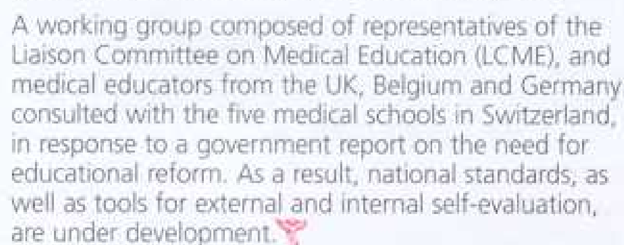
The Linkoping Faculty of Health Sciences is itself a center for innovation in medical education. The medical school and residencies are driven by problem-based and small group learning and multi-professional teamwork. Much attention is paid to communication skills, with videotaping and analysis of patient encounters throughout the training continuum. In Sweden, there seems to be general interest in moving away from traditional teaching methods in a number of educational venues. The Swedish government recently completed a study of teaching quality in the universities and declared that the deans will not receive funding if steps for faculty development to improve the educational program are not taken.

It is perhaps not surprising that the educational preoccupations of other countries are very similar to those in the United States. The workshops at the Linkoping conference covered topics such as defining good supervision developing an evidence-based curriculum that integrates competencies and new technology, and the role of simulated patients in the acquisition of clinical competencies. A majority of the sessions and workshops were, in fact, devoted to the very competencies and the outcome-assessment approach that the ACGME approved in February 1999 (also see "ACGME Approves Incorporation of General Competencies into Program Requirements Language" on page 10 of this issue of the *ACGME Bulletin*). For example, in the UK, the Royal College of Paediatrics is developing assessment strategies for residents using competence-based methods. In Norway, the medical faculty at the University of Oslo has introduced a completely revised and innovative curriculum focused on problem-based learning involving strategies for outcome evaluation. The University of Dundee has defined 12 broad learning outcomes for their residency curricula. Despite the differences among countries in the structuring and oversight for residency training, there are many shared strategies for innovation and improvement.

Status reports were also given at the AMEE conference on medical school accreditation in Mexico and Switzerland. Mexico is in the process of organizing an accreditation system for its 63 medical schools. To assure ownership of the system by the schools, it has been considered crucial to involve them directly in the process, rather than adopting the process used by the Liaison Committee on Medical Education (LCME) whole cloth. Accreditation

standards have now been developed and agreed to by the schools. The oversight process has been in operation for two years and is run by the Association of Medical Schools of Mexico. Fifteen schools have been accredited and another 15 are expected to achieve accreditation in the next two years. The Ministry of Health withholds facilities and resources from unaccredited schools that have not at least initiated the application process.

A working group composed of representatives of the Liaison Committee on Medical Education (LCME), and medical educators from the UK, Belgium and Germany consulted with the five medical schools in Switzerland, in response to a government report on the need for educational reform. As a result, national standards, as well as tools for external and internal self-evaluation, are under development.



Cultural Competence Requirements in GME

Fred Donini-Lenhoff, American Medical Association

In response to an item in the May 1999 AMA Graduate Medical Education Bulletin, a number of residency programs, many of them in primary care specialties, have indicated to the American Medical Association that they cover cultural competence issues in their didactic and clinical education and experience.

The program requirements of the Accreditation Council for Graduate Medical Education (ACGME) Program Requirements contain varying levels of specificity for cultural competence instruction. Family practice guidelines, for example, require instruction in "[s]ensitivity to gender, race, age, sexual orientation, and cultural differences in patients" (V.A.D.1.j.). The requirements for Pediatrics state that curricula should include "[c]ommunity-oriented care with focus on the health needs of all children within a community, particularly underserved populations" and "[t]he multicultural dimensions of health care" (V.B.5.a.,b.).

Of all specialties, psychiatry appears to have the most explicit requirements for education in cultural competence: "The residency program should provide its residents with instruction about American culture and subcultures, particularly those found in the patient community associated with the training program. This instruction should include such issues as sex, race, ethnicity, religion/spirituality, and sexual orientation. Many physicians may not be sufficiently familiar with attitudes, values, and social norms prevalent among various groups of contemporary Americans" (V.B.2.d.).

