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Editor's Introduction:

Not In A Vacuum

Ingrid Philibert

With the first 120 days of the implementation of the ACGME's new common duty hour standards having flown by, one observation that stands out is that implementation of the standards, and accreditation more generally, occur within the greater context of the nation's health care system. This issue of the ACGME Bulletin aggregates articles that delve into that greater context and how it affects resident education.

The lead article by Dr. Leach explores the sensitive topic whether residents are students or workers, presenting the view of the ACGME. A piece by F. Daniel Duffy, MD, provides a provocative vision of the accreditation system of the future, and an interview with Myrl Weinberg, President of the National Health Council, offers an external view of the goals of physician education. This issue also includes an article on residents' perspective of medical errors, and sums up the observations gathered during the first four months under the new duty hour standards, discussing their relevance to efforts to refine the accreditation standards. Collectively, these articles are evidence that accreditation does not occur in a vacuum, and must be sensitive to multiple constituencies and their expectations for education, patient care and the role of the accrediting organization.

Executive Director's Column:

Residents - Students or Workers?

The ACGME's View

David Leach, MD

David C Leach, MD

We don't receive wisdom; we must discover it for ourselves, after a journey that no one can take for us or spare us.

-- Marcel Proust

Something remarkable happens between the first and senior years of residency. Should anyone doubt that residents are students, let them round with a new medical school graduate and a chief resident; the difference is breathtaking. Yet some do doubt this; some think of residents as employees.

In 1976 the National Labor Relations Board ruled in the Cedars-Sinai case that residents were students; in 1999 the same board said that they were both students and employees, and had enough characteristics of employees to warrant protection by the National Labor Relations Act. Some residents join unions. Conversations between programs and residents now include topics about salary, benefits, retirement plans, and contracts. The ACGME itself requires that institutions provide a forum for discussion of such issues. A major lawsuit is based on the assumption that residents are employees rather than students. Yet the fundamental and inescapable fact remains that the primary purpose of residency is education, to acquire sufficient practical experience to be able to practice independently.

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Each resident is unique; all resist labels, including the labels of student or

employee. Taking care of sick patients can be seen as work or as joint discovery, clarification of the confusion that frequently accompanies the initial story. Clarification benefits the patient; discerning patterns, recognizing the familiar helps in knowing what is going on and what to do about it. Clarification may also be occurring within the resident; a superficial understanding of disease may be deepened, details thought to be minor may be revealed as crucial. Integrating abstract book learning with particular and very real patients, again and again, is essential to the formation of good clinicians.

Whether we think of residency as work or learning, or both, is revealed by what we notice and how we express what we notice. Genuine learning is accompanied by the capacity for wonder and awe, a reverence for life that is missing in dreary product oriented models of work. Learning also engages the integrity and identify of the teacher. Learning is triadic not dyadic – the patient, the resident, and the teacher must all be present. The following are offered as things that might be noticed to discern if residents are being viewed as students or employees:

Does the whole person show up?

Distractions constantly invite us away from the immediate tasks of learning and patient care. We teach who we are; technique is relatively unimportant. Residents seek to mimic good clinicians. They notice not only who their teachers are, but also how they are. They notice if their teachers are fully present to patients and to themselves. Good teachers teach from personal wholeness and guide the resident toward personal wholeness.[1] Good teaching requires that the whole person show up.[2]

"Good teachers teach from personal wholeness and guide the resident toward personal wholeness."

Is the activity cooperative or strictly productive?

Medicine is a cooperative art; it cooperates with the body's natural tendency to heal. Teaching is also a cooperative art, cooperating with the mind's natural tendency to seek the truth. The quality of these activities is dependent on the quality of the relationships supporting them. Employers have a different type of relationship with employees than teachers do with students. It is evident to any careful observer. It is noticed in the quality of the conversations.

Is the activity best described as education or formation?

Superficial education can look like employment. Conveying information needed to get the job done occurs in many employment settings. The formation of physicians also requires that needed information be conveyed, but formation goes much deeper. As the name implies, formation involves shaping, shaping of character as well as capacity. It occurs in response to both internal and external forces. Individuals are molded, values clarified, and behaviors aligned. Aristotle said that character depends on community and community depends on character.[3] In other words, individuals are shaped by the quality of their relationships, families, schools, and communities. Those individuals, in turn, grow up and determine the quality of their communities. Medicine is a noble profession, in part because the formation of physicians is linked with the quality of the larger society.

Does the activity encourage fidelity as well as effectiveness?

Chief residents are much more effective than first year residents. They have the knowledge, experience, and skill to accomplish more and function at a higher level. They are students in the sense that they have learned so much. Yet the true test of formation involves fidelity as well as effectiveness. Society has entrusted us with values as well as techniques. The quality of health care depends on values as well as skill. The formation of residents is incomplete unless it results in clarification of the substance of medicine as well as its forms. Enduring principles that govern relationships between the doctor and patient, the doctor and colleagues, and the profession and society are essential and part of the social contract. As recently reported in the Journal of the American College of Surgery, "There is no true deterrent to the incorporation of professionalism into my daily practice. It is something that I signed on for long ago, and it began in my soul."[4]

"There is no true deterrent to the incorporation of professionalism into my daily practice. It is something that I signed on for long ago, and it began in my soul."

Does the activity appear to be complex or complicated?

Each resident, like each patient, is unique. Each emerges in formation, and what emerges may not be initially predictable. The process of formation of residents is complex, as opposed to complicated. Glouberman and Zimmerman have offered a model of complicated and complex activities that is relevant to medicine and medical education.[5] Their metaphors are sending a rocket to the moon (complicated), and raising a child (complex). Rules are helpful for the former, and values for the latter. Employees follow rules, students emerge guided by rules and values. Solutions to problems in formation are frequently developed in response to the particular case, and may be unique. This concept is especially relevant to the ACGME. Our structure encourages internally developed solutions that are in turn reviewed by peers, rather than prescriptive rules that inhibit complexity and favor complicated. The inexorable tendency to over prescribe must be resisted. The reform of duty hours provides an example of a complicated approach, not framed by the ACGME, but by society. Competencies are an example of a complex initiative.

