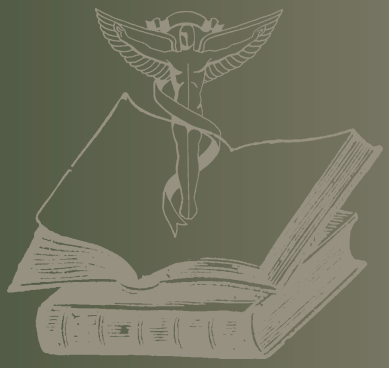

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Accreditation Council for Graduate Medical Education
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ACGME BULLETIN October 2001

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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Editor's Introduction:

Some Internal and External Views of the Accreditation Process

Originality is simply a pair of fresh eyes.

- Thomas Wentworth Higginson

Over the past months, medical education appears to have faced greater public scrutiny. Reports in the media have covered residents' long duty hours; diminishing interest in medicine as a career; and the plight of teaching hospitals. Many hospitals are faced with the problem of maintaining adequate staffing with a shrinking pool of qualified workers and the specter of a health care system inadequately staffed and unable to care for those in need has been raised. Most recently, the ability of the nation's health care system to respond to threats posed by bio-terrorism has been questioned. Related to resident education, newspaper coverage and a petition to the Occupational Safety and Health Administration have heightened interest in how graduate medical education is organized and what systems are in place to safeguard residents' health and ability to learn, and the safety of patients in the care of those residents.

Increased interest in medical education and the institutions in which it occurs has brought the ACGME, as the accrediting entity for resident education, closer to the public's attention. Our role in ensuring that duty hours are appropriate from the multiple perspectives of effective learning, safe patient care and resident safety has been mentioned in the coverage of the duty hour debate. Yet most members of the public likely still do not know how the ACGME does its work. Within our own community, residents and many others may also not completely understand how accreditation functions and what its objectives are. To be most relevant in our accrediting activities, we need the perspective of these publics. The public members of the ACGME provided some of it. They also alert us how difficult it can be for an "outsider" to understand the systems of medical education and accreditation, even if the outsider is part of the most intimate and involved discussions on these subjects. The ACGME values the "voice of the public" provided by the public members. It is refreshing and sobering to be reminded that "80 hours per week" sounds like a lot to most Americans. It is also important for any accrediting body to realize how its actions are perceived by those not part of the process.

This issue of the ACGME's Bulletin captures views of the ACGME and its accreditation activities from several individuals - both "observers" and "participants." They include an article on professionalism by an ethicist; and perceptions of the accreditation process by an observer from another country and by a relatively new staff member. They also include a fresh look at our processes by the members of our community – thoughts about accreditation resulting from work done by the Chairs of the Residency Review Committees (RRCs) at a recent retreat. The regular column by the ACGME's Executive Director's Column seeks a simple accreditation model for an increasingly complex environment, but one whose simplicity "lies on the other side of complexity." This issue also provides the usual ACGME information items, along with updates on

the Outcome Project and on how the Council is addressing resident duty hours, one of the issues that have sparked the current public interest. We realize that most graduate medical education programs are microcosms of the events, thoughts and perceptions that operate at the national level. We hope that the topic of how the graduate medical education community and its accrediting body are perceived is of interest, and that this issue of the Bulletin provokes thought.

Executive Director's Column: Seeking the Simplicity on the Other Side of Complexity

David C. Leach, MD

Some have described accreditation as a trailing edge phenomenon. Accreditation standards reflect time-tested and mainstream practices rather than new and relatively untested concepts. However, constrained resources and increasingly complex medical advances create an urgent need for academic health centers to adapt intelligently to a rapidly changing environment. In such a setting, trailing edge accreditation may be less relevant and may even get in the way of best medical practice. Needed is a system that encourages adaptability, yet preserves fidelity to established principles without being overly prescriptive. Properly applied, the use of educational outcome measures offers an opportunity to achieve both flexibility and accountability.

"Needed is a system that encourages adaptability, yet preserves fidelity to established principles without being overly prescriptive."

Sponsoring institutions, residency programs, Residency Review Committees and the ACGME itself are all in the first phase of implementing the ACGME general competencies and outcome assessment project. This phase, *Forming the Initial Response,* will last until June 2002. The second phase, *Sharpening the Focus and Definition of the Competencies,* will begin in July 2002 and last for four years. The two phases offer the opportunity to develop an accreditation system that is more relevant and aligned with emerging best practices. A crucial nexus of accreditation, certification, constrained resources and calls for increased accountability enables an improved model to emerge.

The six general competencies (patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice) can be described as "organizing principles that permit conversations about our work" (attributed to Marvin Dunn). Regardless of the specialty, place, type of sponsor, or year of training, these domains offer a framework for describing what good training looks like. They are organizing principles, not prescriptive rules. Three other organizing principles are: measurement; the educational continuum; and ongoing improvement. Our profession can be defined by the competencies we care about, the type of measures we use to judge them, what distinguishes novice from master, and how we go about improving our work.

"I wouldn't give a fig for the simplicity this side of complexity, but I would give my life for the simplicity on the other side of complexity."

