

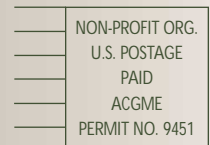


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**ACGME** BULLETIN October 2000

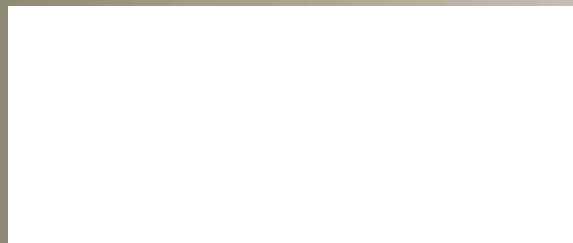
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## Accreditation Council for Graduate Medical Education



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 over 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

### Trust Me, I'm A Doctor

The ACGME's stakeholders include residency programs, residents, medical students, specialty boards, patients, the government and the public. The public is the hardest group to define and, in many ways, it is the most important of our stakeholder groups. Its members reasonably expect that newly minted physicians have acquired state-of-the-art clinical and professional skills and are prepared to meet their patients' needs by the time they graduate from an accredited residency program, especially since programs are supported by public funds. What can be done to strengthen the natural alliance between the medical profession and the public during these challenging times? Is it enough to say, "Trust me; I'm a doctor." Is it sufficient that someone has graduated from an accredited program? Finally, does the public understand the role of accreditation in safeguarding the quality of physician education? Do we need to make our work and their safeguards crystal-clear? If so, what type of information should be presented? How can it be configured in ways understandable and useful to the public? How can we engage in a partnership with the public that will focus on our common purpose of improving education and patient care?

There are more questions than answers. To explore the questions and seek some of the answers, the ACGME has done several things to further the dialogue with the public. Recently, it added a third public member to its twenty-six member Board of Directors. Furthermore, it now encourages its public members to attend all, even closed, committee meetings of the ACGME, its subcommittees and its Residency Review Committees (RRCs). Public members regularly attend the Executive Committee meetings and have begun to attend RRC meetings. They bring intelligence, the insight of non-physician citizens and consumers of health care, and a critical public perspective to deliberations. An article in this issue of the *Bulletin* reports some of their thoughts captured in a recent interview.

On June 27, 2000, the ACGME became a separately incorporated entity. This allows the Council to benefit to a greater extent from the wealth of experience and the positions of our member organizations and yet holds each of the Directors of the ACGME to high standards of fiduciary responsibility, standards that place the public's concerns in a prominent position. Directors are free to be objective on issues such as resident work hours that are of special interest to patients and the general public.

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A crucial question that remains is how much and what kind of information the ACGME should provide to the public. Presently the accreditation status of each

residency program is available on our web site. The length of the cycle between reviews is also available. The information missing for the public is what the various status designations imply, and what the cycle length says about a given RRC's comfort level with a program's ability to educate residents. Specific citations are not available. Nor are normative data about the actions of the 26 different RRCs.

Data external to, but capable of illuminating, programs are publicly available. But they are not uniformly accessible, and often not conveniently configured. They include pass rates on the board exam; information from resident and recent graduate surveys; general institutional quality indicators; data from patient surveys; and data on an academic department's grants and publications. In addition, areas of particular concern to the public, such as the average number of resident work hours, could be displayed. How much data will be needed to make the public comfortable with the system that educates its physicians is not exactly known. The ACGME will struggle with this issue until we get it right. However, "Trust me I'm a doctor" may have to be replaced with, "In God we trust, all others must bring data." 

## Enhancing Public Oversight of Accreditation - An Interview with the ACGME's Public Members

*Ingrid Philibert*

In the preceding article, Dr. Leach comments on the public's trust in the qualification of physicians. The public members play a pivotal role in safeguarding this trust. The ACGME's mission statement indicates that it "... strives to improve evaluation methods and processes that are valid, fair, open, and ethical." In keeping with this, its public members are ultimately responsible for ensuring that public expectations for quality and accountability are met.

In the past, the ACGME had two public members. In September 1999, it appointed Mr. Duncan McDonald, Vice President for Public Affairs and Development for the University of Oregon, as the third, joining Kay Huffman Goodwin and Agnar Pytte, PhD. The members' backgrounds are diverse. Ms. Goodwin has served as the chair of the University of West Virginia System's Board of Trustees, and sits on the Board of West Virginia University Hospitals and the West Virginia United Health System. Agnar Pytte, PhD, recently retired from the

Presidency of Case Western Reserve University. His research career focused on theoretical plasma physics and nuclear fusion. Mr. McDonald's background combines journalism and political science. Ms. Goodwin and Mr. McDonald are familiar with accreditation. She serves as the public member of the North Central Association of Colleges and Schools West Virginia Accreditation Committee; he has been Chair of the National Accrediting Committee for Education in Journalism and Mass Communications. The interview included Paul Friedmann, MD, who just concluded his term as Chair of the ACGME, and R. Edward Howell, the current ACGME Chair.

Asked what attracted them to their role, the members commented on their deep interest in education. Ms.