Medicine has an obligation to defend the resident as student. Efforts to shape the formation of physicians as employment weaken the profession by inviting only part of the whole person

to show up; by assuming that the only important elements in the activity are productive rather than cooperative; by diminishing the formative process to one of simply transmitting information that will soon be out of date; by encouraging effectiveness alone at the expense of fidelity to enduring values; and by reducing a complex activity to merely complicated. The profession should be clear about substance and about form. It should preserve substance and modify form.[6] The substance of medicine includes teaching; the word *doctor* is derived from *docere:* to teach.

Sources:

1) Palmer, Parker J. Reflections on a program for "the formation of teachers." Fetzer Institute, 1992.
2) Paul Batalden, personal communication, 2003.
3) Aristotle, The Politics. Penguin Classics, Book III, 1992.
4) Gruen, et.al. J. Am. Col. Surg. 197:605-8, 2003.
5) Glouberman S. and Zimmerman B. Complicated and Complex: The reform of Medicare in Canada; discussion paper number 8, The Commission on the Future of Healthcare in Canada. 2002.
6) Hock D. The birth of the chaordic age. 1999.

The Accreditation System after Next

F. Daniel Duffy, M.D.

Residency education aims to produce a workforce of physicians who aspire to provide the high quality healthcare described by the Institute of Medicine (IOM) in *Crossing the Quality Chasm*.[1] The IOM emphasized that the ideal is patient-centered, effective, efficient, timely, safe, and equitable care. Crossing the gap separating ideal care from current care will challenge health professions education, including resident education to change.[2] The challenge is particularly important for the ACGME, because it can influence the content, process and outcome of resident education through accreditation.

Residency education is practical and practice-based learning. ***Figure 1,*** adapted from Klob's concept of experiential learning describes the salient components of practice-based learning in GME.[3] The learning cycle begins with junior physicians providing care to real patients, the step labeled "practice." Teaching and learning occurs when expert senior physicians observe the practice of junior physicians, and provide feedback, reflecting on the learner's performance compared to standards or benchmarks. Some standards reflect evidence-based guidelines, most represent the expert clinician's tacitly incorporated knowledge, experience and values. The feedback with guided reflection is the basis for professional education.

"Teaching and learning occurs when expert senior physicians observe the practice of junior physicians, and provide feedback, reflecting on the learner's performance compared to standards or benchmarks."

The General Competencies

In 1999, the ACGME defined six general competencies for resident education. The first four, Medical Knowledge, Patient Care, Professionalism, Communications and Interpersonal skills, have been recognized for some time as essential aspects of competence. Two new skills – Systems-based Practice and Practice-based Learning and Improvement – expand the concept of competence by recognizing that patient care occurs in a system of individuals, technologies and methods. The new competencies extend the traditional goal for personal learning and self-improvement to include competence in influencing and changing the delivery system. For learning professionalism, communications and interpersonal skills, or basic patient care skills like history taking or physical examination, students must move beyond lectures, discussions and reading to interact with patients and experienced physicians who demonstrate proficiency in these skills and can observe developing competence in others. To develop competence in systems-based practice, residents must be active participants in delivering medical care.

Measuring system-based practice moves evaluation more deeply into the contexts, and could include patient needs, care processes and the systems to support them.

A goal of education based on the general competencies is competency-based evaluation. Medical knowledge is measured through standardized examinations. Measures of professionalism, communications and interpersonal skills, and clinical skills rely on direct observation and performance rating by an experienced observer, based on interactions with real patients, simulations or Objective Standardized Clinical Examinations (OSCEs). Measuring systems-based practice moves evaluation more deeply into the contexts, and could include patient needs, care processes and the systems to support them. Evaluation of practice-based learning and improvement could adopt methods from the artistic fields, such as a "portfolio of improvement activities." The generic competency is that all physicians should apply the scientific method to improve the care delivered by the micro-systems in which the physician works.

The Five Stages of the Accreditation Process

Before considering what an accreditation process that embraces the principles of outcomes-based education might look like, it is useful to examine the evolution of accreditation through five suggested stages. The first, the Apprenticeship, is really proto-accreditation. In this model, a teacher or mentor takes on a protégée and through their working together, the learner acquires the tacit knowledge of the master. At the second stage, with increasing numbers of apprenticeships, a small culture of learners and their mentors codify the knowledge and methods of the emerging discipline and apprenticeships evolve into programs.

At this point accreditation emerges, and programs seek external evaluation of their structure and content. Third, as the discipline advances, educational process becomes increasingly standardized, and accreditation begins to prescribe formal learning activities such as conferences, a listing of topics to be learned, and the number and types of patients residents should see. The ACGME's accreditation system reached the height of stage three at the turn of the millennium and is evolving to the fourth stage, accreditation based on educational outcomes. This bases accreditation on the quality of the graduates' competence to practice. To achieve stage four accreditation, programs and the ACGME must use educational outcomes.

The ACGME Outcome Project reminds the profession that the goal of graduate medical education is to produce practitioners who are competent to participate in the delivery of high quality medical care in diverse systems, and who will continue to learn and improve themselves and their systems of care throughout a lifetime of practice. The ACGME has committed its accreditation machinery to influence the quality of the care physicians deliver by focusing on clinical care-outcomes produced by residents, physicians, and teaching organizations. At this fifth stage, the primary focus of accreditation is the quality of medical care – the patient-centeredness, timeliness, safety, effectiveness, efficiency, and equity of the care delivered by the accredited residency training programs.

"The ACGME has committed its accreditation machinery to influence the quality of the care physicians deliver by focusing on clinical care-outcomes produced by residents, physicians, and teaching organizations."

Moving to Stage Five

With ACGME accreditation moving from stage three to stage four, it is useful to look at the elements of the structure- and process-based accreditation system. These include specifications for the characteristics of the program director, faculty and staff, and the educational, clinical and research facilities. Some structural elements may remain in newer accreditation systems; but will cease to be requirements and begin to function as benchmarks used to define the programs that produce the best care and caregivers. Entirely relinquishing requirements designed to protect residents from overwork and under-training seems unlikely until outcome measures for working conditions and resident satisfaction can be established. Educational requirements for written curricula, conferences and evaluation processes will also be relaxed in stage four, because rigid standards force programs to adapt local circumstances to requirements that may be too specific to make sense locally. When measures of outcome excellence become available, programs will be freed from micro-regulations. Unfortunately, transitioning from stage three to stage four will require measures that are based on professional consensus and that possess adequate scientific validity.

