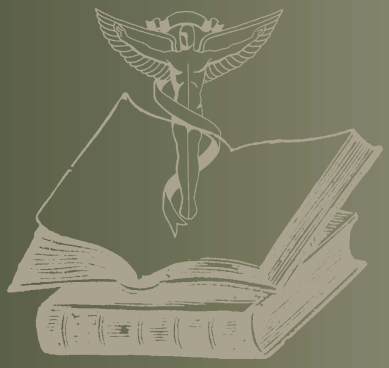

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ACGME BULLETIN July 2001

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ACGME BULLETIN July 2001

Accreditation Council for Graduate Medical Education

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

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Executive Director's Column:

David C. Leach, MD

Framing the Dialogue on Resident Duty Hours

We view language as a means for communicating and conveying ideas. However, it is said that language's use in communications is a secondary role - its primary function is to help us think. From that perspective, the commonly used expression "resident work hours" is unfortunate; it limits thinking and polarizes communication. One of the ACGME's public members has said that, "On no other topic is there such disparity between the perceptions of the profession and the public than on the issue of resident duty hours." Given that, what do we, as members of the profession, really mean when we say "resident work hours," and what language should we use? What do the members of the public refer to when they use the term? Most important, how can we use language to both broaden the dialogue and clarify our thinking on this topic?

Patients deserve safe care and residents deserve effective learning. Good learning requires good health care, and good health care requires good learning. This premise is robust enough to support genuine dialogue. Teaching hospitals attract smart physicians and sick patients. How should we design our work to provide the best patient care and the best education for residents? In general, a small group of people provides care for each patient in a teaching hospital. Each group consists of students and residents at differing levels of experience, attending senior physicians who are fully trained, physician consultants, and other health professionals. Scholars of life within organizations recognize that these small groups constitute "microsystems" within a larger health care system. What characteristics of such microsystems promote good learning and good health care? What is the balance between individual fatigue, continuity of patient care, supervision of residents, and what are the aggregate cognitive, technical and professional resources and responsibilities of such a microsystem?

"Patients have the right to expect competent care in all phases of an acute illness, and residents have a right to expect competent supervision at all aspects of their education in which they interface with patients."

The answers to these questions require a broader frame than "resident work hours." They can be found in the basic design of inpatient care. Using that frame, resident work hours can be seen in a way that incorporates context as well as rules. The context is a system of care and education that precludes abandonment of either patients or residents. Patients have the right to expect competent care in all phases of an acute illness, and residents have a right to expect competent supervision at all aspects of their education in which they interface with

Figure 1

NUMBER OF PROGRAMS AND INSTITUTIONS CITED FOR WORK HOURS AND RELATED REQUIREMENTS 1999 and 2000

Specialty	Percent of Programs Cited 1999	Percent of Programs Cited 2000
INSTITUTIONAL REVIEW	20.0%	8.0%
Allergy and Immunology	22.0%	8.0%
Anesthesiology	2.0%	2.0%
Colon and Rectal Surgery	33.0%	6.0%
Dermatology	7.0%	0.0%
Emergency Medicine	10.0%	6.0%
Family Practice	13.0%	8.0%
Internal Medicine (Core)	30.0%	10.0%
Subspecialties	4.0%	2.0%
Medical Genetics	6.0%	0.0%
Neurological Surgery	10.0%	5.0%
Neurology	14.0%	14.0%
Nuclear Medicine	0.0%	0.0%
Obstetrics and Gynecology	19.0%	5.0%
Ophthalmology	13.0%	0.0%
Orthopaedic Surgery	29.0%	10.0%
Subspecialties	10.0%	4.0%
Otolaryngology	10.0%	3.0%
Anatomic and Clinical Pathology	20.0%	2.0%
Subspecialties	6.0%	2.0%
Pediatrics	21.0%	16.0%
Physical Medicine and Rehabilitation	12.0%	12.0%
Plastic Surgery	10.0%	10.0%
Preventive Medicine	0.0%	0.0%
Psychiatry	0.0%	0.0%
Radiology-Diagnostic	0.0%	1.5%
Radiation Oncology	0.0%	0.0%
Surgery-General	36.0%	35.0%
Vascular	17.0%	9.0%
Pediatric	53.0%	44.0%
Thoracic Surgery	16.0%	21.0%
Urology	8.0%	2.7%
Transitional Year	24.0%	23.0%