Goodwin is the daughter of a family practice physician, and stated that she, "saw the results of an excellent medical education up close and personal." Dr. Pytte added he had spent nearly his entire life in education and his responsibilities as Provost at Dartmouth College, and later President of Case Western Reserve University gave him insight into the complex nature of physician education. Mr. McDonald stated, "I was intrigued and flattered when I was asked to be part of the organization that accredits graduate medical education in the United States and has major influence internationally." All noted that the rigor of the accreditation process and the dedication with which the work is approached is gratifying, as is the amazing volunteer commitment by physicians and non-physicians - from ACGME directors to RRC members - to ensure sound education and practice in their specialty and in the medical community overall. Ms. Goodwin credited Robert D'Alessandri, MD, Dean of West Virginia University School of Medicine and former Chair of the ACGME, with the outstanding quality of medical education in her state. She noted she is honored to assist the medical education community, and is grateful to her father and Dr. D'Alessandri.

The members feel their role has given them insight into the impact of rapid change in medicine on education, including how mergers and hospital closures can profoundly disrupt residents' lives. Mr. Duncan stated,

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**"...one of the ironies of public membership is part of the attraction: 'As public members, we are given a very private insight into the functioning of the ACGME.'"**

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"I have learned about the delicate balance of resident complement and patient volume - that too many residents and not enough patients can be as detrimental to education as too many patients and not enough residents." He added that one of the ironies of public membership is part of the attraction: "As public members, we are given a very private insight into the functioning of the ACGME."

**Question:** *What characterizes effective public membership of the ACGME?*

**Ms. Goodwin:** Having public members is important to the public. Having three makes it possible to have a public member participate on all committees, to bring the public's perspective to the table and report to the public on the Council's efforts. It is also important that public members familiarize themselves with the work of the RRCs, to enable them to inform the public about how this work contributes to educational quality.

**Dr. Pytte:** Effective public membership should reflect two things. First, as non-physicians, the public members have a different perspective, that of "patient" and "member of society" interested in education and the

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quality of care. This is important when the ACGME considers such issues as resident work hours. The public is concerned that residents provide care while exhausted. The members of the discipline care about work hours, but need to balance this with their concerns that residents learn the entire depth and breadth of practice in the specialty. Our perspective is closer to that of the public at large, but is informed by our interactions with the ACGME. The second function is to report to the public on the ACGME's activities, to explain what we have learned, and to ensure that these activities have appropriate public oversight.

**Question:** *How do public members contribute to an accreditation process that is responsive to the needs of the public?*

**Dr. Pytte:** I said earlier that one of the functions of the public members is to inform the public about the role of accreditation. I don't think we are doing as much in this area as we could. As a former university president, I speak to individuals and influential groups about the impressive work the ACGME is doing. However, I don't reach a meaningful number of the many Americans who may be concerned and need to hear this message. The public members can do some of this, but the ACGME itself needs to do more to connect with the public.

**Mr. McDonald:** One of the responsibilities of the public members involves advising the ACGME on reporting information to the public. I understand that not all data can be public, but my bias as a journalist is, "more is better."

**Ms. Goodwin:** I agree. More is better.

**Dr. Pytte:** I disagree somewhat, the public is not interested in every detail about the accreditation of more than 7,700 residency programs. It wants the larger picture: that there are systems that safeguard physician education and patient care in hospitals where physicians train, and that these are functioning as they should. Also, the public may not completely understand how physicians are educated, and explaining and defending the educational process is something public members should do.

**Question:** *What could the ACGME and its public members do to define the public's expectations for physician education quality?*

**Mr. McDonald:** The context for the public's expectations is its concern for patient care quality and safety. When we discuss the public release of accreditation information, we need to understand this context. At present, the public has access to information on programs' accredi-

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tation status and cycle length, but does not understand the implications of this information without a more detailed explanation. Another context is provided by the changes in health care, which create an environment in which it is more difficult to educate residents. The public hears about this, and we must stress that the ACGME is doing all it can to ensure that residents are educated appropriately. Data will play a role in this, but data alone cannot accomplish it.


**Dr. Friedmann:** Yes, the public is interested how the data are used. For example, on the issue of work hours, the public wants to know what the ACGME does to help improve the state of things after it cites a program for resident work hours.

**Mr. Howell:** Work hours are a complex issue. Residents learn by doing, and the public rightfully asks what is done to ensure safe patient care. Our attitude must be, "the buck stops here." At the same time, physicians in practice may work just as many hours, but there is less concern about their level of exhaustion and how it may impact performance.

**Question:** How can the ACGME improve its systems for communicating with the public?

**Mr. McDonald:** Communicating with the public is important, but potentially much more critical is finding ways for the public to communicate with the ACGME, and what role the public members may play in this. Establishing this communication will be vital to assuring the public that it truly has opportunity to provide input into the process.

**Mr. Howell:** Opening up communication channels is important. Beyond the general public, two critical stakeholder groups are residents and medical students. We need to enhance the system that allows them to communicate with the ACGME, and will be well served to have our public members engaged in this process. I am impressed with the enthusiasm and zeal the public members bring to the ACGME. Going to three public members truly has resulted in more energetic oversight of our accreditation processes.

**Dr. Friedmann concluded:** What we take away from this interview is that we need to do more to inform the public about the ACGME's role in ensuring "good learning for good health care," and we should think of ways for the public to communicate with us. In all of this, we can take advantage of the knowledge and dedication of our public members. Soliciting their participation to the fullest extent will contribute to our effectiveness. 

## Resident Retreats as a Way to Facilitate Communication and Learning

*Jill Klessig, MD*

Being providers of medical education requires academic institutions to be responsive to the sometimes conflicting needs of a number of stakeholders. Residents expect that a defined set of factual information and clinical/professional skills will be taught to them in an effective atmosphere that is sensitive to their needs as learners and as individuals. Outside agencies, including the ACGME and the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), future employers, the federal government and the public have requirements, evaluative procedures and expectations for competency that must be met. While meeting these goals, the institution must ensure that the education provided to residents reflects the practice environment that they will enter on completion of training. Thus, institutions need a mechanism that provides the opportunity to impart the required and/or desirable facets of education, that can also be used to evaluate and, when needed, reform the existing training environment. Resident retreats, either on an institutional or program level, provide a possible mechanism for achieving these goals.