"Entirely relinquishing requirements designed to protect residents from overwork and under-training seems unlikely until outcome measures for working conditions and resident satisfaction can be established."

An important standard for accreditation of resident education is evidence of high quality patient care. It is not believable that quality clinical education can occur in an environment that produces substandard quality medical care, or that lacks habitual examination of its outcomes and does not diligently work to improve them. The only effective way to achieve an outcome-based accreditation system is to use reliable, valid, and credible evaluations of programs' educational and clinical outcomes. Most RRCs use certifying board pass rates as one measure of graduates' medical knowledge, and some use resident questionnaires to assess compliance with regulations and residents' satisfaction with their education and clinical experience. Dossiers of grants and publications are credible outcome measures of research productivity of the program and its faculty. With the exception of JCAHO accreditation of the sponsoring health care organizations, hardly any RRCs use clinical care outcome measures for determining the quality of hospital and ambulatory care.

A Paradoxical Relationship between Good Learning and Good Health Care

Paradoxically, a stage three or four accreditation system that focuses on educational requirements, but fails to attend to medical care outcomes may impede competent, patient-centered care. When hospitals and clinics are regarded primarily as classrooms or learning laboratories, it diminishes attention to improving them as systems for patient-centered, timely and safe care. In such systems, unsatisfactory patient outcomes are interpreted as reflecting poor resident performance, and satisfactory ones as indicators of good resident performance. This misses the central premise of systems-based care that outcomes result from the collective and integrated work of many people, processes, methods, and technology. Outcomes are simultaneously a personal experience for the patient, the resident and the teacher, not a grade on a classroom exercise.

The second barrier to excellent patient care in stages three and four is the concept that residency programs comprise courses of study similar to courses in any graduate school, differing only in that they involve practical application of knowledge and skills. From this perspective, patient care comes second to the educational needs of residents. Residents regard their clinical rotations as matriculation into specific courses of study, when it actually is an assignment to a stable, integrated micro-system of patient care. Learning occurs through the clinical micro-system's team applying its own practice-based learning

and improvement. Without such a focus on patient-centered care and practice-based learning on how to improve it, residents relegate follow-up, continuity and integration of care to the realm of "systems problems." They may consider them to be beyond the scope of education or influence of physicians. When problems occur, residents and faculty adopt a hands-off attitude regarding the micro-system and welcome the perspective that rotations are time-limited, unrelated, temporary interactions with patients and teams of caregivers, and if uninteresting or difficult, they will end with the beginning of the next rotation.

The third philosophical barrier imposed by first focusing on the educational aspects of residency is that patients and their clinical information become merely audiovisual aids for teaching facts, concepts and procedures to residents and students. This perspective manifests frequently in training programs on bedside rounds when a patient is used as an object for demonstrating physical findings or eliciting the "patient's story" of an interesting illness. These rounds are respectful and humane. While focusing on physical examination and communications training, they often fail to advance the process of care for the patient and are an inefficient way to learn clinical skills. Lastly, the endless conflict between service and education may cause "good patient care" to become an idealized concept, rather than real-life, full participation in high-performing micro-systems designed to achieve the best possible patient outcomes.

"The third philosophical barrier imposed by first focusing on the educational aspects of residency is that patients and their clinical information become merely audiovisual aids..."

New Measures of Competence

As accreditation evolves from a focus on educational structures and processes, to incorporating educational and clinical outcomes, measures that provide formative and summative evaluations such as board pass rates could be used to assess the quality of a program. There are important measures we might consider adding to an outcomes-based accreditation dossier. They include faculty peer ratings for clinical and educational performance. The American Board of Internal Medicine has demonstrated that peer ratings are a robust, reliable and valid measure of the competence of physicians. Including peer measures would be internal to the institution and residency program, but it could function as an external measure and could be administered by a dispassionate third party. Faculty satisfaction with educational and patient care experiences could serve as a measure of the effectiveness of the reflective learning practiced in the program. Another measure could be patients' rating of their care. Patient satisfaction, particularly with the professionalism and interpersonal competence of faculty, residents and staff are an important measure of the quality of the educational environment. Finally, in the future we will base accreditation decisions on indicators of the quality of care provided by the institution seeking accreditation for its programs.

"When hospitals and clinics are regarded primarily as classrooms or learning laboratories, it diminishes attention to improving them as systems for patient-centered, timely and safe care."

One added structure and process measure worthy of consideration is the extent to which functional teams are used in teaching institutions' care systems. Residency education can no longer be thought of as education of the physician only. To realize competence in the six domains and the IOM aims for quality care, we must tear down the silos of professional education and look at the process of care from an integrated approach.

Putting it All Together

What would the incorporation of measures of health care quality, physician performance, and micro-system performance into accreditation decision look like? It would encompass adding quality measures for the care delivered, measures of integration, teamwork, and most of all a habit of continuous learning from practice to improve the system of care. Measures would include the reports of patients, residents and graduates and, most important, reports from faculty and other members of the health care team. There could also be "hard" indicators of sponsoring institutions' effort to continually improve the quality of medical care. The greatest challenge to this accreditation system may involve overcoming strongly held beliefs, among them beliefs about the autonomy of physician action. The new system will require that we celebrate the interdependence of individuals working within systems of care. We also must incorporate the methods of scientific evidence toward learning about care systems and we must link excellence in patient-centered care with continuous professional development.

The "accreditation system after next" could be cybernetic. The ACGME's accreditation review and decisions, in such an imagined future, need only document that self-evaluation, comparison to benchmarks and improvement of educational and patient care performance are regular processes in the program and its sponsoring institution, and a habit of the people working in them. Detailed regulations about the structure and function of the training programs would give way to institutional self-knowledge derived from constant appraisal of how well the institution meets its customers' needs (patients and residents). Accreditation then becomes a process of public and professional accountability for maintaining a process of perpetual improvement toward the ideal of perfection.