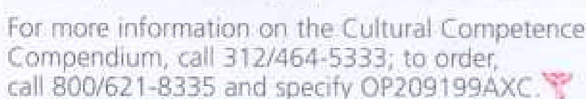
As shown in the AMA's newly published Cultural Competence Compendium, a 460-page resource guide, the specialty societies for psychiatry also have produced a relatively large number of model curricula. The American Psychiatric Association, for example, has published four different psychiatry residency curricula in its journal Academic Psychiatry. These curricula emphasize the special health care needs of Hispanics, American Indians and Alaska Natives, homosexuals, and women. Two additional curricula, for the care of African-Americans and Asians, are planned.

Other cultural competence highlights:

- The ACGME's 'General Competencies' document (see page 11 in this issue of the *ACGME Bulletin*) proposes that all resident physicians and fellows learn to "communicate effectively and demonstrate caring and respectful behaviors when interacting with patients" and "demonstrate sensitivity and responsiveness to cultural differences, including awareness of their own and their patients' cultural perspectives."
- The AMA's 1999 Annual Survey of GME Programs includes a new question to ascertain programs' cultural competence activities.
- Michael J. Scotti, Jr., MD, Vice President of Medical Education for the AMA, has spoken at national conferences of the need to incorporate the "fifth competence" cultural competence into curricula across the medical education continuum, to complement the four existing competencies (cognitive, technical, behavioral, and managerial).

The concept of cultural competence education in residency education appears to be growing. As patients in our increasingly diverse nation begin to expect care that respects their multiple cultural influences, physicians will be motivated to learn how to deliver culturally appropriate care. As accrediting agencies and specialty societies begin to monitor instruction in cultural competence and gauge that instruction's outcomes, the "fifth competence" will take its place as an integral part of health care.

For more information on the Cultural Competence Compendium, call 312/464-5333; to order, call 800/621-8335 and specify OP209199AXC.



"As patients in our increasingly diverse nation begin to expect care that respects their multiple cultural influences, physicians will be motivated to learn how to deliver culturally appropriate care."

Highlights from the September 1999 ACGME Meeting

Invitational Conference on Destabilizing Forces in GME

The September meeting of the Accreditation Council was preceded by an invitational planning conference that brought together 20 renowned individuals with broad expertise and understanding of graduate medical education (GME), its processes and the setting in which it occurs. This group met to discuss how aspects of the current environment appear to have a destabilizing influence on GME. Factors examined included changes in the financing of residency education; faculty availability and the reward systems for teaching and supervision; and the patient populations receiving care at teaching institutions. In addition to these factors within the teaching hospital community, the group concluded that changes in the larger external environment for health care, including continued growth in scientific knowledge, the disclosure of the Human Genome, and the use of advanced computing capabilities in all aspects of health care, including medical education, contribute to the destabilizing effect.

The group sought to identify ways to counteract the impact of these forces. Among the approaches suggested was a Request for Proposal (RFP) Process to promote new linkages and innovative approaches to improve the quality of residency education. Potential areas for the application of RFPs include investigating the relationship between excellence in patient care and excellence in GME; organizational models that would give residents a voice on matters important to their education; and the use of outcomes measures in improving the educational process. Through these RFPs, individual programs and institutions will be encouraged to develop new programs, efforts and linkages to ensure the success of their GME programs in the current environment. One aim of the RFP process is to foster innovation in GME via the accreditation process.

The discussions and findings of the two-day planning conference will be developed into proceedings that will be published by the ACGME. In addition, on March 4 and 5, 2000, the ACGME will hold a conference, entitled "Good Learning for Good Healthcare" that will expand upon the work of the planning conference.

Retreat for RRC Council of Chairs and ACGME Field Staff

Sunday, September 26th was devoted to a full-day retreat for the RRC Council of Chairs with the ACGME field staff. The goal of the retreat was to increase communication between the two groups about issues relevant to both, including efforts to enhance the quality of the information used in the accreditation process and how to ensure effective communication between the two groups.