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**"The major goal, regardless of organization, is improved communication among various participants in an organization."**

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The concept of a retreat is not novel. Industry has used retreats for years to achieve a wide variety of goals. The major goal, regardless of organization, is improved communication among various participants in an organization. Medical educators have found resident retreats an effective means of achieving educational or programmatic goals that are otherwise difficult to accomplish. The majority of medical education programs

that utilize retreats have found them to be valuable, but they are not without drawbacks.

### **Goals for Resident Retreats**

The substantial time and financial resources required for a retreat, and the complex logistics of obtaining coverage for patient care obligations, make it necessary

that the program or institution establish goals for resident retreats that justify the resource expenditure. Two major reasons to sponsor a retreat are listed below.

**1. Improved social interactions.** Residency training is a stressful time in an individual's life, and group support among residents and faculty is essential to achieving successful educational outcomes. A retreat allows residents and faculty to interact in a social setting, and emphasizes that they are colleagues. The more informal setting may help improve two-way communication and decrease barriers to effective interactions throughout the year. This may lead to better educational outcomes as well as improved patient care. The relaxed atmosphere also allows participants to renew their enthusiasm for residency education.

**2. Enhanced education, evaluation and/or accreditation performance.** A retreat is an excellent opportunity to cover ACGME/RRC requirements at the program or institutional level. Two major areas that can be tied to RRC requirements are education and evaluation. There are many educational objectives a retreat can accomplish. For example, some topics are less well-suited for teaching in a lecture, attending round, or morning report format. A retreat allows for small group sessions and blocks of educational time, as well as having all residents in one place at the same time. There are some topics, like death and dying, that can generate strong feelings in residents. The retreat allows residents and faculty to discuss them, and have time to deal with emotions without having to immediately go back to patient care. Additionally, a retreat provides an excellent opportunity to conduct program evaluations. Because all residents are present, the program can distribute written evaluation forms and be assured that all are returned, without breaching confidentiality by requiring that the forms be signed. With residents and attendings present, the group can engage in effective dialogue about the positive and negative aspects of the program, and what should be changed. Small group sessions can be designed to address specific problems, especially if they are identified ahead of time. Most important, a retreat format, structured well, allows the opportunity for all residents to have input into the program, not just vocal or dissatisfied individuals.

### ***Barriers to Resident Retreats***

One of the major barriers to a successful retreat is the expense involved. Sometimes, the available resources dictate the format of the retreat, instead of the reverse. It is important to note however, that a very successful retreat can be held with a minimal financial outlay. Most programs use a combination of funding schemes for retreats. Common ones include: having the residents pay all or part of the cost of the retreat; ask faculty to pay an assessment (on a mandatory or voluntary basis) to defray resident expenses; take a percentage of private attendings' clinical income; solicit non-restricted educational grants from pharmaceutical companies; or solicit graduates of the program for donations. The sponsoring institution can also be asked to pay for the retreat.

However, if the institution pays for one specialty, it should expect to be asked to pay for all.

There are other factors that must be considered. Coverage is an issue that appears to be an insurmountable obstacle, but can be managed with a variety of schemes. If the retreat is sponsored by a program or institution, there also is concern that the institution may be legally responsible for any adverse outcomes, including accidents, inappropriate behavior, or the like. Lastly, the quality of the retreat is important, because a poor retreat may worsen existing problems or resident dissatisfaction with the program.

### ***Structuring Resident Retreats***

The timing and location of retreats are important. An essential component of a retreat is to take all participants out of their normal working environment, and place them where they can interact in a positive fashion. Many locations are possible, including beaches, hotels, parks, conference centers and other sites. The timing of the retreat is to some extent related to specified goals. If the main goal is to allow residents to get to know each other, to introduce programmatic changes, or to give specific educational sessions (such as procedure skills), then the beginning of the academic year may be best. If evaluating the program is an essential component, the retreat should be held closer to the end. However, if held later in the year, the retreat must be scheduled far enough in advance of the new academic year that there is still time to implement any changes that are suggested. The length of the retreat depends on

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**“The retreat allows residents and faculty to discuss difficult issues, and have time to deal with emotions without having to immediately go back to patient care.”**

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the goals, the distance from the institution, and the funds available. Most retreats are from one to three days in length.

The content really depends on the goals that the program or institution wants to meet. It is essential that the question "what is in it for me?" (the resident) is addressed in planning the event. If the content merely focuses on the program's or institution's needs, the meeting will not be successful. Potential content areas include:


- (1) Bonding activities, because one of the most important goals is to improve communication. Sample activities include group sports, team building activities, "Resident Olympics," etc.
- (2) Panel discussions with patients. These could include patients from different religious or cultural backgrounds discussing aspects of their religion that impact patient care; patients who are dying talking about their feelings; or patients who were dissatisfied with their care discussing the reasons for this.
- (3) Panel discussions with the program's graduates who have entered various career tracks (private practice, HMOs, academics, pharmaceutical industry) and who discuss the pros and cons of specific practice opportunities. This gives trainees a more realistic picture of current employment situations than recruiters do. An added advantage of having graduates participate is that they can be involved in the sessions that assess the program, and discuss what they wish the program had taught them.
- (4) Workshops to enhance procedural skills.
- (5) Mock trials (this is especially good for risk management issues).
- (6) Role playing exercises.
- (7) Showing commercial movies or TV excerpts to illustrate points of relevance to the program.
- (8) Curriculum and program evaluations.
- (9) Teaching techniques with sample exercises.
- (10) Having the entire group air issues or hold a "gripe" session.