1) Institute of Medicine Crossing the Quality Chasm. Washington, DC, 2001.
2) Institute of Medicine . Report on changing health professions education, Washington, DC, 2003.
3) Klob, David. Experiential Learning: Experience as the source of Learning and Development. New Jersey: Prentiss-Hall, 1984

Physicians' Graduate Training: What Matters

An Interview with Myrl Weinberg, President, National Health Council

Ingrid Philibert

Question: The name of your organization may not be familiar to most individuals in residency education. Can you tell our readers about its mission and how is it relevant to the training of the next generation of physicians?

Ms. Weinberg: The mission of the National Health Council is to improve the health of all people, particularly those with chronic diseases and/or disabilities. We do this primarily by working through a group of stakeholders that includes approximately 50 organizations representing individuals with chronic diseases and disabilities, 30 groups that represent providers, the health care community, and organizations interested in improving health care for Americans. The Council's role is to look at broad issues, and to address them in multiple ways.

Question: What three to four attributes of physicians do you think are most relevant to a high-quality, effective patient care?

Ms. Weinberg: We are working with the Foundation of the American Board of Internal Medicine on the Physician Charter[1] and would take some of the most important attributes directly from the Charter. They include a real commitment to professional competence, decision-making based on current scientific knowledge and medical evidence, and a commitment to life-long learning, including openness to new technologies. Technologies here goes beyond new modalities of care to systems for communicating with patients and to maximize the use of integrated information in their care. Another attribute that is important to the Council is patient-centered care. Everyone benefits when physicians implement care in a way that puts the patient at the center. It makes doctors sensitive to issues of health literacy, cultural competence, and it facilitates a full discussion of the issues with the patient and his or her family. Patients interpret this as a sign of interest and respect on the part of their doctor.

Question: What are the most important attributes of the health care system? How could these be emphasized in residency education?

Ms. Weinberg: We believe the important attributes of the health care system are similar to those important for physicians. They encompass a patient-centered health care system, and care based on a team approach in which the patient is a fully integrated member. We also recognize the benefits of having truly effective communication with patients. We could conceive that there will be individuals whose primary role is communicating with patients, and ensuring that they understand their care and are able to adhere to their treatment regimen. An attribute of the health care system that is growing in importance is the ability to gather data that can improve care. Most of the data collection and analysis capabilities we have now did not exist ten years ago, and we are just realizing what powerful tools they are becoming.

The Council also emphasizes the involvement of patients' families and friends in the care process. We believe that the medical community welcoming them as "another pair of eyes and ears" is an important attribute of a well-functioning health care system, both at the team level and at the level of the overall system. An especially important area for the support of families and friends involves assisting with transitions between health care settings, such as going home from the hospital, entering long-term care or hospice care.

Question: How could patients help facilitate the education and professional formation of their physicians, both residents and physicians already in practice?

Ms. Weinberg: The education of physicians would benefit from enhancements in some areas where patients are not able to help, such as increasing medical students' and residents' exposure to preventive care and management of health. Where patients can help is in increasing the focus on the care of the whole person. I have a sense that medical education does not focus on this aspect of care to any great extent.

A real benefit will come from having individual physicians assume more of a team approach to care – and one where the team includes the patient, other stakeholders in health care and the community. Patients have a shared responsibility in managing their health, and in the coming years physicians may expect that patients will increasingly educate themselves about their condition, its treatment and related information. As patients assume a more active role, this requires physicians to become respectful partners in care. We know that involves added work in getting the patient's "buy-in" for medical decisions, but shared responsibility could result in less liability exposure for physicians. The more we make the patient a partner in care, the more we will succeed in getting adherence to treatment, be able to address lifestyle issues that affect health, and ultimately improve health while reducing medical expenditures.

"Everyone benefits when physicians implement care in a way that puts the patient at the center."

Partnering with patients also benefits physicians. Many physicians feel they have no real role improving access to health care and in societal decisions about care when, in fact, their input is very important. We have physician groups as members of the Council, because they feel strongly about patients being represented in the care process, but they also see the value of having patients and their families weigh in on issues of concern to physicians.

1 ABIM Foundations, ACP-ASIM Foundation, European Federation of Internal Medicine. Medical Professionalism in the New Millenium, A Physician Charter). Philadelphia, 2003.

Ms. Myrl Weinberg is the President of the National Health Council. The Council, a private, nonprofit umbrella organization of more than 110 national health-related organizations, works to bring quality health care to all people, especially those with chronic diseases and/or disabilities. Its membership includes 50 voluntary health agencies, which together represent approximately 100 million people with chronic diseases and/or disabilities.

A Crosswalk between the ACGME and IOM Competencies[1]

ACGME/ABMS Competencies	*IOM Competencies*
Patient Care Interpersonal skills and communication Professionalism	These competencies stress provision of patient-centered care by medical professionals.
Interpersonal skills and communication Systems-based practice	These competencies form the basis for medical professionals to participate in the interdisciplinary teamwork necessary to provide quality healthcare.
Medical knowledge Practice-based learning and improvement	These competencies promote and encourage evidence-based medical practice.
Practice-based learning and improvement Systems-based practice	These competencies will focus on competencies necessary to encourage continual quality improvement in medical practice.
Patient Care. Practice-based learning and improvement (Interpersonal skills and communication)	These competencies require the development and utilization of a sound and affordable informatics system(s).

[1] ACGME/ABMS. Institute of Medicine, "Crossing the Quality Chasm: A New Health System for the 21st Century."

Outcomes Project Update:

A Crosswalk Between the ACGME/ABMS Competencies and the IOM's Competencies for the Health Care System

The document below is a crosswalk that seeks to link the six ACGME/ABMS competencies for medical practice, which operate at the level of the individual physician, to the five competencies for the health care system identified in the Institute of Medicine (IOM) report Crossing the Quality Chasm.[1] The aim of presenting this crosswalk is to show how the ACGME/ABMS competencies for individual physicians dovetail with the expectations for an ideal 21st century health care system.

Health Care Errors Residents Notice

Rebecca Minter, MD

Residents truly function on the front lines of patient care delivery. From this vantage point, they are in a unique position to identify dysfunction, problems and inefficiencies that exist in the system. Yet, usually they lack the power or the empowerment to affect change. During the September meeting of the ACGME Board of Directors, the members of the RRC Resident Council tackled the job of identifying errors and near-misses they have experienced while in the trenches, and offered possible solutions for errors they viewed as system failures.