Source: ACGME, 2001

patients. When programs violate institutional or program requirements relevant to resident work conditions, duty hours or supervision, they violate these expectations. In this context, the failure to adhere to duty hour requirements is a symptom. The underlying problem may be the failure of small groups or microsystems to have in place a system of care that guarantees patient and resident safety; it may be factors in the larger institutional environment in which these microsystems operate. Either way, it is a serious problem.

In 1999 the Residency Review Committees (RRCs) found a sizable percentage of programs in many disciplines in violation of resident duty hour requirements. As a result, several RRCs now require an immediate progress report from the institution having stewardship over a program that receives such a citation. This report must detail how the problem is being fixed. As a possible effect of this added RRC scrutiny, the frequency of citations for violations related to duty hours and related requirements has declined dramatically in several disciplines. Other specialties have shown themselves less well prepared to change. A comparison of the percentage of programs cited in 1999 and 2000 for duty hour and related violations citations is provided in ***Figure 1.*** The ACGME will continue to cite programs that violate resident duty hour standards and the associated requirements. We will also continue to hold sponsoring institutions accountable for such violations. Patterns of repeated violations will result in adverse accreditation actions. The Council

"The ACGME will continue to cite programs that violate resident duty hour standards and the associated requirements. We will also continue to hold sponsoring institutions accountable for such violations."

plans to collect and disseminate information on novel and successful efforts at the program and institutional level to address the issue of resident duty hours and the associated concerns of resident fatigue, and patient and resident safety. More about the ACGME's initiative to collect this information is provided in the article entitled "Duty Hours - Searching for Solutions" in this issue of the ***ACGME Bulletin***.

The ACGME is aware that, ultimately, the resolution of this problem does not rest with its accreditation activities. Instead, it rests with residency programs, their sponsoring institutions, the small groups or microsystems in these programs and institutions, and the larger "macrosystem" of the various medical disciplines and their readiness to make high-quality care and education, and patient and resident safety a priority.

ACGME Strives to Improve Relationships with Appointing Organizations

Marsha Miller

Currently there is no central repository of knowledge about the forty organizations that appoint physicians to the ACGME's twenty-six Residency Review Committees and to the Council's Board of Directors. David C. Leach, MD, Executive Director of the ACGME, called on the Health Care Improvement Leadership Development division of the Center for the Evaluative Clinical Sciences at Dartmouth College for assistance in evaluating the work of the ACGME as it relates to its appointing organizations. The ACGME was particularly interested in learning more about the appointment processes, the use of educational outcome measures, improving communication, and working more effectively with the numerous appointing organizations.

Led by Paul B. Batalden, MD, seventeen students from Dartmouth's Masters Program in Evaluative Clinical Sciences conducted the survey. Working in teams, they interviewed 49 persons representing 40 organizations.

The process began with gathering preliminary data about each appointing organization from a variety of sources: ACGME, printed documents, and web-based information. The interview format was developed jointly by the teams of interviewers, the senior staff of the Health Care Improvement Leadership Development division at Dartmouth, and the senior staff of the ACGME. It was pilot-tested by each interview team and modified as questions emerged and the best methods for eliciting the desired information were identified.

The interviews revealed a number of recurrent themes. Many related directly to the ACGME's role and relationships with the appointing organizations, including several recommendations. These called for the ACGME to:

- Develop cross-disciplinary and interactive teaching aids that would help programs in teaching the six competencies. "Systems-based practice," "practice-based learning and improvement," and "professionalism" would be excellent starting points.
- Engage in an ongoing evaluation of the progress,

Photo of Dr. Paul Batalden and Dr. Stephen Plume, both of Dartmouth College, with the Health Care Improvement Leadership Development students who conducted the survey of the ACGME's appointing organizations.

the costs, and the validity of the general competencies and the use of outcome measures in graduate medical education. This information should be used to appropriately amend the Council's recommendations.