Oliver Wendell Holmes said: " I wouldn't give a fig for the simplicity this side of complexity, but I would give my life for the simplicity on the other side of complexity" (as quoted in Peter Scholtes *The Leader's Handbook*). As we form initial responses to the ACGME Competencies we immediately confront two possible errors: forming a prematurely simple but irrelevant response, and getting bogged down in complexity. We should begin with the aim of achieving the simplicity on

the other side of complexity. What might it look like? A clear understanding of what skills the resident is expected to demonstrate and a set of assessment tools that confirm achievement of those skills are two things needed to get us to "the simplicity on the other side of complexity." The skill sets are broad and will require representative rather than comprehensive testing. Combining different assessment approaches can compensate for the deficiencies of any single modality. Multiple observations over time can illuminate growth or lack thereof in skill sets. Assessment approaches that are feasible, and are woven into the experiential learning get closer to an assessment of actual performance. A range of assessment tools can be found on the ACGME web site (www.acgme.org).

Residency Review Committees (RRCs) are presently forming their initial response to this accreditation initiative. Gail McGuiness, MD, chair of the RRC for Pediatrics, chairs a "Think Tank" of RRC members from several disciplines. The group is using the nine months remaining between now and the "implementation date" of July 2002 to clarify expectations for the RRCs themselves and for accredited programs. The group's report will illuminate the work of the various RRCs. A relational database will enable experiences with different assessment techniques to be analyzed, allowing simple and effective methods to be identified.

"Clarifying what we want residents to learn and demonstrating whether they have learned those things will also clarify the substance and form of medicine."

In this time of significant change in the environment for residency education, and in the accreditation process, it is important to remember that the only things real in any residency program are the people functioning within it, and the relationships they have with each other. These relationships can either inhibit or facilitate learning. Clarifying what we want residents to learn and demonstrating whether they have learned those things will also clarify the substance and form of medicine. To paraphrase the architect Louis Henry Sullivan: Form ever follows function, or substance. The relationship of residents, faculty and patients is at the core of the substance of education. When the accreditation process will get at the heart of that substance, we will have reached the simplicity on the other side of complexity.

Developing Competency in Professionalism: The Potential and the Pitfalls

Mark G. Kuczewski, PhD

What is Professionalism?

Everyone currently seems to be interested in professionalism. As readers of this publication are well aware, accrediting bodies such as the ACGME require that the programs they oversee foster competency in professionalism. Furthermore, it is a topic of increasing interest in the medical and the bioethics literature. Why? Clearly there are many answers to this question but a few bear exploring.

Invoking a sense of professionalism promises to revive aspirations for physicians that have long seemed unattainable or perhaps, less attainable in recent years. As historian David Rothman notes, the focus of discussions of professionalism has increasingly become economic arrangements that might compromise the fiduciary relationship between the physician and patient[1]. The financial incentives to reduce utilization, gifts from pharmaceutical companies, monetary rewards for recruiting patients to clinical trials, and misplaced personal investments can lead to utilization patterns that do not place the best interest of the patient paramount. Such matters clearly deserve attention. However, the word 'professionalism' also has a variety of connotations in ordinary discourse and these reverberate through many discussions of professionalism. Among the common issues associated with professionalism are:

- Medical etiquette - Problems of grooming, dress, hygiene, and punctuality;
- Interpersonal communication - Skills in conveying meaning to and gathering information from patients, members of the health care team, students, and other health care providers along the continuum of care;

- Medical ethics - a. Issues related to the character of the physician (honesty, does not mistreat, abuse, or sexually harass students, residents, or nurses, does not engage in sexual relations with patients) b. Skills related to treatment decision making such as procuring informed consent, assessing patient decision-making capacity, and end-of-life decision making and care for patients;.
- Cultural competence and sensitivity;
- Service to society - Civic leadership related to health issues, service to the underserved, the uninsured and the poor.

What can it mean that such diverse meanings are united under one banner of "professionalism?" Should we try to make sense of such a many faceted term or is it likely to be vacuous because it is so all encompassing? I believe that the professionalism movement presents a tremendous opportunity and is worth the effort to ferret out the core meaning that provides this movement its impetus. Virtually all philosophies of medicine give primacy to the physician-patient relationship.[2] Clearly medicine exists to serve patients. This occurs because illness renders a patient vulnerable and in need of the technical expertise of the physician, an expertise that the patient is poorly situated to evaluate, the patient needs to be able to trust the medical professional. Fostering this "fiduciary" relationship (from "fides," the Latin word for "trust") traditionally formed the focal meaning of professionalism and led to an emphasis on technical competence. However, the turn toward financial relationships as well as the multifarious connotations we have highlighted reflects the evolution of the physician-patient relationship.

"Most immediately associated with professionalism proper are those norms that are closest to direct patient care such as those related to truth telling and informed consent."