Subscription Model for Financing GME Accreditation

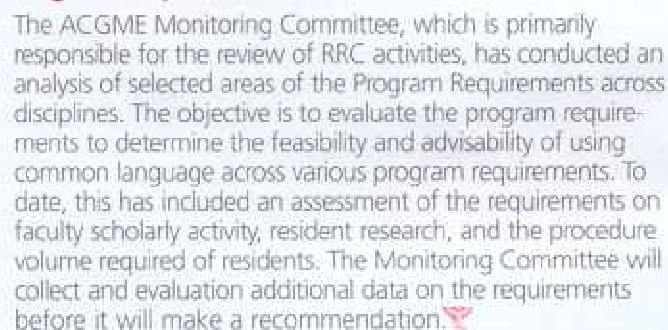
The budget for fiscal year 2000, which was approved by the ACGME at its September meeting, incorporates a significant change in the way the ACGME charges programs and institutions for the cost of its accreditation activities. Effective January 1, 2000, the methodology for charging, which is presently based on a fee for each site visit and an annual fee based on the institution's number of residents, will be discontinued and replaced with an annual fee for each accredited program, under a 'subscription' model (described in more detail in *"ACGME Changes System for Assessing Fees for Accredited Programs"* on page 11 of this issue of the ***ACGME Bulletin).***

ACGME Approves Incorporation of General Competencies into Program Requirements Language

On September 28, 1999, the ACGME resolved that all Residency Review Committees (RRCs) should incorporate the six General Competencies approved by the ACGME in February 1999 into their Program Requirements. The six general competencies represent an important step toward the implementation of outcomes-based accreditation. The competencies have been developed over the past two years by the ACGME with broad input from the GME community. They encompass patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice. The proposed minimum language for inclusion in the Program Requirements is shown in ***Exhibit 1*** on page 11.

To correspond to the language used by the American Board of Medical Specialties (ABMS) for the physician competencies used in the Board certification and recertification process, the competency formerly termed 'Clinical Science' was renamed 'Medical Knowledge.' The incorporation of the general competencies into the Program Requirements language is scheduled for completion by June 30, 2001. Next steps include the phase-in of the competencies and the development of evaluation methods and tools. Application of the general competencies to the accreditation of residency education programs is scheduled to be completed by June 30, 2006.

Monitoring Committee Analyzes Language in the Program Requirements



The ACGME Monitoring Committee, which is primarily responsible for the review of RRC activities, has conducted an analysis of selected areas of the Program Requirements across disciplines. The objective is to evaluate the program requirements to determine the feasibility and advisability of using common language across various program requirements. To date, this has included an assessment of the requirements on faculty scholarly activity, resident research, and the procedure volume required of residents. The Monitoring Committee will collect and evaluation additional data on the requirements before it will make a recommendation.

Exhibit 1
ACGME General Competencies
(Minimum Program Requirements Language)

IV. Educational Program

The residency program must require its residents to obtain competencies in the six areas below to the level expected of a new practitioner. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate:

a. Patient Care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health;

b. Medical Knowledge about established and evolving biomedical, clinical, and cognate (e.g., epidemiological and social-behavioral) sciences and the application of this knowledge to patient care;

c. Practice-Based Learning and Improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care;

d. Interpersonal and Communication Skills that result in effective information exchange and teaming with patients, their families, and other health professionals;

e. Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population;

f. Systems-Based Practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

V. Evaluation

A. Evaluation of Residents

The residency program must demonstrate that it has an effective plan for assessing resident performance throughout the program and for utilizing assessment results to improve resident performance. This plan should include:

1. use of dependable measures to assess residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;
2. mechanisms for providing regular and timely performance feedback to residents;
3. a process involving use of assessment results to achieve progressive improvements in residents' competence and performance.

Programs that do not have a set of measures in place must develop a plan for improving their evaluations and must demonstrate progress in implementing the plan.