- Work to develop a bridge between the language of the competencies and the world of residents.
- Take steps to reduce unnecessary and unwanted variations in the appointing process, in concert with the appointing organizations.
- Continue to develop joint programs and activities with the American Board of Medical Specialties (ABMS). It was noted that the current balanced partnership between the ACGME and ABMS is appreciated and should be maintained.
- Develop a program of regular communication with the appointing organizations to address new directions, innovations, and progress in new initiatives.

The ACGME is in the process of evaluating the study and its findings. The Council wishes to acknowledge with appreciation Dr. Batalden and his students — Kofi Cash, Kate Coburn, Graeme Currie, Tina Foster, MD, Allan Frost, MD, Patrick Herson, MD, Gili Lushkov, Gregory Ogrinc, MD, Jean-Pierre Ouanes, Karen Reed-Szulewski, Ryan Sahr, Stacy Sanders, Jennifer Stevens, Allyson Stone, Tara Thacker, and Karl Welke, MD-- and to Alicia Wardell, who coordinated the project at Dartmouth.

Marsha Miller is an Associate Executive Director at the ACGME. She served as the ACGME's coordinator for the project

The Importance of the Resident Interview to the Accreditation Process

Betty Chang, MDCM and Ingrid Philibert

Each year, the Accreditation Council for Graduate Medical Education (ACGME) site visits between 2,000 and 2,200 residency education programs, and interviews between one and twelve residents during each visit. Thus, approximately 9,000 to 15,000 residents annually have direct input into the information collection process for the accreditation of their residency education programs. The accreditation site visit begins with the program completing a self-study report – the Program Information Form (PIF). The information provided in the PIF is verified and clarified during the site visit, and the

interview with the residents is a vital component of this process. The goal is to check the accuracy of the information provided and to resolve any discrepancies or ambiguities. This verification is critical to the objectivity of the accreditation process. It involves asking the residents a series of questions that gather information about aspects of the program relevant to them and that verify the information the program provided in the program information form. The interview always concludes with a question about what the residents view as the program's strengths and weaknesses.

"...as a group, residents have a unique view of the program's patient care services because they see them in operation 24 hours a day, seven days a week."

Residents' importance to the accreditation process is not due to any eagerness on their part to reveal negative things about their programs. On the contrary, often they are reluctant to compromise their program's accreditation status by mentioning potential deficits the RRC may then cite. But, as a group, residents have a unique view of the program's patient care services because they see them in operation 24 hours a day, seven days a week. In addition, as the consumers of the education offered by the program, they are well-acquainted with its strengths and weaknesses. During the site visit, their input provides vital insights into both the educational and patient care performance of the program, in keeping with the ACGME's goal of ensuring high-quality education and safe and effective patient care.

The Importance of Peer Selection

Residents are a critical element of the accreditation process. It is thus important that residents have the opportunity to comment on their education, and that the group who participates in the site visit interview is representative of the program's "educational consumers." The ACGME interviews all available residents when a program has twelve or fewer residents. For larger programs, a group of approximately twelve residents, representing all years of training, is selected for the interview. The most meaningful way to ensure that this group is representative of the program's residents is to have them selected by their peers. To add to the information provided by residents being interviewed, in the near future the ACGME will use a short written or electronic survey to expand the cohort being surveyed, and to offer each resident the opportunity to comment on his or her education.

Having the residents who participate in the interview "selected by their peers" means just that - that all residents who participate are selected entirely by their resident colleagues. A group of residents selected by the program director, or having the residents pick among a "pre-selected" pool does not constitute peer selection. To verify the peer selection process, the ACGME site visitors routinely ask the residents how they were selected for participation in the interview, and their responses are recorded in the site visit report.

During the interview, information spills out rapidly from the residents in the interview group, and collectively this provides a picture of how the residents perceive their education. Program directors occasionally ask whether the opinion of a sole "disgruntled resident" can sway the entire interview. This is truly not a concern, because the interview process seeks a consensus among the residents, and this consensus is recorded by the site visitor. When a consensus cannot be achieved for a given question, the full breadth of responses is recorded, indicating whether the given statement was the opinion of an individual resident or that of a subgroup of the interviewees. Thus, if a resident's experience is different from that of his or her colleagues, the results are reported, but they appear next to the information provided by his or her peers. Residents' names are never identified in the site visit report.