The duty to foster the patient's well-being remains paramount. However, the physician-patient encounter now takes place within a web of interlocking relationships involving other health care professionals, third-party payers, and a society that seeks leadership concerning the integrity of these relationships. Training physicians to be professional means teaching them to navigate this complex terrain in a way that continues to serve the patient's best interest. We might best think of *medical professionalism as the norms of the relationships in which physicians engage in the care of patients.*

This definition in terms of relationships sheds light on the interrelationships among the competencies. Most immediately associated with professionalism proper are those norms that are closest to direct patient care such as those related to truth telling and informed consent. Of course, the implementation of these norms will draw upon communication skills and require knowledge of, and an ability to successfully navigate, the systems in which this encounter takes place. Because education must always proceed in stages, it is useful to have the competencies subdivided as has been done in the ACGME list. But, it is important in designing professionalism programs to be sure that training is directed at all the relationships that contribute to patient care and to appreciate them as integral to professionalism.

The Promise of a Focus on Professionalism

At Loyola University Medical Center, we see great promise in the new focus on professionalism. Loyola University Chicago is a Jesuit, Catholic university. Deep within this heritage is a tradition of educating persons to serve others and promote justice.[3] This tradition can easily be adapted to the language of professionalism in medicine. And, it is likely that such language might be far more efficacious than the traditional language of duty and ethics.

Ethics has long been a suspect term in medicine as it suggests outsiders invading the domain of the physician to "police" clinical practice. But, emphasizing the leadership role of the physician in serving the interests of the patient and the health needs of society clearly have the ring of being endogenous to good doctoring. As a result, professionalism provides us with a vocabulary to call physicians back to their vocation. This notion of re-appropriating endogenous elements of medical tradition and medical practice has guided our efforts.

Although we have a variety of initiatives under way to develop competency in professionalism among our residents and medical students, I will highlight just one. We have recently embarked on a focus group project with our residents to determine "best practices" related to professionalism and to use their credibility to educate our medical students in these practices. Our first forays into this area involve discussion of cases in which residents disagreed with a treatment plan or some behavior of a physician. We gathered several residents and presented them with an initial case scenario in which an attending physician complied with the request of a patient's adult daughter to withhold prognostic information from the patient.

We created a videotape of the residents' reactions to the scenario and showed this video to our third-year medical students as part of their education in professionalism. The residents' discussion served a variety of purposes: (1) identifying approaches to discussing the case with the attending physician; (2) verifying that this kind of case scenario was commonplace and that such a difference of opinion could be effectively addressed by the resident; (3) identifying the assistance of other members of the health care team, e.g., social work staff, who could be of help; and (4) demonstrating a commitment to reason through the scenario to secure a resolution that fostered the patient's good.

We believe that we will learn much from this initial group and the ones that follow it as residents "in the trenches" probably know a good deal about strategies for resolution and have a high degree of credibility with our medica students owing to the intimate role-modeling relationship of residents to medical students in the clinical years. Furthermore, asking our residents to reflect on their best practices may be an effective way to foster their own professional competence and to elicit their commitment to such practices.[4] We believe this kind of reflection and role modeling must permeate our professionalism education efforts.

The Peril of the Path of Least Resistance

Any good thing can go wrong. It's not hard to see how this can happen with the attention given professionalism as a competency. Here are some obvious (and, perhaps, not so obvious) possibilities:

- Professionalism might become operatively associated with etiquette and discipline issues.
- Medical schools and residency programs may create effective disciplinary channels to deal with the unprofessional behavior of students and residents but fail adequately to address student mistreatment and related unprofessional behaviors of faculty.
- We could fail to connect professionalism with systems-based practice issues and thereby, turn professionalism in on itself rather than outward toward the role of the physician as civic leader.

All accreditation standards go through periods in which they are new, and the opportunities they provide for innovation and restructuring generate excitement, or anxiety, as the case may be. But, the ultimate measure of such standards is how they are institutionalized and implemented on an ongoing basis. Many factors help to determine this legacy including power relationships within organizations.

"All accreditation standards go through periods in which they are new, and the opportunities they provide for innovation and restructuring generate excitement, or anxiety, as the case may be."

Although the professionalism of medical students and residents is more likely to be shaped by the behavior of their role models than any other single factor, it is probably the hardest factor to address. The behavior of faculty physicians in terms of student mistreatment including sexual harassment and failure to work effectively as part of a health care team are difficult behaviors to change and are not easily addressed given the realities of academic medicine in which faculty who are productive researchers and generate significant practice revenue must be prized. At the same time, there are no barriers to medical school or residency faculty using professionalism as a catch-all to penalize their students and residents for virtually any annoying behavior.

This can easily create a situation that compounds the cynicism of future physicians.

Similarly, professionalism must not be a term that enables a turn inward on the profession of medicine. As the norms of the physician's relationships, it is an invitation to look outward toward those relationships and to foster the patient's good through them. This approach must extend through the interpersonal realms into systems-based practice so that the physician can serve the patient and the public at all levels. This reconnection with leadership is, perhaps, the antidote to a view of professionalism as one more way to levy external demands on the physician. It may be the way to prevent "professionalism" from going the way of "ethics."[5]

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Mark G. Kuczewski, PhD, is the Director of the Neiswanger Institute for Bioethics and Health Policy, Stritch School of Medicine, Loyola University Chicago. He is a philosopher by training whose research and writings have focused extensively on clinical ethical decision making and is the author of ***Fragmentation and Consensus: Communitarian and Casuist Bioethics*** (Georgetown University Press, 1997), co-author (with Rosa Lynn Pinkus) of the popular ***An Ethics Casebook for Hospitals: Practical Approaches to Everyday Cases*** (Georgetown University Press, 1999), and co-editor (with Ronald Polansky) of Bioethics: Ancient Themes in Contemporary Issues <http://mitpress.mit.edu/bioethics-series.html> (MIT Press, 2000). His research interests include disability ethics, all aspects of informed consent, research ethics, and the teaching of professionalism.