B. Program Evaluation

1. The residency program should use resident performance and outcome assessment results in their evaluation of the educational effectiveness of the residency program.
2. The residency program should have in place a process for using resident and performance assessment results together with other program evaluation results to improve the residency program.

ACGME, 1999

ACGME Changes System for Assessing Fees for Accredited Programs

John Nylen

At its September 1999 meeting, the ACGME Board approved a new methodology for assessing the accreditation fees for all ACGME accredited programs, which will become effective January 1, 2000. The new approach eliminates the annual Resident Fee, as well as the fee associated with the Site Visit, and replaces them with an annual Accreditation Fee for every program. The accreditation fee will be assessed each January 1 and will cover the academic year (e.g., the period from the prior July 1 to the following June 30). This fee structure, defined as a subscription model, will allow the ACGME to continue to increase and improve the services provided to every program.

For historical perspective, it worth noting that since its creation in 1979, the ACGME has relied on two main fees — the site visit fee and the annual resident fee — to cover the costs of accreditation. Over the past several years, the ACGME has evolved into an organization that provides more than the processing of program information forms and accreditation decision letters. Increasingly, additional services and information are being requested by Residency Review Committees and training programs. In response, operative logs, program director training sessions, an Internet presence, and program consultation services have been or are being developed to provide products and services beyond that of processing the accreditation decisions.

RRC UPDATE COLUMN

ACGME Approves Changes in Program Requirements and Revises the Manual of Policy and Procedures

At its September 1999 meeting, the ACGME approved several important revisions in the Program Requirements and the Manual of Policy and Procedures for GME Review Committees. These changes are highlighted here and selected ones are discussed in more detail below.

- *Change in Program Requirements for Pediatrics Subspecialties* Revised Program Requirements for the Subspecialties of Pediatrics will become effective on July 1, 2000. The revised language will become available on the ACGME's web site (http://www.acgme.org) after December 1, 1999.
- *Change in Internal Medicine Requirements Related to the Board Examination*
The Program Requirements for Internal Medicine were revised to raise the pass rate for program graduates on the American Board of Internal Medicine from 50 percent to 60 percent for first-time takers, and to raise the percentage of graduates taking the exam from 75 percent to 80 percent.
- *Revisions in the Manual of Policy and Procedures for RRC Review: Language Regarding Notification of Program Changes and Board "Equivalency" for Program Directors*
A number of revisions are being made to the Manual of Policy and Procedures for RRC Review to bring the policy statements in line with present practice, particularly with regard to preparing and revising Program Requirements. The revised manual is presented on the ACGME web site (http://www.acgme.org) for review and comment by interested parties. Comment must be made in the next 60 days and may be made electronically.

  One of the changes in the Manual of Policies and Procedures will clarify the requirement for notification of the Executive Director of the RRC or the Institutional Review Committee (IRC) of changes in the educational program. The proposed change is discussed in more detail below. In another change to the Manual, the language on the qualifications of program directors and faculty is being revised to eliminate the words "suitable equivalent qualifications" and substituted the phrase "appropriate educational qualifications as determined by the RRC" as an alternative to Board certification in the requirement for program directors and teaching staff.
- *ACGME Creates "Inactive Program" Status*
A new ACGME status category, "Inactive Program," which will become available on January 1, 2000, recognizes that some programs may not have any residents in them in a given year. The new status category provides an alternative to voluntary withdrawal for programs that do not have any residents training in them.

(continued from page 11)

In addition, rather than interacting with the ACGME only at the time of the site visit, most programs utilize one or more of these services throughout the year. This trend is expected to continue and become more prominent as the Council's accreditation activities shift to an outcomes-based model.

Changing to a subscription model offered an equitable way to reflect this increase in services and their more ongoing, 'year-round' nature. An added benefit is that once fees are stabilized, the plan is to have no increases for three years, as all programs will share in the cost of accreditation, not merely those having a site visit in a given year. This new fee structure will enable the ACGME to stabilize fees over a number of years rather than have yearly increases in fees.