### ***The Outcome of Retreats***

In general, retreats are an effective method of achieving the goals listed above, and in improving resident satisfaction with the program. They can let the residents know that they are valued partners in the educational process. The impact on a program may be subtle or very profound. Enhanced interaction among the participants often results in an environ-

ment more conducive to education and patient care. Specific changes, such as new call schedules or different lectures, can be implemented. The program may be better prepared for an RRC site visit, or the retreat can be used to explain why certain changes must be made to enhance compliance with ACGME/RRC guidelines. However, merely holding a retreat is not sufficient. The most critical element is follow-up. If residents' suggestions and complaints are discussed at a retreat, but no action is taken, increased dissatisfaction and anger may result. Not only are

problems left unaddressed, but the residents may feel that the discussions were solely "show." In contrast, improved resident satisfaction may lead to more enthusiasm for the educational process, which results in more active participation in education, patient care and institutional activities, such as JCAHO visits.

In summary, resident retreats can be an effective way to enhance communications within a program, conduct program evaluations, implement curricular changes, deliver educational content, and improve morale. They allow this to be done in a non-threatening environment where all residents, and many of the faculty, are present and in which it may be easier to elicit participation. 

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**"If residents' suggestions and complaints are discussed at a retreat, but no action is taken, increased dissatisfaction and anger may result."**

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## **Complaints Against Residency Programs**

*Marsha A. Miller*

In 1998 the ACGME decided to test the hypothesis that the centralization of complaints along with data collection would demonstrate patterns and make the processing and resolution of residency complaints more effective. Before this change, complaints were handled separately by each specialty's RRC Executive Director. Decentralization made it hard to discern patterns. In order to make the residency complaint process more effective, changes in the Institutional Requirements, and new policies and procedures for egregious violations and for residency complaints were implemented, and a residency complaint data base was developed.

The Institutional Requirements were strengthened and make the protection of resident rights more explicit. The following Institutional Requirements are especially important to note. They were approved by the ACGME at its September 26, 2000, meeting and are effective immediately. Look for the newly approved Institutional Requirements on the ACGME website ([www.acgme.org](http://www.acgme.org)) in November. The wording that is bolded and underlined highlights the new language.

### **Additions to the Institutional Requirements to Enhance Resident Protection**

- I.B.3.f.4. Establishment and implementation of fair institutional policies and procedures for adjudication of resident complaints and grievances related to actions which could result in dismissal, **non-renewal of agreement of appointment, or any other action that** could threaten a resident's intended career development.
- II.C.3.c. **Non-renewal of Agreements of Appointment: Institutions must ensure that programs provide their residents with a written notice of intent not to renew a resident's agreement of appointment no later than four months prior to the end of the resident's current agreement of appointment. However, if the primary reason(s) for the non-renewal occur(s) within the four months prior to the end of the agreement of appointment, institutions must ensure that programs provide their residents with as much written notice of the intent not to renew as the circumstances will reasonably allow, prior to the end of the agreement of appointment. Residents must be allowed to implement the institution's grievance procedures as addressed in section I.B.3.f(4), when they have received a written notice of intent not to renew their agreements of appointment.**
- II.C.9 Residency Closure/Reduction: **All sponsoring institutions must have a written policy that** addresses a reduction in size or closure of a residency program. The policy must specify that if an institution intends to reduce the size of a residency program or to close a residency program, the institution must inform the residents as soon as possible. In the event of such a reduction or closure, institutions must allow residents

already in the program to complete their education or assist the residents in enrolling in an ACGME-accredited program in which they can continue their education.

The ACGME developed new policy and procedures for dealing with "Alleged Egregious Accreditation Violations or Catastrophic Institutional Events." An egregious violation is an occurrence of an accreditation violation or a catastrophic institutional event that because of its urgency is addressed outside of the established complaint process of the ACGME. The ACGME Executive Director, David C. Leach, MD reviews these allegations initially and then decides whether to convene a meeting with the Institutional Review Committee Chair and the RRC Council Chair. This committee determines whether an immediate on-site survey and consultation should occur. Some complaints that have been considered egregious are programs that close without notifying the residents in good time and fail to assist the residents in locating other positions, programs that operate without supervision, and programs that blatantly do not follow grievance and due process procedures.

The ACGME rewrote its procedures for handling all complaints. Especially important in the rewrite is the emphasis placed upon the ACGME's responsibility to monitor and, if warranted, take adverse action against programs that violate the ACGME Institutional and/or Program Requirements, including probationary accreditation or withdrawal from the accreditation process. Because the ACGME can only cite programs for accreditation violations and/or take an adverse action, it is important that residents first exhaust all due process avenues within the institution before filing a complaint with the ACGME. The ACGME cannot adjudicate disputes between program directors and residents, and once a resident is dismissed from the program the ACGME cannot get them reinstated. Sometimes the Residency Review Committees (RRC) will permit a temporary increase in resident complement to programs willing to take a resident that has been unfairly dismissed. In order for the RRC to grant a temporary increase, the program must be in good standing and have adequate resources.