The ACGME's General Competency and Outcome Assessment Project: Countdown to Implementation

Susan Swing, PhD

In less than nine months, the ACGME and RRCs will begin reviewing program information for evidence that implementation of the general competencies is occurring. From July 2002 through June 2006, one major task for programs is to make sure they provide an educational environment and teaching-learning experiences that foster residents' development in all six general competency domains. Programs also will need to use methods that provide accurate, objective evidence when assessing resident performance. The identification of learning objectives for the competencies is a prerequisite of both these tasks. Not all implementation tasks must be accomplished at once, but steady progress is expected.

Currently, the ACGME is working to better define implementation expectations. One part of this work is to define a "good enough" assessment system, or in other words a set of methods that will produce sound evidence of residents' attainment of the competencies. This model system is intended to guide implementation, not prescribe exactly what programs should do. One group involved in this work is the RRC Outcome Project Think Tank, chaired by Dr. Gail McGuinness and composed of current and former RRC or ACGME members from nine specialties. This Think Tank also will participate in work to identify interim benchmarks that the RRCs and programs themselves can use to gauge adequacy of implementation progress. The goal is to complete this work by July 2002.

An efficient path to improving teaching and assessment of the competencies will involve taking advantage of opportunities to learn and apply existing ideas. The ACGME is pleased to announce the recent expansion of our General Competency and Outcome Assessment website to include, among other things, example assessment methods for two competencies. The posting of assessments for the other competencies will follow at later dates. Another new addition to the web site, named "Reports from the Field," will feature short descriptions of activities that programs are engaged in to facilitate teaching and learning of the competencies.

Increasingly, sessions about the competencies are being provided at national meetings sponsored by program director associations and medical education organizations such as the Association of American Medical Colleges and the Association for Hospitals of Medical Education. The ACGME's own workshop, "Mastering the Accreditation Process" provides learning opportunities through didactic sessions and poster presentations. In March 2002, the ACGME is partnering with the American Board of Medical Specialties to sponsor the first of six conferences to address the general competencies. The first conference will address patient-physician communication.

Programs' use of sound assessment techniques will be a central focus of this phase of implementation and represent the first step toward increasing emphasis on outcome assessment in accreditation. This first phase of implementation of the Outcome Project will not dramatically change the way that accreditation is done. However, an even greater good will be accomplished if programs' efforts produce new physicians committed to the values and skills the general competencies represent.

Susan Swing PhD, is the ACGME's Director of Research and the principal investigator for the Robert Wood Johnson-funded grant that supports the ACGME's Outcome Project

"An efficient path to improving teaching and assessment of the competencies will involve taking advantage of opportunities to learn and apply existing ideas."

Graduate Medical Education – A Point of View from Abroad

Christophe Segouin. MD, translated by Judith Armbruster, PhD

Recently, I had the opportunity to be an observer at three ACGME accreditation visits for different specialties. I was invited by the ACGME to share my impressions of the process from a European perspective. Before giving my reactions I will provide a quick sketch of the French system.

Two facts about France are important: the universities and the hospital systems are public, and medical education from beginning to end is conducted under the auspices of these public universities. France's 44 "medical schools," more accurately referred to as "medical faculties," belong administratively to the universities. The clinical training takes place in public University Hospital Centers that are responsible for the clinical training of physicians. In metropolitan Paris, for example, this is the Assistance Publique-Hopitaux de Paris, for which I work.

Medical education is virtually free to the student and initial registration is open to anyone who has passed the *baccalaureate,* the exam taken after the equivalent of high school in the United States. However, approximately 90 percent of the beginning students are eliminated at the end of the first year by a difficult selection exam that covers the year's didactic content. The entire course of medical education, through completion of specialist training, is about eleven years in duration and is divided into a continuum of three cycles, the last of which is the period of specialty training (residency). Like in the US, the duration of this period depends on the medical specialty.

To enter residency training in France, the student must take a competitive exam that is given every year. The score on this exam, not the performance in the preceding years of training, determines the student's success in obtaining his or her choice of specialty and location. Specialist training comprises a minimum of four years, organized into eight rotations each of six months duration. If, instead of specialist training, the student chooses to become a general practitioner, he or she spends two years in hospital rotations and six months in a supervised private office practice.

The medical degree and the right to practice are not awarded until completion of specialty training, and until the resident has prepared and defended a thesis under

the authority of the university. The specialty colleges or associations play no role at this final stage, it is rather the medical faculty within the university that delivers the "specialty doctorate degree," and with it the right to practice in the specialty.