Many errors and "near misses" were identified and discussed. The three major categories surfaced as recurring themes. The first encompassed medication errors, including ordering the wrong drug; ordering the wrong dosage; failing to order the drug; failing to identify drug-drug interactions; delay in patients receiving the drug after it had been ordered; the wrong patient receiving the drug; or the patient receiving the wrong drug. The second category entailed delays in diagnosis, incorrect diagnosis, or a missed diagnosis; and the third encompassed delays in treatment or lack of appropriate follow-up once an appropriate plan was formulated. Although these categories of errors have been identified in the general literature on health care errors and thus are not a surprising finding,[1] the reasons identified for their occurrence were interesting. Some appear to be a result of the unique role residents play in the health care delivery system.

For each error or near miss identified, the members of the RRC Resident Council considered where the system of care had broken down. Lack of knowledge or experience was not the most common reason identified for the mistakes. Rather, errors frequently were the result of a lack of patient centered care. The two most commonly cited reasons for error were that important patient-specific information was not obtained or applied, or there was a failure in the execution of the plan of care once it was formulated.

"Lack of supervision...resulted from a cultural mentality that taught residents it was a "sign of weakness" to ask for help."

The particular aspects of patient-centered care that were identified as problematic related to insufficient time to gather and consider all of the data for a particular patient; making assumptions based on outside information without personally verifying the data; and inability to obtain important past patient records or studies. Lack of supervision was also cited in relation to errors of patient-centered care. It resulted from a cultural mentality that taught residents it was a "sign of weakness" to ask for help, or faculty spread so thin that when residents asked for help it was not available.

The reasons for failure to execute the plan of care for a patient were often thought to be lack of resources or fragmentation of care. Though appropriate plans of care

were developed for patients, an inability to schedule necessary tests or consultations in a timely manner and the lack of a clear mechanism for follow-up contributed to adverse outcomes for patients. It was felt that once a plan of care was developed it was rarely communicated appropriately to other physicians providing care for the patient, and that the lack of an adequate medical records system only exacerbated the poor communication and fragmentation of care. The nature of residency itself leads to fragmented care as residents rotate on and off services.

"The nature of residency itself leads to fragmented care as residents rotate on and off services."

When asked whether they had reported the errors that they had witnessed or been involved with, and whether or not they offered possible solutions to prevent them from happening again, some members of the RRC Resident Council said "yes"; others said "no". Residents who answered "yes" had certain conditions in place. They felt they had a safe environment for reporting errors, rather than a punitive one that used blame or shame. Once an error had been reported, the residents were engaged in the process of creating the system safeguards that would prevent the error in the future. Lastly, and most importantly, their departments and teaching institutions were interested in making changes and in constantly improving.

"Residents are full of will and ideas for improvement, but need help with the execution."

Tom Nolan, a leading quality-improvement scholar, identifies three essential pre-conditions for improvement: will, ideas, and execution.[2, 3] Residents are full of will and ideas for improvement, but need help with the execution. Many errors within the system were identified, and potential solutions offered by the Resident Council. At the same time, the errors probably do not differ from those reported by residents at your institution.

(1) Volpp KGM, Grande D. Residents' suggestions for reducing errors in teaching hospitals. N Engl J Med 2003;348:851-5.

(2) Nolan T. A primer on leading improvement in health care. Presented at the Fifth European Forum on Quality Improvement in Health Care, Amsterdam, March 24, 2000.

(3) Berwick D. Errors today and errors tomorrow. N Engl J Med 2003; 348:2

Residents Reporting Non-Compliance in Their Programs – A Look at the Issues and Suggestions for a New Approach

Ingrid Philibert

Confidential Reporting - What It Is and Isn't, and What it Could Be

Confidential reporting or the term the writer would like to, but cannot, avoid – whistle blowing – refers to insiders, including residents, going public with claims of inadequate practices, lack of adherence to standards or even malfeasance in their organizations. The overwhelming reason individuals engage in this practice is their belief in the need for honesty. In disclosing the problem in the hope that it will be remedied, they become "whistle-blowers." Reporting to outside authorities about organizational wrongdoings exists in industry, government, education and other venues. Watergate and the Pentagon Papers raised it to public prominence in the 1970s. Recent widely publicized examples include the FBI chief counsel in the Minneapolis office who disclosed flaws in the nation's systems to thwart terrorist attacks and the Enron vice president who warned about the impending accounting scandal in her organization. Residents who report to the ACGME alleged non-compliance with the accreditation standards are examples as well.

Systems allowing insiders to go public with their concerns date back hundreds of years. Qui tam ("he who sues on behalf of the king as well as for himself") provisions existed in 13th Century Britain and in the United States, the first laws date back to the Civil War, when Congress at the request of President Lincoln enacted a law to combat fraud in military procurement. Qui tam provisions make it possible for private citizens to sue in the name of the government and reap a portion of the savings as reward. Confusion has arisen from this attribute of whistle-blowing, and many now think it is mostly motivated by financial interest, not a desire for accountability. This contrasts sharply with a view of confidential reporting of problems by insiders as an important component of a functioning quality improvement process. Although there are substantive differences between residency education and the employment setting, the literature on reporting by insiders is relevant to what happens to residents who make complaints about alleged non-compliance with the standards. The ACGME's experience in this area indicates that the vision of a

"The ACGME's experience in this area indicates that the vision of a system that produces improvement but carries no risk to the reporter is quite remote from the reality some residents face when they raise concerns about their program."

CALL FOR ABSTRACTS

2004 ACGME ANNUAL EDUCATIONAL CONFERENCE
March 3-5, 2004
The Marvin R. Dunn Poster Session

"Initiatives in GME: Teaching and Assessing the Competencies; Implementing the Duty Hours Requirements"

The Accreditation Council for Graduate Medical Education (ACGME) invites proposals for poster presentations and short communications at its annual conference on March 3-5, 2004 at the Hyatt Regency McCormick Place in Chicago, Illinois. Program directors, faculty, administrators and residents interested or involved in graduate medical education (GME) are encouraged to submit proposals.