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**"...in the absence of a clear violation of an accreditation requirement, the ACGME cannot adjudicate a dispute between a resident and his/her program director."**

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As complaints are received at the ACGME, they are directed to one person who enters the information into a database. Each Executive Director can still choose to handle the complaint or leave it with the "complaint administrator." If handled by the Executive Director, all information, including the outcome, is forwarded to the complaint administrator for data entry.

The centralization and data collection showed results and patterns emerged. The data collection from January 1998 through September 2000, displayed in **Figure 1**, shows the result of 86 individuals filing complaints with

the ACGME. Twenty-five of the complaints were anonymous, and the ACGME does not handle anonymous complaints. The stated reason for anonymity is fear of reprisal and loss of position although the ACGME keeps the resident's name confidential. Some of the complainants' allegations were not singular but included violations of multiple Institutional and/or Program requirements. Inadequate or no due process and/or lack of grievance procedures topped the chart, with inadequate work environment and excessive duty hours coming in second. **Figure 2** shows the breakdown of the number of complaints for specialties that received

——— **Figure 1** ———

**Types of Complaints Received by the ACGME**  
January 1998-September 2000

<b>Complaint</b>	<b>Frequency*</b>
Inadequate or no due process/lack of grievance procedures . . . . .	25
Inadequate work environment and excessive duty hours . . . . .	23
Lack of evaluation and feedback . . . . .	13
Discrimination . . . . .	9
Poor Educational Program . . . . .	9
Inadequate supervision or lack of supervision . . . . .	8
Contract Disputes . . . . .	5

\*Numbers do not equal total number of complaints, because some dealt with more than one concern.

——— **Figure 2** ———

**Breakdown of Complaints among Specialties With More than Five Complaints**  
January 1998-September 2000

<b>Specialty</b>	<b>Number of Complaints</b>
Internal Medicine (includes subspecialties) . . . . .	21
Diagnostic Radiology . . . . .	9
Surgery . . . . .	9
Emergency Medicine . . . . .	8
Anesthesiology . . . . .	7
Family Practice . . . . .	6
Pediatrics (includes subspecialties) . . . . .	6
Psychiatry . . . . .	5
All Other Specialties . . . . .	11
Total . . . . .	86

more than five complaints, again for the period from January 1998 to September 2000. Internal Medicine, General Surgery and Diagnostic Radiology have the highest number of complaints, with Emergency Medicine, Anesthesiology, close behind General Surgery and Diagnostic Radiology.

Due to the nature of the complaints, there was variation in the way they were handled. Some complaints caused site visits to be scheduled or the cycle shortened, others were placed in the program's file for the site visitor to pay particular attention to at the next survey, some were dismissed because of lack of evidence, and some are still in process and not yet resolved.


Two of the complaints during this time period were considered egregious violations; both had to do with lack of due process. One program had probation proposed and both have been scheduled for an institutional review. As of this writing, the outcome is not yet known.

Also, the ACGME saw for the first time a pattern. A complaint regarding lack of due process came from four residents in different programs at the same institution. This caused the ACGME to schedule an immediate Institutional Review.

Centralization of complaints and data collected supported the ACGME's decision to strengthen its procedures for and processing of residency complaints. The procedures outlined above have been implemented and can be found on the ACGME website at [www.acgme.org](http://www.acgme.org).

Finally, what can programs do to avoid residency complaints? It is simple.

- Develop fair institutional policies and procedures, distribute them to the residents and faculty, and most importantly, follow them.
- Provide formal written evaluations and prompt feedback.
- Have residents and faculty sign evaluations.
- Document and keep copies of everything in the resident file and permit the residents access to their files.

The ACGME is committed to graduate medical education and to one of its most important stakeholders – the future doctors of America. 

## Two Frequently Asked Questions about the ACGME Outcome Project: Time-Line and Minimum Language

*Susan Swing, PhD and Patricia Surdyk, PhD*

### *Time Line*

The ACGME is continuing with the phasing-in of its accreditation system based on educational outcomes. The Council determined that language addressing the general competencies must be placed in all Program and the Institutional Requirements by July 1, 2001. RRCs may either opt to use the ACGME's Minimum Language for the General Competencies, or may develop their own language for the competencies and evaluation requirements. The latter must be approved by the ACGME's Program Requirements Committee. For specialties in which language related to the general competencies has not previously been present in the Requirements, the period from July 1, 2001 to June 30, 2002 will allow programs time to phase in the revised

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requirements. During this period, these efforts may be highlighted in site visit reports as “best practices,” but programs will not be held accountable for the added education and evaluation requirements created by the competencies. They will not be part of the formal accreditation review. This will provide RRCs and programs some added time to plan for implementation of the competencies and development and incorporation of a growing number of increasingly more dependable assessment tools.

### **Minimum Language**

This next section provides answers to some frequently asked questions about the "Minimum Language."

### **Educational Program**

*"The residency program must require its residents to obtain competencies...to the level expected of a new practitioner"* reflects the essence of the Outcome Project. Not only are residents expected to engage in educational activities, but, the learning objectives of those activities must be achieved.


### **Evaluation**

A great deal of background work is currently underway to help RRCs determine what an *"...effective plan for assessing resident performance"* might look like in the various specialties in which training is accredited by the ACGME, and which assessment methods might be considered *"dependable."* Within the next several months, results of a joint initiative between the ACGME and the American Board of Medical Specialties (ABMS) and discussions of the Outcome Project Advisory Group concerning model assessment systems will become available. In addition, the aim of the "Toolbox of Assessment Methods" is to identify *"dependable [assessment] measures."*

The statement: *"Programs that do not have a set of measures...must demonstrate progress in implementing the plan"* acknowledges that many programs will need time to do an acceptable job of implementing evaluation methods that are increasingly more dependable and useful for improving their educational program. This requirement allows programs to **phase in** improvements in evaluation as an expected "outcome" of the Outcome Project.