Impressions of the ACGME Site Visit:
I was interested in learning first-hand about the ACGME site visit process because of my prior experiences with evaluations audits in Canada, through the Canadian Council on Health Services Accreditation and with the process in other parts of Europe. The evaluation method that has long been used in North America, involving preparation of self-study documents and verification of data through on-site interviews with individuals and groups, is relatively new in Europe. This is true especially of France, where policies and oversight for medical education are at the national level, without direct evaluation of the regional applications in the medical faculties. What strikes me about the North American model, and I noticed the same in Quebec, is the apparent absence of coordination among the various accrediting bodies, such as the LCME, the ACGME, and JCAHO.

"The evaluation method that has long been used in North America, involving preparation of self-study documents and verification of data through on-site interviews with individuals and groups, is relatively new in Europe."

I was impressed with how thoroughly the ACGME site visitor, Dr. Barbara Bush, had prepared for the day, especially her familiarity with the forms and the accreditation standards for each specialty. Her patience in conducting the series of interviews with the program director, faculty and residents allowed much important detail about the program to be verbalized from different perspectives. I also was struck by the spirit of cooperation with which the documents had been prepared for the survey and with which the visits proceeded. Although France's system is moving toward more formal assessment, we are still far from a culture of systematic evaluation, whether or not it is carried out by physician peers.

I was struck by the importance given to the residents' opinions and the amount of time spent allowing them to express these. The interest in their rights seems to me indicative of a different culture. In France, residents had to unionize to have their rights respected by the public agencies and hospital employers. I also noted the attention given to questions about counseling for substance abuse and psychiatric problems. The same problems exist in France, but we do not deal with them as directly.

The question of work hours was raised in all site visits I observed. It is also a recurrent theme in France. Regulations have evolved considerably in France, especially with regard to limiting on-call hours, which are now restricted to one night a week, one Sunday a month, and no more than 24 consecutive hours on call. Residents also receive extra pay beyond their normal salary for all on-call hours worked. The question of "moonlighting" does not seem to be in an issue in France.

I find the system for funding residency education in the United States very complicated, with its mix of public and private funds that seem to come from a variety of sources. In one of the subspecialty programs I visited, the fellows were paid from both hospital funds and department practice monies. In France, there is no private funding of physician training - residents at all levels are paid directly by the hospital from public funds allocated according to the number of authorized resident positions.

Conclusions
In France, we have very different approaches to evaluation. The assessment of medical training in the United States is much more formalized and, I would even say, more explicit than in France. We tend to rely more on internal structures and communication. This is possible because the universities and medical faculties all belong to a national network. At the same time, there are indicators of change in our system. Although the specialty programs are not formally evaluated, in the last several years the rotation sites have been subject to evaluation and accreditation by regional commissions. Certain specialties are more advanced, and have organized their own inspection visits of the sites. Also, the residents are now asked to fill out an evaluation on each rotation they complete. Since residents make their own selection of rotations every six months, the comments of other residents are carefully consulted before a choice is made.

In conclusion, I am impressed by the ACGME's ability to define standards for all the specialties and systematically assess compliance through the site review process. During my visit, I also learned something about the ACGME's Outcome Project. It seems that the goal of this initiative – programs conducting an assessment of their effectiveness in teaching general physician competencies – adds a very important dimension to assuring the quality of training.

In July, the ACGME hosted a visitor from France, Dr. Christophe Segouin, who is with the Assistance Publique-Hopitaux de Paris, the public hospital system of Paris which is responsible for physician training. Dr. Segouin and Dr. Judith Armbruster, Executive Director of the RRCs for Anesthesiology and Diagnostic Radiology, accompanied Dr. Barbara Bush, ACGME field representative, on site visits to several residency programs. We asked Dr. Segouin to share his thoughts about the ACGME survey process and to comment on some of the differences between our two systems. Dr. Armbruster translated his remarks.

The Site Visit from the Eyes of Someone New to the Process

Jerry Vasilias, PhD

Since rejoining the ACGME in May 2001, I have met several field representatives who have explained to me the components of the accreditation site visit. Yet it was only after I accompanied Dr. Barbara Bush, an experienced member of the ACGME field staff, on two site visits, that I obtained a more complete picture of how the site visit fits into the ACGME accreditation process.

Each site visit began with a one-hour interview with the program director, who was asked to discuss how past citations had been addressed. Both program directors had reviewed the previous citations and were able to detail significant steps they had made to correct them. The program directors were also asked to provide evidence of required educational components such as residents' formative and summative resident evaluations, and to clarify any parts of the document that were vague or incomplete. If Dr. Bush thought there might be a potential area of non-compliance, the area would be discussed in detail during this interview, to explore detail that would assist the Residency Review Committee in assessing whether the program met the requirements. In the two programs I visited, there did not appear to be any significant areas of concern.

Next came the interview with the residents. They are the customers of the education program and one of the key constituencies of the accreditation process. For both site visits, the sample of residents to be interviewed was selected by their peers. At the beginning of the interview, the site visitor provided a brief overview of the ACGME and the accreditation process, and explained the importance of the residents' role in corroborating the information the program director provided in the Program Information Form (PIF). The resident interview also began with questions about past citations and proceeded to supervision, duty hours, call schedules, resident evaluations, and moonlighting. The program director and the faculty are not present during the resident interview, and residents are reassured that their responses are confidential.