SUGGESTED TOPICS FOR SUBMISSION

The ACGME has a special interest in soliciting abstracts that focus on approaches to teaching and/or assessing any of the six general competencies and efforts toward faculty development focusing around the competencies. This year's poster selections will be limited to 1) innovative approaches, completed or in-progress, that focus on teaching and assessing the six general competencies and 2) creative approaches that address the issue of resident duty hours and demonstrate their impact on education and patient/resident safety at the program or institutional level. Several abstracts from Category One (see above) will be selected for oral presentation at the competency workshops on Friday morning, March 5, 2004. Those selected will be notified in advance of the workshop.

SUBMISSION PROCESS

To be considered for a presentation, your abstract submission must be received electronically by **January 9, 2004.** All submissions will be reviewed and evaluated by the judging panel for relevance, content and clarity. Notification of acceptance for presentation will be e-mailed by **January 16, 2004.** Individuals selected for the oral short communications will present on Friday morning, March 5, 2004. Poster presenters will be required to prepare a poster for the session and be available from 5:00 - 7:00 p.m. on the evening of Thursday, March 4, 2004 to discuss the poster. Accepted abstract submissions will be printed for distribution to program participants as a part of the workshop agenda.

ALL PRESENTERS ARE REQUIRED TO REGISTER FOR THE WORKSHOP

FORMATTING INSTRUCTIONS

Abstracts must be submitted as a single-page document typed in Microsoft Word or Word Perfect. Margins should be 1-inch on all sides. DO NOT use abbreviations in the abstract title. The abstract title should be typed in ALL CAPS. The title should be brief, but clearly indicate the nature of the project or investigation.

TEAR AT PERFORATION

The author(s) name(s) and institutional affiliation(s) should be typed in TITLE CASE (upper and lower letters) on the line after the title. The abstract must be sent to abstracts@acgme.org as an e-mail attachment. The sender of the abstract should be the lead author. All communication will occur with the lead author. Questions regarding the abstracts should also be sent to this electronic address. NOTE: Simple graphs or tables may be included if they fit on the single page. The text of the abstract must be organized into the sections below (use headings in bold):

1. **Purpose** of investigation or project
2. **Methodology,** including investigation or project design and analysis
3. **Summary** of results (if applicable)
4. **Conclusions**

Abstract Checklist:

1. The abstract must be typed in 10-pt or 12-pt Arial or Times Roman font style; margins must be 1-inch on all sides.
2. The title should be typed in ALL CAPS.
3. Content of abstract should be single-spaced with double-space only between title and authors' names.
4. The abstract must not exceed 300 words and must fit on a single page. Not more than three references may be included. If references are used, they must still fit on the single page.

TEAR AT PERFORATION

SUBMISSION DEADLINE AND NOTIFICATION

All submissions must be received at the ACGME office no later than January 9, 2004. Submissions must be sent electronically according to the format outlined above. No substitutions will be accepted. Authors will receive confirmation of their submission upon its receipt in the ACGME office. The first author will be notified by January 16, 2004 whether the submission has been accepted for poster or oral presentation. Display specifications and communication guidelines will be provided at the time of acceptance.

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

system that produces improvement but carries no risk to the reporter is quite remote from the reality some residents face when they raise concerns about their program.

A Bleak Fate

Insider reporting can be an issue for the organization being reported, but it is at least as problematic for the individual making the report. This "cost of speaking the truth" has been prominent in the stories of individuals who identify fraud, danger or inadequacies in the practices of organizations. The majority resign or lose their jobs. Findings are similar for the Ralph Nader's early studies published in 1972 and more recent studies.[1, 2]

The ranks of whistle-blowers increased dramatically in the 1980s,[3] or at least coverage of their activities in books and the media became more frequent and prominent. One researcher of the phenomenon noted that accounts of whistle-blowing call attention to the laudable, principled actions of individuals against the lax but powerful system, and the empirical content – what happens to the reporter – "stands in an uneasy relationship with [this] narrative form."[4] He added that authors who celebrate whistle-blowing may identify with, and vicariously participate in, a prohibited and potentially risky practive as a form of romanticizing individual moral outrage against the practices of corporations[5]

Going public with reports of flawed organizational practices may result in organization-level efforts to retaliate, but reporting need not be external to get the reporter into trouble with his or her peers. One of the most long-lived findings of the famous Hawthorne studies at the General Electric Plant in Hawthorne near Chicago were three rules for harmony in the work place: Don't be a rate buster (work too hard) or a chiseler (work too little) and, by all means, don't be a squealer.[6] Colleagues who "squeal" to management or to an external authority may face ostracism, the practice in British labor settings of "being sent to Coventry."

"...residency education is a relational process that depends on personal teaching and supervision provided by faculty and more senior residents."

Particular Issues for Residents

Facing negative reactions from peers is one only aspect of the difficulties some residents face when they disclose non-compliance in their programs to the ACGME, or internally to their program and institutional leaders. Residents are particularly vulnerable, in part because they lack power in the hierarchies of their organizations. But more critical is the observation that residency education is a relational process that depends on personal teaching and supervision provided by faculty and more senior residents. Stated another way, in addition to social harmony and collegiality, the very delivery of residents' educational curriculum depends to a considerable extent on the goodwill of faculty and more senior colleagues. We allude to this relational aspect when we discuss anecdotes of residents who have "run afoul of the nursing staff," but are less comfortable discussing this matter when it involves faculty and other residents.