A major goal of the Outcome Project is to define and implement an expanded role for continuous improve-

*using resident and performance assessment results together with other program evaluation results to improve the residency program."*

Both the Full version and Minimum Language versions of the competencies, answers to other frequently asked questions and a copy of the first edition of the "Toolbox" can be found by selecting the **Outcome Project link** on the ACGME web site at [www.acgme.org](http://www.acgme.org). In the weeks to come, this site will continue to grow with additional resources to assist programs in their efforts to integrate the general competencies and improved assessment methods into their educational planning. 

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**"A major goal of the  
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residency programs."**

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ment in residency programs. Thus, the section entitled *"Program Evaluation"* outlines the expectation that the residency program *"should have in place a process for*

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## RRC/IRC COLUMN

### **ACGME Approves Revised Institutional Requirements**

The ACGME adopted the revisions of the Institutional Requirements at its September 26, 2000 meeting to become effective immediately. The majority of the changes helped clarify existing requirements, particularly those that pertain to the internal review process. A few noteworthy changes are shown in **Exhibit 1** below.

#### ———— Exhibit 1 ————

#### Changes and Additions to the Institutional Requirements Effective September 26, 2000

1. The GME Committee is charged with the responsibility for reviewing on a regular basis all ACGME letters of accreditation and monitoring correction plans. (I.B.3.c.)
2. Regular internal reviews must be conducted of all subspecialty programs. (I.B.3.d.)
3. The internal review must be conducted by the GMEC, or a body designated by the GMEC, which must include faculty, residents, and administrators from within the institution but from programs other than the one that is being reviewed. (I.B.3.d.(1)).
4. All internal reviews are to be conducted at approximately the midpoint between ACGME program surveys. (I.B.3.d.(2)).

Aside from these clarifications, there were three new additions:

1. All individuals involved in GME (administrators, residents and faculty, etc.) must have access to adequate communication technologies and technological support to include at least computers and access to the internet. (I.B.)
2. If an institution intends not to renew a resident's contract, it must ensure that the resident is notified in writing no later than four months prior to the end of the resident's current contract. However, if the intent not to renew a contract occurs within the four months prior to the end of the contract, institutions must ensure that programs provide the resident with as much written notice of the intent as circumstances will reasonably allow prior to the end of the contract. Residents must be allowed to implement the institution's grievance procedures as addressed in section I.B.3.f.(4) when they have received a written notice of intent not to renew their contracts. (II.B.4)
3. All sponsoring institutions must have a written policy that addresses professional activities outside the educational program to include moonlighting that is in compliance with requirement II.C.11.

#### **Changes in the Requirements for Family Practice and Pediatrics**

For Family Practice, the revisions, including the incorporation of the ACGME competencies that were available on the Website for comment earlier this year and that were discussed at the Program Director Workshop in June, were approved by ACGME in September 2000.

A workshop on the practical application of the competencies in programs in Family Practice and Pediatrics will be included in the ACGME Mastering the Accreditation Workshop in March 2001.

#### **Other Changes in Program Requirements**

The ACGME approved revisions to the Program Requirements for Radiation Oncology, Obstetrics-Gynecology, Preventive Medicine, and minor revisions to the Program Requirements for three subspecialties of Internal Medicine — Hematology, Hematology-Oncology, and Nephrology.

The Council also approved the addition of the General Competencies language to the following Program Requirements: Colon and Rectal Surgery, Family Practice, Neurology and Pediatrics.

The new requirements, included those with the addition of the General Competencies language, will become effective July 1, 2001. All new program requirements can be found at the ACGME's address on the World Wide Web ([Http://www.acgme.org](http://www.acgme.org)). Program requirements that have been approved but are not yet in effect, are located within each RRC web page, under the subheading "Approved but not currently in effect."

## Other Highlights from the September 2000 ACGME Meeting

### *Election of ACGME Officers and Recognition of Outgoing Directors*

The ACGME elected the following Officers of the ACGME for 2001: Daniel H. Winship, MD, AAMC (Vice-Chair), Richard Allen, MD, AMA (Treasurer), John I. Fishburne, Jr., MD, CMSS (Officer), D. David Glass, MD, ABMS (Officer).

R. Edward Howell, Chief Executive Officer of the University of Iowa Hospitals and Clinics, and incoming ACGME Chair, recognized the contributions to the ACGME made by Paul Friedmann, MD, ACGME Chair whose term ended at this meeting. The ACGME also recognized the contributions of the other ACGME Directors whose terms ended: David L. Nahrwold, MD, who served as a member of the Executive Committee and Chair of the Committee on Strategic Initiatives; Carol Berkowitz, MD, who serves as Chair, RRC Council of Chairs; Charles E. Allen, MD, F. Stephen Larned, MD, who also served as Chair of the Monitoring Committee; Ellison C. Pierce, MD, and Stephen J. Thomas, MD, who completed his term as Vice-Chair, RRC Council of Chairs.