The fees for ACGME accredited programs fiscal year 2000 will be:

Programs with more than five (5) residents:	$2,500
Programs with five (5) residents or less:	$2,000

This fee structure, defined as a subscription model, will allow the ACGME to continue to increase and improve the services provided to every program. Because the ACGME recognizes that institution may be in the middle of their fiscal year and were not able to budget for this 'mid-year' change in charge structure, for Year 2000 fees only, institutions may opt to make four equal payment over the year in lieu of the full payment due January 31, 2000.

Table 1 shows a financial comparison between the current fee structure and the subscription model. The current average length of the accreditation cycle for all programs is slightly longer than three years. The analysis assumes a program with a three-year accreditation cycle. Accreditation site visits occur in the year 2000 and then again in 2003. If the current model were continued, fees would increase with inflation, estimated annually at 3 percent.

It is important to note that there are different subscription fees for programs with fewer than five residents than

RRC/IRC Notification of Program Changes

To clarify the requirement for notification of the ACGME of major changes in the program or spon-soring institution, the following new language was inserted into the ACGME Manual of Policy and Procedures:

- The Executive Director of the relevant RRC/IRC must be notified promptly of any major changes in the organization of the program, including changes in program directors, institutional sponsorship, loss of significant resources (including key faculty), or discontinuation of rotations to participating institutions. Since the complement of residents in a program must be commensurate with the total capacity of the program to offer each resident an educational experience consistent with accreditation standards, any change in the total number of resi dents in the training program must be reported to the RRC Executive Director as well.
- Each program must provide accurate and complete data on various aspects of the program as required for the ACGME to fulfill its public responsibilities.

This language provides much-needed clarification in the requirement that the ACGME must be notified of major changes in the program, until now stated only in the ACGME letter of notification a without specific explanation of the types of changes that should be reported. Programs generally have notified the RRCs about changes in program director, significant relocation of training among affiliated sites and the addition or deletion of major affiliated institutions. At the same time, there has been less uniformity in how this requirement is interpreted to apply to major changes in faculty complement, or to institutional changes such as mergers, closure or relocation of facilities, and changes in ownership and control.

The RRCs have required and will continue to require prior notice and approval of changes that impact the educational program, including changes in major affiliated institutions and changes at these institutions in resident complement, both increases and decreases. If an institution or program has a question on whether notification of the ACGME/RRC is indicated in a given set of circumstances, it is generally advisable to contact the Executive Director of the RRC for situations where changes are made that impact the program's educational resources, including changes in affiliated institutions and changes in sponsorship. Information and questions about institutional changes, such as mergers; changes in ownership; closures of facilities and similar major changes in the program should be directed to the Executive Director of the Institutional Review Committee or to the Director of Director of Field Staff Activities, who also maintains the ACGME's institutional database.

(continued from page 12)

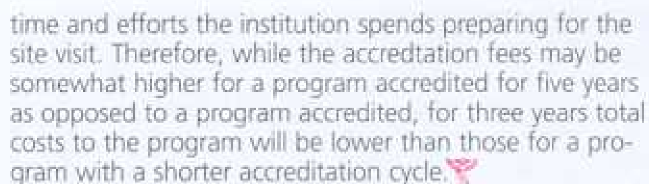
those with more than five residents. As shown in the example in ***Table 1***, the program with one resident will pay more over the four years, but only approximately $1,000, or $250 per year. The programs with more residents incur less expense over the four-year period.

It is evident that small programs on five-year site visit cycles under the new model will have accreditation fees somewhat higher than what they would have been under a continuation of the old financing approach. It needs to be noted, however, that the major cost to a program or an institution is not the fees charged for the ACGME's accreditation activities, but the cost associated with the