As the interview progressed, residents became more comfortable and forthcoming with information, and a rich conversation ensued. The residents' discussion of the strengths and weaknesses of the program, and their suggested improvements, provided the most frank dialogue. During the entire interview, the surveyor simultaneously facilitated the interview and determined if residents' responses were in line with the information in the PIF. For a few discrepancies that emerged, the surveyor gauged the level of consensus among the residents. Interviews from faculty and other administrative officials supplemented the meeting with the residents and program directors. There was a final meeting with the program director, who was asked to respond to several small discrepancies revealed in the resident interview. Most ambiguities were addressed and resolved; a few that were not were written down as such to be reported in the surveyor's report.

Observing the two programs increased my understanding of how the site visit fits into the accreditation process, and enhanced my respect for the program directors, residents, faculty, and field representatives involved in this process. From my perspective, all have important roles to play, including the field representative, who

"It occurred to me that the field representative must become a specialist in the area they are surveying on a particular day."

must be proficient in a role that is equal parts interviewer, meeting facilitator, listener, and detective, and who is charged with verifying and clarifying information and generating a fact-based report for the RRC. It occurred to me that the field representative must become a specialist in the area they are surveying on a particular day. For the visits I observed, the site visitor functioned as an expert in family practice one day, and demonstrated knowledge in the requirements for the transitional year on the next. I was also impressed with the efficiency of the information collection process, given the amount of information that was explored and verified. The members of the field staff conduct three site visits per week, and their complex work is performed in a relatively short amount of time. Often the visit involves individuals whose familiarity with the process is limited, yet who are eager to present their programs in a favorable light. Given these facts, the broad skills required for the position of field representative are readily apparent. Finally, for many in the graduate medical education community, site visitors are the faces of the accreditation process, and they function as ambassadors of the ACGME and as sources of information about accreditation. This transcends their already important role as fact finder and verifier for the RRC.

Jerry Vasilias, PhD, is the Associate Director of Field Activities. He rejoined the ACGME in May 2001, after three years with another organization. In this prior employment with the ACGME, he worked in the Department of Research.

ACGME News

ACGME Hires New RRC Executive Director

Marvin Dunn, MD

The ACGME is pleased to welcome Patricia Levenberg, PhD, RN as its newest RRC Executive Director. She comes to the ACGME from the Society of Critical Care where she was Director of Program Development. Prior to that she was Senior Policy Analyst for Federation Relations of the AMA. Dr. Levenberg received her BSN from Ohio State University, a MS degree in Public Health Nursing from the University of Colorado, and an MA and PhD in Sociology from the University of Illinois at Chicago. Dr. Levenberg has had extensive experience in Pediatric Nurse Practitioner programs at both Rush University and the University of Chicago.

Dr. Levenberg joined the ACGME in mid October. During the course of the academic year she will assume responsibility as Executive Director for the RRCs in Otolaryngology, Ophthalmology, and Allergy and Immunology. She will work with the current Accreditation Administrators for these RRCs - Ms. Eileen Keane for Ophthalmology and Ms. Louise Castile for Otolaryngology and Allergy and Immunology. At the same time, the responsibility for staff support for several other RRCs has been shifted. Dr. Doris Stoll has accepted responsibility as RRC Executive Director for both General and Thoracic Surgery. Ms. Keane will continue as Accreditation Administrator for these two RRCs. Dr. Larry Sulton has assumed the responsibility for the RRC in Neurology, and Ms. Sheila Hart will continue as Accreditation Administrator for this RRC.

Field Staff News

In September, Warren A. Todd, Jr., MD, joined the ACGME as a part-time field representative. Dr. Todd received his undergraduate and medical school training from the University of Mississippi. He completed residency training in Pediatrics at the University of Texas Medical Branch, Galveston, Texas, fellowship training in Pediatric Infectious Diseases at the University of Colorado School of Medicine, and received a Masters in Public Administration Degree in Health Service Management from Golden Gate University. Dr. Todd's prior professional experience entailed a range of teaching and administrative positions with the United States Army Medical Department, including Director of the Army Medical Corps Branch in Alexandria, Virginia. Upon retirement from the United States Army, he started a consulting firm providing health care organizations with his expertise in the areas of continuous quality improvement, organizational re-engineering, and devising disease management programs. He resides in Birmingham Alabama with his wife and son.

ACGME Approves Revisions to Program Requirements in Several Specialties, Discontinues Accreditation of Immunopathology

The ACGME approved the revisions to the program requirements to incorporate language on the general competencies for two specialties, Allergy and Immunology and Nuclear Medicine. The Council also approved revisions to the program requirements for Musculoskeletal Oncology and Sports Medicine, both subspecialties of Orthopaedic Surgery. All of these modifications will become effective July 1, 2002. The ACGME approved the minor revision to the program requirements for General Surgery, and Craniofacial Surgery (plastic surgery), to become effective November 11, 2001, and also approved a minor revision to the program requirements for Thoracic Surgery, effective November 1, 2001.

Because of a change in how Pathology is practiced, the ACGME approved the request from the RRC for Pathology to terminate accreditation in the subspecialty of Immunopathology. No active programs in Immunopathology existed at the time of this action.