"Having the residents who participate in the interview "selected by their peers" means just that — that all residents who participate are selected entirely by their resident colleagues."

Insight to Benefit Programs and Sponsoring Institutions

Collecting information that takes advantage of residents' insight into their educational program need not and should not be limited to the accreditation site visit, or the internal review conducted by the program. When opportunities exist for improvement in education or patient care, residents are generally aware of them. David Leach, MD, Executive Director of the ACGME, has stated that "residents live in the cracks of the system," and cannot escape the imperfections of their program. Program directors who are committed to better educa-

"The result of adapting the IOM's ten rules is a system of caring, nurturing and cooperation, centered on the learner."

tion and patient care should regularly convene their residents and solicit their suggestions. They will find them an informed source about the program's strengths and weaknesses, as well as suggestions for how the latter could be addressed.

Residents have the information to change their program for the better, but residents alone cannot make these changes, especially if the change requires resources or impacts the way care is provided. The ACGME hears from residents that they lack access to the power structure of the institution and their recommendations are often not considered or implemented. Most meaningful change requires resources, and residents generally have little voice in decisions on how resources are allocated. Also, their experience in graduate medical education is at the level of "first-person singular," they often do not have experience within other institutions or knowledge of successful approaches used in these other settings. We wholeheartedly agree that residents lack power at the institutional level, but feel that it need not always be this way.

Where the institution's leadership has involved residents in efforts to improve the educational program, this has proven to be a powerful approach. True, most improvement efforts require added institutional resources. Making a program "more educational" frequently involves releasing residents from clinical care that does not have a high educational yield. This carries a significant price tag. At the same time, the literature on these efforts has demonstrated that they often have other positive effects on the institution, which can offset some of the costs of changing staffing patterns. These generally widely differing initiatives have one thing in common. They are able to identify and address inefficient and, often, dysfunctional aspects of care. Residents know about these problems. However, without being asked for their input into efforts to improve the system, they may accept the problem as a "given" or, because of the time limitation of a 30-day rotation schedule, may be unable to effect change.

Some programs and sponsoring institutions have taken advantage of the power of the information residing in their residents. They have created forums for information-sharing between the residents and the program or institutional leadership to explore ways to improve education and patient care. Less well-developed are efforts to learn what has worked at other institutions, with the intent of adopting or adapting successful approaches. Potentially, national resident organizations could have a meaningful role in this. An added focus on the creation of learning laboratories would allow resident organizations to explore which interventions have the greatest positive impact on resident education, quality of life and satisfaction. This could complement their current advocacy-based approach.

Applying the IOM's 10 Rules for a 21st Century Health Care System to Education

The last issue of the ACGME Bulletin contained an article on the Institute of Medicine's recently released report, entitled, "Crossing the Quality Chasm: A New Health System for the 21st Century." At the 2001 Spring meeting of the Group on Resident Affairs of the Association of American Medical Colleges, David Leach, MD, Executive Director of the ACGME, adapted the IOM's ten rules from the venue of health care to that of medical education ***(Figure 1).*** The result is a system of caring, nurturing and cooperation, centered on the learner. As residents describe the "optimal program" during the site visit interview, their comments echo the rules in ***Figure 1,*** demonstrating that they have a mental image of the ideal education system that embraces these rules as guiding principles.

Figure 1

Ten Simple Rules for a 21st Century Medical Education System

Adapted from the IOM's Rules for a 21st Century Health Care System

- Learning is based on a continuous nurturing relationship
- Learning is customized according to learners' needs
- The learner is the source of control
- Knowledge is shared and information flows freely
- Education is evidenced-based
- Safety is a system property
- Transparency is a necessity
- Learners' needs are anticipated
- Waste is continuously decreased
- Learning occurs in an environment of cooperation among all health professionals

Betty Chang, MDCM, is a fellow in at John Hopkins University and the resident member of the ACGME's Board of Directors.