Table 1

	2000	2001	2002	2003	Sub-Total	Total Cost After 4 Years (Site Visit + Resident Fees)
Current Fee Structure						
Site Visit Fee	$3,350	$3,650				
Resident Fee	$ 55	$ 56	$ 57	$ 59		
1 Resident + 2 Site Visits	$ 55	$ 56	$ 57	$ 59	$ 227	$ 7,227
13 Residents + 2 Site Visits	$ 715	$ 728	$ 741	$ 767	$ 2,951	$ 9,951
50 Residents + 2 Site Visits	$2,750	$2,800	$2,850	$2,950	$11,350	$18,350
Proposed Fee Structure						
Fewer than five Residents	$2,000	$2,000	$2,000	$2,250		$ 8,250
Five or more Residents	$2,500	$2,500	$2,500	$2,750		$10,250

ACGME 1999



time and efforts the institution spends preparing for the site visit. Therefore, while the accredtation fees may be somewhat higher for a program accredited for five years as opposed to a program accredited, for three years total costs to the program will be lower than those for a program with a shorter accreditation cycle.

ACGME Launches Effort to Improve the Site Visit Experience

Ingrid Philibert

The agendas of both the September 26 retreat for the Council of RRC Chairs and the ACGME field staff and the recent meeting of the ACGME Committee on Strategic Initiatives included discussions of how to improve the information collected during the accreditation site visit as well as the actual site visit experience. These discussions provide the foundation for future ACGME initiatives to enhance the site visit. Several efforts in this area are already underway, and are described in this article.

Evaluating the Site Visit Experience

The ACGME has traditionally sent a one-page written questionnaire to each program that had an accreditation site visit in the prior month. This survey has a response rate of 85 to 90 percent. This year, the instrument will be revised to offer the field representatives more information on how to improve the site visit experience from the program's perspective. In addition, a survey of the RRC reviewers for each program, which has been conducted for a number of years and has a response rate of approximately 75 percent, is also being revised to collect more detailed information about how the site visit report could be made more informative and useful for the RRC review. The revision of both instruments will be concluded in January 2000.

Spot Telephone Interviews of Program Directors

In August 1999, the ACGME's Department of Field Staff Activities initiated spot telephone interviews of program directors following a site visits. Program directors are selected randomly from among those surveyed the preceding months. The goal is to interview an annual sample of programs for each of the 19 members of the ACGME field staff. For each field representative, three to four recently-surveyed programs will be contacted. The information will be used along with the data from the written surveys of program directors and RRC reviewers to enhance the feedback provided to the site visitor and, through this, the performance of the site surveyor.

As part of its ongoing initiative to improve the site visit experience and the value of the information collected as part of the accreditation process, the ACGME welcomes

your suggestions for how the accreditation site visit could be made as valuable and meaningful for programs as possible. Please provide them to Ingrid Philibert, Director, Field Staff Activities, via electronic mail to iphilibert@acgme.org, via telephone to 312/464-4948, or via FACSIMILE to 312/464-4098.

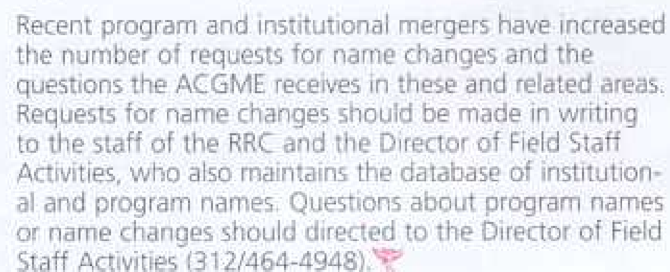
How an ACGME-Accredited Program Gets its Name

Ingrid Philibert

Annually, between October and December, a reconciliation occurs between the databases of the ACGME and the American Medical Association (AMA). The reconciliation eliminates differences in programs and sponsoring and participating institutions listed in the ACGME's database and the data used to produce the AMA Graduate Medical Education Directory, commonly known as the 'Green Book.' Each year, a number of programs have questions about this process. The summary presented here is intended to answer some frequently asked questions.

The program name published in the Green Book is the ACGME-established 'official' name. Information about name changes received by either organization are forwarded to the other. When a request for a name change does not conform to the ACGME's naming conventions, detailed in the next paragraph, ACGME staff will contact the program to discuss options.