Changes to the Institutional Review Policy Manual

The ACGME approved the revisions to the Manual of Policies and Procedures for Graduate Medical Education Review Committees, effective September 11, 2001. Incorporated into the overall manual was Section C, the Manual of Policies and Procedures for the Institutional Review Committee. With the approval of the manual, several new policies were approved for immediate implementation. They include a change in the IRC's operational policy to discontinue formal institutional reviews of institutions with two or more programs that come under the purview of a single RRC. Henceforth, these institutions will follow the same procedures for institutional review as the single-program institutions. A second revision to the Manual (Section V.B.10) now formally prohibits the submission of applications or re-applications for new programs from sponsoring institutions with a confirmed unfavorable status on the institutional review.

Other Highlights from the September 2001 ACGME Meeting

ACGME Formulates Plan for Addressing Duty Hours

Several of the ACGME's Committees continued to address the issue of resident duty hours, noting that the real issue is not simply work hours but the residents' work and learning environment, and the circumstances that keep residents on duty for long hours. It was noted that addressing the larger issue, including the opportunity to redesign the work of residents, would require the efforts and collaboration of the entire academic medical community. However, there is a component of the resident duty hours debate that is clearly in the purview of the ACGME — development and enforcement of standards and associated education and information dissemination activities that the Council needs to address. After extensive discussion, it was noted that focusing solely on hours may polarize the discussion

"...the real issue is not simply work hours but the residents' work and learning environment, and the circumstances that keep residents on duty for long hours."

and may also omit essential elements from the perspective of ensuring an appropriate learning environment for residents. The ACGME approved the establishment of an ACGME Work Group on Duty Hours and the Learning Environment, as recommended by the Committee on Strategic Initiatives. Selected elements of the charge to the Work Group are:

- Develop of a definition of "duty hours" that considers the context of the learning and patient care environment;
- Define the ACGME's responsibility in ensuring that duty hours are appropriate to residents' learning needs, safe patient care, and the safety of residents;
- Create a generic template for the ACGME's duty hour requirements, focusing on the elements of a standard that must be addressed across all specialties; and
- Formulate a plan to communicate the ACGME's standards, policies and enforcement efforts to legislative and regulatory bodies and the public.

Pharmaceutical Support and Involvement in Graduate Medical Education

The Committee on Strategic Initiatives and the ACGME Board of Directors in Plenary Session discussed the extent of financial support for and involvement in graduate medical education by pharmaceutical companies, and the concern that gifts and financial support from these companies may influence the content of education and impact residents. The Council agreed that while the larger issue of pharmaceutical support goes beyond resident education and the purview of the ACGME, there is an educational component – how pharmaceutical company involvement in education impacts on residents' decisions and prescribing patterns. It was also suggested that treating the impact on residents as an educational issue would allow the application of the concept of the ACGME's general competencies – specifically Professionalism; Communication Skills; Practice-based Learning and Improvement; and Systems-Based Practice.

ACGME Announces Recipients of the Parker J. Palmer Award

The ACGME selected ten program directors to be the recipients of the first Parker J. Palmer "Courage to Teach" Awards. The award was established in February 2001 to recognize outstanding program directors in graduate medical education. The recipients were selected by the ACGME Executive Committee from a list of 90 nominees. Criteria for selection included demonstrated commitment to education with evidence of successful mentoring, program development, and improvement; external recognition; letters of support from program directors; service to education through participation on national committees and efforts, among others. Following are the names of the recipients.

Robert W. Block, MD, Emergency Medicine, University of Oklahoma College of Medicine, Tulsa, OK

Virginia U. Collier, MD, Internal Medicine, Christiana Care Health Services, Newark, DE

George C. Curry, MD, Diagnostic Radiology, University of Texas Southwestern Medical Center, Dallas, TX

Alfred D. Fleming, MD, Obstetrics-Gynecology, Creighton University, Omaha, NE

William H. Hester, MD, Family Practice, McLeod Regional Medical Center, Florence, SC

Earl D. Kemp, MD, Family Practice, Sioux Valley Hospitals & Health Systems, Sioux Falls, SD

Gail A. McGuinness, MD, Neonatology, University of Iowa Hospital, Iowa City, IA

Claude H. Organ, MD, General Surgery, University of California, San Francisco-East Bay, Oakland, CA

Keith D. Wrenn, MD, Emergency Medicine, Vanderbilt University Medical Center, Nashville, TN

Nikitas J. Zervanos, MD, Family Practice, Lancaster General Hospital, Lancaster, PA

ACGME Elects New Directors

The ACGME elected the following individuals to its Board of Directors: Melissa Thomas, MD, PhD, representative for the AMA; Allen S. Lichter, MD, representative for the AAMC; and Mark Laret, representative for the AHA. They will serve three-year terms. The following individuals were re-elected for a second term: Charles Rice, MD (AAMC); Edward L. Langston, MD, RPH (AMA); Harold J. Fallon, MD, MACP (CMSS); John I. Fishburne, Jr, MD (CMSS). In addition, two public directors of the ACGME were elected to serve an additional term: Kay Huffman Goodwin, to serve a third two-year term; and Duncan L. McDonald, to serve a second two-year term. The ACGME also appointed the following individuals as officers of the Board: Charles L. Rice, MD, Chair Elect; David Glass, MD (ABMS), Treasurer; and John I. Fishburne, MD and Edward L. Langston, MD, as officers of the Council.