RRC/IRC COLUMN

Institutional Review for Institutions Sponsoring One Core Residency Program

The ACGME discussed a recommendation from the Institutional Review Committee that institutions that sponsor one ACGME-accredited core program and subspecialty programs under the purview of the same Residency Review Committee (RRC) will now be reviewed by that RRC. An example of such an institution is a hospital sponsoring a Family Practice and programs in the two subspecialties of Family Practice, Geriatrics and Sports Medicine. Final approval of the recommendations will occur at the September 2001 meeting.

Until now, all institutions with two or more programs, including those with programs under the purview of a single RRC, were subject to a full Institutional Review. Under the new approach, institutions sponsoring one or more programs reviewed by the same RRC, will receive a more focused institutional assessment by that RRC, using a set of questions that collects information on compliance with the relevant institutional issues. The ACGME also discussed recommendations for the implementation of this approach, including development of a uniform set of questions to assess institutions' ability to meet the relevant institutional sponsorship obligations.

ACGME Approves Molecular Genetic Pathology

The ACGME approved new Program Requirements in the subspecialty of Molecular Genetic Pathology, effective June 12, 2001. The new discipline will function as a subspecialty of Pathology as well as Medical Genetics.

Other ACGME Actions

The Council approved revisions to the Program Requirements for Orthopaedic Surgery, Pediatric Orthopaedics, and Orthopaedic Trauma. The modifications will become effective July 1, 2002.

The ACGME acknowledged the addition of the general competencies to the Program Requirements for Medical Genetics, Neurological Surgery, Ophthalmology, Otolaryngology, General Surgery, Thoracic Surgery, and Urology. The Council also approved revision to the Institutional Requirements to incorporate the six General Competencies. The effective date for all of these revisions is July 1, 2002.

Other Highlights from the June 2001 ACGME Meeting

ACGME and ABMS Sponsor Symposia on the General Competencies

ACGME and the American Board of Medical Specialties (ABMS) have partnered in sponsoring an annual symposium in each of the next six years to address the general competencies. Each symposium will offer an overview of curriculum and evaluation approaches for one of competencies and opportunities for discussion. The first symposium, planned for March 2002, will address Communication Skills.

ACGME Discusses Duty Hours

Several ACGME committees and the Council as a whole discussed the issue of resident duty hours. The discussions uniformly acknowledged the complexity of this issue. It was also noted that duty hours, supervision and residents' work environment are closely linked, and that violations of duty hour standards are symptoms of programs' more general lack of attention to the educational needs of residents and to the demands of safe and effective patient care. The Council acknowledged that the public's perception of resident duty hours and the perception within the medical discipline are not consistent. It recommended that ACGME efforts to address the issue should clarify the program and institutional requirements regarding resident duty hours and the intent behind the standards, as well as strengthen enforcement of the existing requirements. It was noted that education of the graduate medical education community and the public regarding the complexity of this issue should be an important element of the ACGME's effort.

RRC Resident Council Meets

The RRC Resident Council comprises the resident members of all RRCs and in the past two years has met annually in conjunction with an ACGME meeting. At its meeting in June, the RRC Resident Council elected a new chair, Rebecca Minter, M.D., a resident in surgery at the University of Florida in Gainesville. Dr. Minter presented the group's report to the ACGME. Main topics discussed by the Council included resident duty hours, a general ACGME resident questionnaire, to be fielded to all residents asking about their perception of their graduate medical education experience, and medical errors.

The members of the RRC Resident Council expressed their concern with a petition the group "Public Citizen," the Committee of Interns and Residents (CIR) and the American Medical Student Association (AMSA) filed with the Occupational Safety and Health Administration (OSHA). The petition requests a general work hour limit for residents of 80 hours per week, limits on on-call time and the number of consecutive hours worked, and suggests a federal enforcement process for the proposed rules (visit the ACGME's site on the World Wide Web for the Council's response to the petition, clarifying the ACGME's duty hour and related standards). The members of the Resident Council noted that setting absolute restrictions on duty hours involves treating the symptoms and not the underlying problem, and that the reasons why some residents work 100 to 120 hours per week need to be explored. Once these causes are identified, opportunities to improve the larger system will emerge. The members also noted that change needs to come from the institutional level. Lack of funding and shortages in some health professions categories are clearly issues for sponsoring institutions, but if these institutions have GME as one of their missions, the needs of their residency education programs must be a priority on their budget.