The ACGME's naming conventions stipulate that all programs at a given sponsoring institution have the same name, and that the specialty is not featured. Thus, the programs in family practice program and surgery at St. Luke's Hospital are both the St. Luke's Hospital Program. Exceptions to this rule can be made when significant portions of the education occur in another institution, and the sponsor agrees that the name should reflect this, e.g., the Holy Name University (Children's Medical Center) Program. Some programs identify a medical school and a clinical institution, such as the Holy Name University/Memorial Hospital Program. Finally, some programs are sponsored by non-hospital entities, and their name generally uses the name of the sponsor, e.g., the Greater City Coroners Office Program.



Recent program and institutional mergers have increased the number of requests for name changes and the questions the ACGME receives in these and related areas. Requests for name changes should be made in writing to the staff of the RRC and the Director of Field Staff Activities, who also maintains the database of institutional and program names. Questions about program names or name changes should directed to the Director of Field Staff Activities (312/464-4948).

ACGME *Letter to the Editor:*

The Impact of Abrupt Closures

In the July 1999 ACGME Bulletin, the editorial "Abrupt Closures of Residency Education Programs - What is at Stake" presented a clear, concise summary of a complex and growing problem. As the Department Chairman and Program Director of the Internal Medicine Program at Mt. Sinai Medical Center of Cleveland, I can assure you that the shock we felt at the announcement of the closure of our program, which was made literally hours before we received our 'Match' results, was profound. The personal tragedies to individuals were well cited in your timely article, but the effect on those of us in the teaching system and the grief we have gone through has been equally deep.

I am pleased to say that all 26 existing residents at post-graduate year levels 2 and 3 were placed in other programs through the kindness of other program directors; efforts made at the institutional and national level by various organizations, including the Residency Review Committee for Internal Medicine and the ACGME; and efforts by the residents themselves. Unfortunately, because of a shortage of positions nationally, the incoming PGY-1 residents did not fare as well, although better than one-half of them were also placed in other programs.

As reductions in financing and other threatening environmental factors impact teaching hospitals, a possibility exists that as many as 25 percent of residency education program may close in the next several years. This is frightening. In the case of Mt. Sinai, the Department of Medicine had provided the hospital with documentation that the institution was not losing money in the residency training program. In addition, at the request of the hospital's administration, the department leadership provided three different scenarios for downsizing the program with cost and revenue projections for each of these. The hospital's administration was impressed and convinced by these, but they had little influence over the banking institutions that were providing money to the system during a difficult financial time. I hasten to add that the physician educators' input into the decision to close the program was not solicited, although the bankers' expertise was clearly not sufficient to make such a dramatic decision that will have implications for the future of the institution. While difficult to measure at this time, it is the belief of medical professionals and many patients that, ultimately, a diminution in the quality of health care will result from these efforts to cut costs at the expense of medical educational. Further erosions of quality may continue until such time as society will recognize its role in health education and in the future availability of well-trained physicians. I hope that this recognition will also rekindle in each physician a sense of his/her community as well.

I thank you for your article about abrupt residency program closures, and continue to struggle with the implications of their implications locally and nationally, as we at Mt. Sinai come through a period of true grieving for the loss of what had been an excellent training program.

D. Roy Ferguson, M.D.
Chairman, Department of Medicine
Mt. Sinai Hospital of Cleveland

CALL FOR ABSTRACTS

MASTERING THE ACCREDITATION PROCESS WORKSHOP

March 2-3, 2000

"Best Practices in Graduate Medical Education"

ACGME

Accreditation Council for Graduate Medical Education

515 North State Street
Suite 2000
Chicago, IL 60610
312.464.4920
Fax: 312.464.4098

The Accreditation Council for Graduate Medical Education invites proposals for poster presentations at its annual *Mastering the Accreditation Process Workshop* on March 2-3, 2000 at the Palmer House Hilton Hotel in Chicago, Illinois. Program directors, faculty, administrators and residents interested or involved in graduate medical education are encouraged to submit proposals.