The role of peers is particularly prominent in residency, but is not unique to it. Research in organizational behavior has recognized the power of horizontal surveillance, operating through peer group scrutiny and pressure to conform to group norms, including norms "not to be a squealer." Observational studies have demonstrated that empowerment in relatively autonomous work teams, like patient care team, produces new models of control, different and potentially more omnipresent and restrictive than classical supervisory models.[7]

There is a third reason. Karl Weick, eminent Rensis Likert professor of management at the University of Michigan, has commented that educational systems are characterized by the co-existence of formal structure and potentially competing local interests. Harmony is achieved though a variety of decoupling systems. They include largely ceremonial inspections, absence of effective evaluations, and tolerance for discretionary behavior. The de-coupling devices are known to insiders, but their public disclosure or debate is proscribed in the interest of confidence in the system.[8]

Different Goals

There are important differences between the original goals of whistle blowing provisions – to expose fraud in procurement systems that unnecessarily depleted royal or governmental coffers – and residents bringing lack of supervision, excessive duty hours, deficits in the evaluation systems, or other non-compliance with the standards to the attention of the ACGME. After some experiences that highlighted the potentially precarious position of residents who report non-compliance, the ACGME is deliberating how to enhance the processes that protect confidential reporters. An initial idea was to adopt a system similar to the Federal Aviation Administration's (FAA's) system for reporting near misses involving commercial aircraft. Because it views reporting as a vital part of an operational safety and quality improvement process, the goals of the FAA's system are close to the ACGME's intent of facilitating improvement through adherence to the standards. The FAA's system is thought by all involved to be a well-functioning process that does not place at risk the individual who reports the near-miss. However, there are substantive differences between the FAA's anonymous process that seeks to identify patterns and the ACGME's need to identify concerns in a particular program.

"As painful as this may be to acknowledge, residents reporting alleged non-compliance to the ACGME is symptomatic of problems at two levels of the local educational environment."

In the final analysis, anonymity is a difficult concept in a setting where the intent is identification of problems in order to get them addressed, and where the accrediting organizations must be fair to both residents and the programs and institutions in which they train.

A Well-Functioning Local Process

A comment the ACGME hears too frequently is that residents hesitate to speak out locally, for fear their actions may cost them the goodwill

of their program director and faculty. As painful as this may be to acknowledge, residents reporting alleged non-compliance to the ACGME is symptomatic of problems at two levels of the local educational environment: (1) a lack of compliance with the standard to which the complaint pertains; and (2) a failure of the sponsoring institution to create an educational environment in which residents may raise and resolve issues without fear of intimidation or retaliation. The latter is a part of the institutional requirements (Institutional Requirements, III.F.1.) and is enforced by the ACGME. The observation that this area continues to be problematic may require this standard to be made more explicit. A non-threatening way to achieve this could consist of offering suggestions for how institutions can create and maintain an environment aimed at continuous improvement through frank discussion of problems.

The ACGME recognizes the importance of a well-functioning local process, and will work with institutional leaders and DIOs to highlight its benefits to education and the attractiveness of residency programs. The Council also is exploring the advantages of educating the membership of teaching institutions' governing boards, and is formulating questions governing bodies should ask about their institutions' residency programs in order to promote "good learning for good healthcare."

Another critical element of a well-functioning local approach is education of residents and faculty about (1) the benefits of continuous improvement in their educational environment; and (2) the lack of professionalism evidenced in actions against individuals who raise issues internally or to an external body. Programs should discuss confidential reporting and retaliation/retribution as part of their professionalism curriculum. This seeks to address retaliation by resident peers, the essentially intractable aspect of this issue. Education should emphasize reporting of problems as a vital and welcome part of an institutional quality improvement program, and celebrate reporters as individuals who facilitate improvement. Discussions could also explore the relational nature of medical education, and the serious and avoidable threat of compromised education for individuals who report concerns. Efforts to educate faculty and residents are clearly more effective when this is done before an incident occurs.

"Education should emphasize reporting of problems as a vital and welcome part of an institutional quality improvement program, and celebrate reporters as individuals who facilitate improvement."

Going Beyond the Local Level

That the ACGME as an accrediting organization has a role in receiving confidential reports about alleged non-compliance with its standards is clear. The goals of facilitating continuous improvement in residency programs cannot be emphasized enough, and are prominent in ACGME documents and Web information related to reporting of alleged non-compliance.

There may be additional roles for the ACGME in contributing to the protection of the individuals who disclose concerns. A necessary but difficult step involves making them aware of the potential risks of reporting. This must be done in a frank and forthright fashion, but without seeming to discourage the disclosure of complaints with the goal of having them addressed.

The literature on the fate of whistleblowers offers ample evidence that federal and state statutes offer only partial protection – that there are large holes in the whistle blower safety net. On the heels of several highly publicized cases involving individuals reporting on wrong-doing in private corporations, Congress added whistle-blower protection provisions to the Sarbanes-Oxley Corporate Accountability Act, signed into law in July 2002. The final version of the bill, however, stipulates that individuals speaking out would receive federal protection only after Congress authorized an investigation in the given case.[9] There may be solutions that could be applied to discourage retaliation, and others that could assist residents who are "displaced" after making a report. The ACGME is currently exploring these options.

"The key message is that, "Everyone tries to do the right thing," and a well-functioning local process keeps reporting within the institution and allows correction of the non-compliance."

Conclusions

That the ACGME needs to promote the message of the importance of an educational environment that allows residents to raise issues without fear of intimidation or retaliation is obvious. In addition, there may be benefit in re-conceptualizing (and renaming) the ACGME's mechanism for reporting concerns to place more emphasis on the benefits of feedback and the important social role confidential reporters play in improving the educational improvement. The key messages are that, "Everyone tries to do the right thing," and that a well-functioning local process keeps reporting within the institution and allows correction of the non-compliance. If reports are made to the ACGME, this must be done in an environment of mutual trust, on the part of the reporter, that he or she will not be harmed by this; on the part of the institution, that the ACGME will allow for a fair hearing of its side of the story; and on the part of the ACGME, that both the reporter and the program/institution are participating in an honest and ethical way that seeks to correct the problem. Creating an environment of trust within which reporting can occur in a functioning, non-threatening form, is beyond the capacity of the ACGME, if it must act alone and without the support of its accredited programs and their sponsoring institutions. Another

reason is that residents cannot rely on federal protection of confidential reporters, despite the faith that some resident advocates place in this approach. Thus, solutions will need to come at the program and institutional level.

At present, the fate of some residents who reported non-compliance in their programs stands in sharp contrast to their institutions' public embracing of continuous improvement, empowerment and professionalism. This does not speak well for the degree to which efforts to promote these concepts stand up to local challenges. Finally, we cannot rely solely on systems to obscure the identity of the reporters, in the hope that they go undetected and that their education and career will suffer not as a result of their actions. Few whistle blowers ultimately are able to keep their identities concealed. A recent speech by Robert Woodward reminded me that the only one who may have succeeded is "deep throat."