The RRC Resident Council also discussed medical errors. The members noted that often these are caused by system problems and that residents, since they are frequently on the front lines, are able to identify problems in the system. Yet most residents never report near misses or close calls they are aware of. They are relieved that nothing terrible happened, but are concerned about blame being assigned. This precludes use of the information in exploring causes of events and helping others to learn from them. The Resident Council members commented that a blame-free reporting system is needed.

ACGME News

Jack Boberg Retires

Marsha Miller

Every once in a while someone comes along that leaves a lasting impact on one's life. For the ACGME and the Residency Review Committees for General Surgery, Thoracic Surgery, and Ophthalmology, that someone has been Jack Boberg, PhD.

Jack came to the ACGME fifteen years ago, having worked three years previously for the AMA's Department of Allied Health Education and Accreditation. Prior to Jack's association with the medical community, he taught theology and cross-cultural studies at the graduate school level. He received his Doctorate of Missiology (theology and cross-cultural studies) from the Gregorian University in Rome. He speaks four languages, German, Italian, Spanish, and French.

An accomplished writer and communicator, Jack has published articles on various aspects of accreditation in Journal of the American Medical Association (JAMA), the Archives of Surgery and the Archives of Ophthalmology. During his years as a theologist, Jack was an editor, radio broadcaster, and translator in Rome. As part of his editorial assignments, he has traveled the world over and now plans to reside near his family in Cold Spring, Kentucky.

Over the years, Jack has made significant contributions to improving the accreditation process. Beginning in 1986, he was instrumental in implementing the Surgical Operative Log system. Most recently, the RRC for General Surgery began to collect operative experience by CPT code. Jack has spent many hours, and sleepless nights, piloting and implementing the CPT Codes project. For many years, he staffed the ACGME Structure and Functions Committee (now Strategic Initiatives), and was instrumental in refining many policies and procedures that are in place today.

In keeping with the ACGME's mission statement "to improve the quality of health care in the United States by ensuring and improving the quality of graduate medical education," Jack was instrumental in guiding the RRCs in developing and enforcing institutional and program requirements that enable good training and health care to take place. Residents, patients and

colleagues have benefitted from his leadership.

Jack had a working motto that kept him focused, and it will forever resound in our ears - "Verdammte Pflicht and Schuldigkeit" (roughly translated from German, it means "damned duty and responsibility"). He will be missed.

ACGME Reorganizes RRC Staffing After Dr. Boberg's Retirement

With the retirement of Dr. Boberg, the AGCME is actively recruiting a new Executive Director. The individual who will assume the new Executive Director position will not be assigned RRCs staffed by Dr. Boberg. Instead, some responsibilities will be shifted among the current Executive Directors, and others will be assigned to the new staff members after an appropriate orientation period.

In the interim, three existing Executive Directors have agreed to take on additional responsibilities. Dr. Doris Stoll will serve as the Executive Director for the General Surgery and Thoracic Surgery RRCs in addition to her current responsibilities. Steve Nestler, PhD, will be the Executive Director for the RRC for Ophthalmology, in addition to his current responsibilities, and staffing of the RRC for Neurology has temporarily shifted from Dr. Paul O'Connor, to Larry Sulton, PhD. Dr. Sulton will retain the RRCs for which he is currently responsible. In each of these circumstances, the Accreditation Administrators and other staff members presently assigned to the RRC will remain in place. The four executive directors look forward to working with their newly assigned RRCs, and all ACGME staff members are hoping to make this transition as smooth and seamless as possible.

Field Staff News

Two new accreditation field representatives joined the ACGME field staff in recent months. William W. Robertson, Jr., MD, joined in May of 2001; Judith H Jacobs, DrPH, joined in July of this year. Dr. Robertson is a board certified orthopaedic surgeon and former ACGME Specialist Site Visitor for orthopaedic surgery. He graduated from Vanderbilt University Medical School, and completed training in orthopaedic surgery at Vanderbilt University Medical Center. He most recently was in academic practice as Professor of Orthopaedics and Pediatrics at George Washington University and Children's National Medical Center in Washington, DC.