SUGGESTED TOPICS FOR SUBMISSION

Submissions relating to the workshop focus are encouraged; however, submissions in any area of graduate medical education are welcome. The ACGME has a particular interest in soliciting abstracts that clearly demonstrate how tools at the disposal of administrators and educators can be used most effectively in the sustaining and enhancement of quality in graduate medical education. Particular areas of interest include, but are not limited to:

- Outcomes Based Methods
- Developing/Measuring Competencies
- Evidence-Based Medicine
- Faculty Development Programs
- Principles of Quality Improvement
- Evaluation Models
- Curriculum Development
- Assessment of Humanistic Qualities
- Educational Impact of Acquisitions and Mergers

The ACGME also has an interest in initiatives that address the following areas:

- Efforts among two or more teaching institutions that successfully blend collaboration on a joint GME venture with competition in their patient care and/or research domains.
- The relationship between excellence in patient care and excellence in GME
- Efforts of institutions to reengineer their educational settings to function with fewer residents or to increase the educational value of residents' rotations
- Use of outcomes measures in improving the educational process
- Use of a resident physician organization to facilitate resident communication
- Effectiveness of GME Committees in improving the quality of residency programs

SUBMISSION PROCESS

ACGME

To be considered for a presentation, your abstract submission must be received by **January 7, 2000**. All submissions will be reviewed and evaluated by the judging panel for relevance to graduate medical education, content and clarity. Notification of acceptance for presentation will be mailed by **January 14, 2000**. Submissions must include an original abstract form plus five copies and a computer diskette. **Please refer to the enclosed format instructions when completing the abstract form.** Presenters will be required to prepare a poster for the session and be available from 5:00 - 7:00 p.m. on the evening of Thursday, March 2, 2000 to discuss the poster. Accepted abstract submissions will be printed for distribution to program participants as a part of the workshop agenda.

ALL SUBMISSIONS MUST BE RECEIVED BY 1/7/2000

FORMATTING INSTRUCTIONS

1. Abstract submissions for **POSTER PRESENTATIONS** should follow the following format instructions:

   Title: In a font no smaller than 10 point, type abstract title in upper case letters, flush left (do NOT underline)

   Author: Skip one line after title. Type author's name in upper and lower case letters and underline, follow with degree abbreviations (without punctuation) and institution. Separate authors from the same institution with a semicolon.

   Text: Skip one line after author listing and type abstract, flush left, single spaced. The full length of the text must NOT extend beyond the lines of the box (4.5"X 6").

2. All individuals submitting presentation proposals must format their proposals on the original abstract format and provide five additional copies and on computer diskette. Submissions must be in letter quality, font size no less than 10 point scalable font.

3. **DEADLINE.** All submissions must be received no later than January 7, 2000.

4. **ACKNOWLEDGMENT.** Please send a stamped, self-addressed postcard if you desire acknowledgment of receipt.

5. **NOTIFICATION.** All abstract authors will be notified of the results by January 14, 2000.

6. Abstracts submitted to other national meetings are acceptable provided they have not been accepted for publication in a peer-reviewed journal prior to the meeting date.

MASTERING THE ACCREDITATION PROCESS WORKSHOP
March 2-3, 2000
"Best Practices in Graduate Medical Education"

Name: ______________________ Organization: ______________________

Work Address: ____

City: ______________________ State: __________ Zip: ________

Daytime Telephone: __________ Fax: __________ E-mail: __________

Specialty: ______________________ Position: ______________________

Send 5 copies and the original abstract to:

ACGME Call for Abstracts
515 N. State St., Suite 2000
Chicago, IL 60610

ABSTRACT DEADLINE
January 7, 2000

NOTIFICATION OF ACCEPTANCE:
January 14, 2000

This abstract has not been accepted for publication in a peer-reviewed journal.

____
Signature of the Author

DO NOT WRITE IN THIS SPACE:
Date Received: __________ Abstract #: __________
Comments:

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- Letter to the Editor: The Impact of Abrupt Closures

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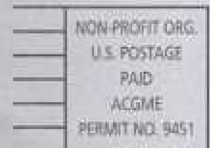

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