The ACGME recognized three directors who completed their terms of office at the September meeting. They are Richard Allen, MD, who served as AMA representative and Chair of the ACGME; Bruce Siegel, MD, MPH, AHA representative; and Daniel Winship, MD, AAMC representative.

RRC Council Explore Opportunities for Improvement in Two Retreats

Ingrid Philibert

In two retreats in May and September of 2001, the RRC Council of Chairs explored ways to explore the structure of the ACGME and RRCs in the context of the programs it accredits and the environment in which they operate, with the objective of exploring opportunities for improvement. Both retreats were attended by the Chairs of the ACGME's 26 RRCs or by their designated representatives. At the retreat on May 12, the members of the RRC Council met with a group of teaching hospital chief executive officers. Together, they considered the purpose of graduate medical education and what activities by program directors, faculty and institutional leaders, including collaborative efforts, would contribute to achieving this purpose. Key results of their discussion included the finding that the quality of the educational programs must be a focus of the institution. Attendees identified five key approaches for enhancing this focus on quality, listed below:

- ❑ Analyzing the use of financial resources to support graduate medical education (GME) and

sharing this information with all stakeholders;

- ❑ Realigning resources to ensure GME dollars are spent on GME;
- ❑ CEOs and program directors collectively identifying common priorities for the institution and the programs;
- ❑ Working toward creating the right model to integrate residents into the care of patients.
- ❑ Making the educational programs an institutional focus, by increasing the extent to which teaching organizations' governance bodies focus on GME.

At the second retreat on September 9, the RRC Council of Chairs met to explore the structure and function of the RRCs. Attendees examined the ACGME through a "microsystems lense," with the objective of identifying opportunities for improvement. The microsystems approach applies concepts from systems theory. It views groups as dynamic systems that have multiple goals and outcomes, including task performance, goal attainment, information processing, and member satisfaction. Attendees were asked to view their Residency Review Committee as a microsystem and to score it on seven identified characteristics of well-functioning microsystems:

- ❑ Constancy of purpose;
- ❑ Alignment of roles and training;
- ❑ Integration of Information;
- ❑ Measurement;
- ❑ Investment in Improvement;
- ❑ Supportiveness of the Larger System; and
- ❑ Connection to Community.

Participants worked to identify specific activities the ACGME, the RRCs, and the RRC Council of Chairs could engage in that would enhance the functioning of these groups. They focused specifically on initiatives that would enhance the linkage between accreditation and education programs and their communities and that could be implemented in the coming 12 to 18 months. Excerpts from the results are shown below, showing a selection of suggested activities for the ACGME, the RRCs and the RRC Council of Chairs.

Enhancing Linkages between Programs and their Communities: What the ACGME Could Do

- ❑ Sponsor conferences/workshops to address the role of the sponsoring institution;
- ❑ Strengthen the role of the Graduate Medical Education Committee (GMEC);
- ❑ Develop a database of current information of relevance to all RRCs;
- ❑ Encourage research and pilot programs to support and disseminate "Best Practices;"
- ❑ Provide assistance to sponsoring institutions in rolling out the General Competencies;
- ❑ Use the ACGME's public members as spokespersons for relevant communities;
- ❑ Promote innovation in areas of interest to programs/institutions (such as the RFP 2000 Project);
- ❑ Resolve the issue of resident duty hours; and
- ❑ Communicate trends and the vision of the ACGME to programs and sponsoring institutions.

Enhancing Linkages between Programs and their Communities: What the RRCs Could Do

- ❑ Enhance the links between the RRCs and the specialty societies;
- ❑ Have RRC Chairs observe each other's meetings;
- ❑ Solicit feedback from program directors regarding the effectiveness of the RRC's processes;
- ❑ Continue work in implementing the competencies at the specialty-specific level;
- ❑ Develop common methods to communicate to program directors, potentially via the Web; and
- ❑ Seek input from program directors, potentially through a program director "focus group."

Enhancing Linkages between Programs and their Communities: What the RRC Council Could Do

- ❑ Coordinate the exchange of "Best Practices" among the RRCs;
- ❑ Coordinate RRC member education and professional development;
- ❑ Work with the ACGME to develop program director training sessions;
- ❑ Identify common training requirements;
- ❑ Hold a forum for RRC Council and Institutional GME Chairs (DIOs); and
- ❑ Continue information exchange between RRC Council and CEOs.

Enhancements to the Outcome Project Web Site

Discover useful tools and tips on the expanded Outcome Project web site at

www.acgme.org/outcome

At this site, you can find:

- ❑ Sample assessment tools for Professionalism and Interpersonal and Communication Skills
- ❑ Key Considerations for Selecting and Implementing Assessment approaches
- ❑ References on assessment
- ❑ RSVP—an opportunity to share ideas
- ❑ An invitation to "Chat"

…and much more useful information!