### *Follow-up on Duty Hour Citations*

This year marked the first time the ACGME published data on the frequency of citations for violations of the requirement governing resident duty hours. (see ACGME Bulletin, April 2000) Across many of the major disciplines, 20 to 30 percent of programs were cited in 1999 for violating duty hour requirements established by groups of their peers. In response, the ACGME has decided to strengthen its mechanisms for responding to work hour citations, by requiring programs that receive this citation, and their sponsoring institution, to respond to the citations immediately with a plan for corrective action.

### *ACGME Fee Structure for 2001*

The ACGME approved the revenue and expense budgets for 2001. The accreditation fees for the year 2001 will remain the same as those for the year 2000. The fee for programs with five residents

or more will thus remain at \$2,500 per year; fees for programs with less than five residents and for inactive programs will continue to be \$2,000 per year. Application fees remain at \$3,000 per application; fees for late cancellations of a scheduled site visit will continue to be \$2,000; and fees for late notice of intent to voluntarily withdraw a program or place it on inactive status will remain at \$1,000.

### *J-1 Visa Holders Training in Non-ACGME Accredited Programs*

The ACGME approved the content of a standard letter to be sent to programs that have individuals on J-1 Visas who want to extend their Visas for additional training in a program not currently accredited by the ACGME or where training is not approved by an ABMS member board. These programs frequently contact the ACGME



R. Edward Howell (left), incoming Chair of the ACGME, receives the gavel from Paul Friedmann, MD, Senior Vice President of Academic Affairs, Baystate Medical Center, and outgoing ACGME Chair.

to request a letter endorsing this action for a particular individual who wants this added training. The ACGME feels that such an endorsement could imply an act of accreditation for these programs, which is not the case. The standard response clarifies this for any program requesting such a letter.

#### *Update on the ACGME Web-Based Accreditation System*

The ACGME's Web-Based Accreditation System, which will collect programs' and institutions' demographic information for the accreditation process, is up and running. Data gathering began on October 9, 2000 at the institutional level, with data being collected from twenty previously identified institutions. This will be followed by phased implementation across the various specialties, beginning mid-November 2000. Data collection will be an ongoing process, and will provide the ACGME with data submitted in "real time."


#### *RFP Process Results in Submission of More Than 65 Proposals*

The Request for Proposals 2000 (RFP 2000) Project to date has resulted in the receipt of more than 65 proposals. Proposals will be evaluated throughout the coming months, and the ACGME plans to highlight the RFP 2000 Project submissions in a special issue of the ACGME Bulletin, to be published in early 2001.

#### *RRC Resident Council*

The ACGME approved the recommendation to establish an RRC Resident Council whose members had been meeting on a semiformal basis as a standing committee of the ACGME. The Chair of the new RRC Resident Council will henceforth be invited to attend all ACGME meetings.

#### *September 22, 2000 Joint Meeting of the ABMS and ACGME*

A meeting of the ACGME and the American Board of Medical Specialties was held on September 22, 2000 to continue the work of the specialty-specific "Quadrads," composed of a Program Director, a Resident, an RRC Chair and a Medical Specialty Board Member. The Quadrads worked throughout the summer to develop discipline-specific language and an initial set of evaluation tools for each of the six competencies. The day was used to determine which competencies spanned all disciplines and what assessment tools could be used to assess competencies. The work of the Quadrads will be completed by the end of October 2000. 

*ACGME Bulletin Editor's Occasional Column:*

## Analyzing Decision-Making in Groups - Findings from the Management Literature with Application for Medical Education

*Ingrid Phillibert*

*"Decision-making is a highly contextual, sacred activity surrounded by myth and ritual, and as much concerned with the interpretive order as with the specifics of particular choices." - James G. March*

Team-based approaches in health care have increasingly become the norm across a wide range of settings. At the same time, use of teams in other work settings has produced a body of literature on team decision making and what characterizes successful teams. Characteristics frequently mentioned include closed-loop communication; differentiating roles while compensating and backing-up individual functions; mutual performance monitoring; and cooperative interaction toward the pursuit of shared objectives (Kraiger and Wenzel, 1997). Most research studies "permanent teams," and many characteristics of effective teams are tied to team longevity. Most health care teams are relatively stable, but some settings – such as emergency rooms and teaching hospitals – are characterized by the use of fluid and flexible "transient teams." What frequently also characterizes these settings is a higher degree of complexity, ambiguity and stress. In teaching settings, the presence of learners adds to complexity, because teaching is carried out simultaneously with patient care, and adds to ambiguity because learners have to 'learn by doing,' by actively participating in diagnosis and treatment decisions being made.

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**"...some settings – such as emergency rooms and teaching hospitals – are characterized by the use of fluid and flexible transient teams."**

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In an article in which he discusses the limits of "sense making" in organizations, Karl Weick (1993) noted that how transient teams deal with difficult, dangerous situations is timely because he states, "the work of organizations is increasingly done in

small temporary outfits in which the stakes are high and where foul-ups can have serious consequences."

It is probably not realistic to expect to find the characteristics of successful permanent teams in their transient counterparts. Weick is thus interested in how transient teams make decisions. Earlier research had focused on the effectiveness of techniques that emphasize rigorous debate among the group members holding opposing opinions produce decisions that are superior to those produced by a harmonious group. Techniques like Devil's Advocacy or Dialectic Inquiry have been used in management teams (and were incorporated into the decision-making repertoire of John F. Kennedy's Cabinet after the disastrous "group think" that produced the Bay of Pigs invasion). The two techniques differ, but both help a team to identify and address diverse assumptions that underlie a given issue.