Dr. Jacobs received a bachelor of sciences degree from the University of Massachusetts and masters and doctorate degrees in public health from the University of North Carolina at Chapel Hill. She served on the public health faculties of Harvard University and Temple University, as well as held positions at the National Institute of Mental Health, the Connecticut Department of Children and Youth Services, and the Boston Department of Health and Hospitals. Between 1993 and 2001 she was an independent consultant, working with mental and public health services organizations.

Two members of the field staff resigned in the spring of 2001. Charles Joslyn, PhD, had served as an accreditation representative since May 1999, and Terry Myers, MD, PhD, had been with the ACGME field staff since January 1999.

ACGME Begins to List Combined Programs

Beginning in the fall of 2001, the ACGME's accreditation database will list combined residency programs. These programs consist of two or more ACGME-accredited programs, such as Internal Medicine/ Pediatrics or Family Practice/Psychiatry. The ACGME does not formally accredit combined programs. Instead, the member boards of the American Board of Medical Specialties (ABMS) accept completion of a combined program as rendering the individual eligible to sit for the Board certification examination. From the ACGME's perspective, combined programs function as tracks within the ACGME accredited core programs, such as internal medicine, pediatrics, family practice, neurology and other disciplines, that offer them. Residents in combined programs count as partial full-time equivalents (FTE's) in the accredited core residency program, generally at .5 FTE (they count at the .33 FTE level if the program combines three core programs).

The ACGME is adding the combined programs to its accreditation database to create a more complete listing of all programs that have residents training in an accredited program, and to enhance communications with the program directors of these programs. Listing them in the database will enable the ACGME to send to their program directors general information mailings and specialty-specific updates for the specialties that make up the combined program. Because combined programs function as tracks within ACGME-accredited programs, the education, evaluation and protection of residents in these programs are the purview of the ACGME and RRCs, and these tracks must comply with the accreditation standards for the disciplines forming the combined program. Of high importance are the requirements for the residents' work environment, supervision and duty hours.

Combined programs are also expected to meet the ACGME requirements for adequate ancillary support services and facilities (call rooms, library), which must be provided to all residents, including those in combined programs.

With approval of the American Medical Association, the program number assigned to combined programs will be the number currently assigned to them by the AMA, with the first digit changed from an "8" to a "7." This was done to avoid confusion with identification numbers for the ACGME's institutional review, which start with an eight. The remaining digits of the combined program's number will remain the same.

For any questions about the addition of the combined programs, please contact Ingrid Philibert, Director, Field Activities, at 312/464-4948.

Bulletin Editor's Occasional Column: Duty Hours - Searching for Solutions

Ingrid Philibert

"....You do what you must do, and you do it well."

- Bob Dylan

In late April 2001, a petition filed with the Occupational Safety and Health Administration (OSHA) requested that OSHA develop federal regulations limiting "work hours" for resident physicians. The petition and other efforts to seek legislative or regulatory solutions to the issue of resident duty hours have triggered an intense debate in the academic community. The debate is about the role of long hours in the education of residents, and whether the reason is to "to facilitate learning" or service obligations on the part of the institutions where residents train. In early May, the ACGME published a response to the petition, which was posted on its web site and disseminated electronically to program directors and institutional officials. In it, the Council clarified its role in formulating and revising the standards for accredited programs and in enforcing them. We also emphasized that the ACGME standards treat duty hours, supervision, and work environment as related matters, with the goal of achieving high-quality education, safe and effective patient care, and resident safety, and that it would not be appropriate to separate monitoring of duty hours, with the intent of enhancing resident safety, and vest it with another entity.

Exhibit 1

Ideas for the ACGME to Address the Issue of Resident Duty Hours via Standards, Survey Activities or Educational and Related Efforts

- Consistently enforce the existing ACGME standards on duty hours.
- Evaluate and refine the standards in light of emerging information on the impact of duty hours on education and patient care.
- Inform the GME community that the ACGME takes the issue of duty hours seriously.
- Create a system for rapid response to violations of duty hour requirements.
- Establish clearly defined limitations on duty hours in all RRC requirements and work toward more uniformity among RRCs with regard to resident duty hour standards.
- Make attention to residents' duty hours, exhaustion and inability to function an explicit part of faculty supervision requirements.
- Gather information on the impact of excess duty hours to inform the discussion.
- Expand the interpretation of the general competencies to include "the need for physicians to understand their own limitations" and "the exchange of information at the time of patient hand-off."
- Explore this issue more thoroughly during accreditation site visits.
- Educate government about the complexity of this issue and its interrelatedness to other standards, such as the balance of education and service, and supervision.
- Listen to the public, whose members support more rigorous enforcement of standards.
- Listen to residents' perceptions of the impact of too many duty hours, and engage the participation of residents in the enforcement of duty hour standards.
- Seek out, recognize and nurture creative responses to addressing this issue.

The current debate about work hours is not always comfortable, because it places the academic community in a position of defending its standards. It must do so in an environment in which the public, many residents and medical students do not understand why appropriate learning cannot be achieved in less than 80 to 100 hours per week (also see the article by Dr. Leach in this issue of the ***ACGME Bulletin***). At the same time, the debate benefits the community by putting at the forefront an issue that has been with us for many years and has been addressed in a less than thorough or optimal way. We need to thank the petitioners for raising the issue.

"...It must do so in an environment in which the public, many residents and medical students do not understand why appropriate learning cannot be achieved in less than 80 to 100 hours."

The past two months have seen more intelligent debate than the more than 10 years since the implementation of New York States 405 regulation limiting resident work hours. Among the groups debating the issue was the ACGME Strategic Initiatives Committee. At its June meeting, the Committee discussed ways in which the ACGME and RRCs could address the issue via their accreditation standards, survey activities and educational and related efforts. Selected ideas from this discussion are shown in ***Exhibit 1.***

Searching for New Models and Solutions

"Few things are harder to put up with than the annoyance of a good example." *- Mark Twain*

The last item in the Strategic Initiatives Committee's list of suggested approaches ***(Exhibit 1)*** involves identification and dissemination of information on successful approaches to address the issue of duty hours. These approaches could be at the program or institutional level, or could be national initiatives by program director groups or other constituencies within the academic community. It would not be fair to create an impression that developing these approaches will be easy, or that there are no barriers to their implementation. David Leach, MD, Executive Director of the ACGME, listed some of the barriers in his recent article in the ***AAMC Reporter,*** entitled "Strengthening the "E" in GME". They include limited resources; system constraints created by sicker patients and shortened lengths of stay; shortages among many health professions; and idealistic residents who fail to trust the system and shoulder a heavy care burden out of a sense of duty.

"...the intense debate on work hours will facilitate the emergence of intelligent, creative solutions."

We can hope that the intense debate on resident duty hours will facilitate the emergence of intelligent, creative solutions, and it may help our solutions to think that these will likely address the issue at two very different levels. Solutions at one level will seek to compress the existing education and service model we are familiar and comfortable with into fewer hours, with more attention to resident exhaustion, need for rest, impact of fatigue on performance and learning, and related matters. In contrast, solutions at the second level would seek to change the educational model, and break its bond with service delivery, or at last recast the relationship between these complementary and competing considerations in a light that advances educational needs and considerations ahead of service demands. Both types of solutions will be welcome. The ACGME is soliciting proposals for solutions to the duty hour issue from accredited programs and their sponsoring institutions. These proposals will be evaluated and a selection will be featured at the Spring 2002 ACGME workshop "Mastering the Accreditation Process." (see the announcement inserted in this issue of the ***ACGME Bulletin***). More information will be forthcoming.

Another important activity which needs to be given priority involves expanding the participants in the debate about work hours to enhance the understanding of the public, residents, medical students, legislators and regulators about the role duty hours play in the education of residents. We need to add to their awareness of the interconnectedness of duty hours with resident supervision and the overall environment for education, emphasizing that the ACGME's standards and processes treat them as related matters. At the same time, exposure to their perceptions of the matter will advance our understanding and increase our sensitivity. The ACGME will lead some of this dialogue, but the major portion of the educational tasks will likely be performed by the residency programs themselves and by their sponsoring institutions.