But these techniques require a more permanent team and time for formal decision-making processes. Weick's focus is on temporary teams and situations of significant complexity requiring rapid decisions. He points out that research in the field

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**"Weick's focus is on temporary teams and situations of significant complexity requiring rapid decisions."**

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has shifted from looking at decision-making in the classical sense to an emphasis what he terms sense making; the role of power in decisions; and models that consider interpersonal and social relations. Sense making is defined as an approach that views reality as "an ongoing accomplishment that emerges from efforts to create order and make retrospective sense of what occurs."

He analyzes sense making, or rather its limits, using the example of a temporary team of U.S. Forest Service firefighters fighting the Mann Gulch Disaster, made famous by Norman McLean's 1992 Book "Young Men and Fire." Based on this, Weick suggests four ways in which a temporary team's resilience in complex situations can be strengthened: (1) improvisation, (2) virtual role systems, (3) a new approach toward "wisdom," and (4) respectful interaction.

The ability to improvise becomes more important as the uncertainty of a situation increases. Yet, Weick states when individuals are put under pressure, they revert to their "most habituated ways of responding."

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**"...to use the various abilities of the members of a team effectively requires the group to identify and synthesize the varying skills of the members and use those most appropriate to the decision at hand."**


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He adds that individuals who "habitually" live on the edge, where improvisation is a necessity, excel in it for just that reason. He defines a virtual role system as each individual being competent in all the roles in a team, to allow them to "assume whatever role is vacated, pick up the activities, and run a credible version of the group." His definition of "wisdom" is overcoming the limitations posed by the firefighters' own definition of their purpose, which was "putting out fires so fast they cannot become large fires." Thus, they had little experience and little perception of themselves having experience in fighting large fires. The parallel to medicine here is particularly poignant.

In defining his fourth recommendation, respectful interaction, Weick suggests that focusing on social relationships and networks in difficult situations enables "social construction," a combined search for meaning. In another article on trust in temporary groups, Weick and colleagues (1996) proposes that trust can be generated in transient teams, and that attentiveness to social structures is vital in this. Individuals "trust" the role the other has been recruited to play – emergency room physician, anesthesiologist – and his/her competency to carry out the role's responsibilities. But this 'role confidence' can be shaken, when the circumstances do not fit the traditional patterns. McLean's book illustrates this point. In dealing with a grass fire on a ridge, the firemen who are trained on forest fires, initially refuse to leave behind their axes, useless in a grassfire and a weight and hindrance in climbing the ridge. When the foreman, who was unfamiliar to most of the team, does something highly unusual – lighting an escape fire, which none of the men had seen before – the men refused to join him. They did this because they did not know him and thus did not trust his decisions, and "there was not time to change this," nor was there time for him to explain. Most of them burn to death. He survives.

What this unlikely story (yet, frighteningly, many of us can think of parallel examples from medicine) demonstrates is that, to use the various abilities of the members of a team effectively requires the group to identify and synthesize the varying skills of the members and use those most appropriate to the decision at hand.

Weick supports his suggestions with the findings of related research in each of the four areas. Yet what remains to be tested is the hypothesis whether improvisation, virtual role systems, respectful interaction, and defining "wisdom" as understanding the complexity of unknown domains, are effective in facilitating information processing in temporary teams in critical situations. Weick's recommendations are not specifically intended to address decision-making in medical teams, and need to be adapted to the medical setting, where team functions cannot easily be exchanged. Other work has explored the impact of individuals on teams having distributed resources, including specific 'static' knowledge and expertise. This could be knowledge in a medical discipline, nursing or another field, combined with role expectations on the part of the individual and his or her team members. Decisions in health care frequently still are not the domain of the team, but are made by a single individual with primary responsibility for the patient (the "treating physician"), often with input from the group. The dynamics of information transfer in these 'input' situations likely

differ from the examples discussed here. At the same time, for decision-making that truly involves a team, the two closest models may be the emergency room, where a team collectively decides how to diagnose and manage a critical patient and the teaching hospital, where residents must learn how to independently diagnose and manage patients but where care must be under the supervision and coordination of a faculty physician. 

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## **A Clarification from the Editor:**

In the June 2000 ACGME Bulletin, we published a letter by Dr. Jonathan Rhoads, commenting on resident work hours. In my response to Dr. Rhoads, I provided a general restatement of the ACGME standards on work hours. Since that general statement did not reflect the specific standards of the various RRCs, we received a few questions about how the ACGME considers the requirement that residents "on average, have one day off in seven, and are on-call no more than every third day."

My general restatement inadvertently left off "on average," making the one day off in seven appear to be an absolute. This resulted in some confusion and it is worthwhile to clarify this requirement by stating that the RRCs and the Institutional Review Committee treat this requirement by aggregating a two-week or four-week period to produce the average. Averages aggregated across periods longer than that, e.g., situations where residents are not permitted four days off per month in some sequence of days, can result in the program being cited for non-compliance.

In addition, a few questions arose because some specialties, like Surgery and Neurological Surgery, phrase this requirement as a "desirable." For example, the Neurological Surgery requirements are as follows: "It is desirable that residents' work schedules be designed so that, on average, excluding exceptional patient care needs, residents have at least one day out of seven free of routine responsibilities and be on-call in the hospital no more than every third night." This produced questions on whether these disciplines place less value on the requirement. It is useful to remember that programs can be cited for failing to comply with a "desirable" requirement. The glossary defines "desirable" as:

A term, along with its companion, "highly desirable," used to designate aspects of an educational program that are not mandatory but are considered to be very important. A program may be cited for failing to do something that is desirable or highly desirable.