As David Leach has often reminded us, "Teaching is a space where obedience to truth is practiced." Accredited programs and their sponsoring institutions should strive to live up to that goal, and seek to protect the educational experience of the truth-tellers in their settings.

(1) Nader, R, Petkas, PJ, Blackwell, K Whistle blowing. 1972. New York: Grossman.

(2) Glazer, MP, Glazer, PM. The whistleblowers. 1989. New York: Basic Books.

(3) Goldberg, J., Holland, B., Truth and Consequence. Omni; 13:2, November 1990.

(4) Perry, N. Indecent exposures: theorizing whistleblowing. Organization Studies; 19; 1998: 235-257.

(5) Ibidem.

(6) Sunstrom E, McIntyre M, Halfhill T, Richards H. Work groups: From the Hawthorne studies to work teams of the 1990's and beyond. Group Dynamics: Theory, Research and Practice, 4; 2000. 44-67.

(7) Barker, J. R. Tightening the iron cage: Concertive control in self-managing teams. Administrative Science Quarterly 38; 1993: 408-437.

(8) Weick, K. Educational organisations as loosely coupled systems. Administrative Science Quarterly 21; 1976: 1-19.

(9) Novak, V. Speaking out: still too risky? Time, 161:4; January 27, 2003.

The 2003 Report "From the Field"

Marianne Gideon, PhD

This year is the third time a report from the field was presented to the Board of Directors at the ACGME's September meeting. In addition to the thoughts of field representatives and program directors, the report also incorporates the views of members of the ACGME staff. Three issues prevailed in 2003: resident duty hours; the implementation of the general competencies; and program directors' lack of time for dealing with the growing paperwork associated with accreditation. Reader may or may not be surprised – these are largely the same issues that were raised in the past two reports.

Duty Hours and the Work Environment:

As their programs require them to keep track of hours, residents realize how many hours they really work and the bad days are no longer the only ones they remember. One hospital administrator said new duty hour regulations make hospital staff value residents more than they did previously. Clinic personnel realize that residents may need to leave without seeing all the patients if they keep them busy with tasks that do not require a physician. One Thoracic Surgery program, which took duty hours limits and the competencies seriously, found that cutting back on resident hours lead to a staffing vacuum. Faculty fears that patients will bear the consequences. Hospital administration is reluctant or unable to provide replacement providers, but the larger problem is that most non-physicians are not qualified to fill all the gaps. Faculty in the same program has concerns about the quality of physicians educated under restricted duty hours, and wonders if graduates will be clock-watchers who no longer feel a calling to serve their patients.

In contrast, a group of internal medicine residents thought patient care was better now that they are working fewer hours. One difference may be the use of night float, and efforts to make night float an educational activity with meaningful morning report and patient hand-off. They reported that night float allows both the day and night residents to know the patients well and can facilitate continuity of care. In some programs that comply with the new duty hour limits, but do not use night float, residents have trouble getting to conferences. Post-call residents must go home by 11 to 12 am and may miss one-fourth to one-third of all noon conferences. When residents do not leave the hospital until 1 pm, they are still apt to skip conferences to get their work done rather then leave it for a colleague. Some residents do not want to go home, and some programs have resorted to asking the program director or chief resident to round at the "witching hour" to make sure post-call residents have left the premises.

"Since no one knows for sure if the competencies or the associated evaluation tools will produce a better physician, the Outcome Project is a faith-based initiative."

The General Competencies

A program director with a wry sense of humor said that, "Since no one knows for sure if the competencies or the associated evaluation tools will produce a better physician, the Outcome Project is a faith-based initiative." He is not alone. Other program directors wonder if the effort they put into the competencies will produce better graduates. Some want more guidance on how to implement the competencies, in part due to concerns that they will put time and money into developing tools that the RRC may ultimately find unacceptable. They want to know exactly what the RRCs will accept. Other programs are encouraged that RRCs are not imposing tools, but encouraging creativity.

"Clinic personnel realize that residents may need to leave without seeing all the patients if they keep them busy with tasks that do not require a physician."

In some programs, the faculty knows there are less expensive and effective measures to evaluate residents. Simply standing in the exam room with a resident and a real patient works. The field staff finds that in institutions where the designated institutional official is committed to implementing the competencies, all core programs and, in some places even the fellowships, are well on their way. Some program directors are curious what the RRCs do with all the information it received about the general competencies. They are not getting feedback yet, which frustrates them. It may simply be too soon to see many citations or kudos in RRC notification letters.

About the Time Issue

Program leaders comment that meeting the ACGME's expectations consumes a lot of their time. Between monitoring duty hours and implementing new evaluation tools, the paper work is overwhelming. Some question the value of the investment of time. They want the ACGME to provide more prototypes and examples of ways to comply with the competencies and the duty hour restrictions.

ACGME bylaws require RRCs to develop an impact statement when they propose to change program requirements. One medicine program director inquired if the ACGME had done a cost analysis of implementing the competencies or duty hours before laying the burden on programs. He hopes that the ACGME will do cost analyses if it makes major changes in the future. ACGME staff attending program directors' meetings hears a strong plea for an intermission, "Please, no new ACGME projects until we can work through the problems with the competencies and duty hours." They added that both necessitate pervasive restructuring of programs, and education of faculty and residents. Program directors feel they cannot handle any more, especially in this era of reduced resources.

Other Comments from the Field

Some residents wonder why the ACGME makes changes effective in July, when all experienced residents have graduated, new residents need much attention, and most of the supervising residents are just learning to be supervisors. In the future, they would like seeing changes made in January when everyone has settled in.

The increasing uses of computer programs – both purchased and home-grown – makes it easier for program directors to keep track of just about everything. Programs using these data collection tools are better able to monitor patient encounters and procedures, and provide more complete and accurate information in their program information forms. They also find that their staff has time to do things other than track down evaluation forms. Small programs find residents and fellows more willing to complete forms on the computer, believing there is more confidentiality.

Overall, it seems that the ACGME has not completely corrected issues identified in the last report from the field. They could be termed "previous citations." The next report from the field will be one year from now.

News from the ACGME September meeting

Strategic Initiatives Committee Embarks on Assessment of the ACGME's Effectiveness

The Strategic Initiatives Committee participated in the first of a series of focus groups that explore measures of the ACGME's effectiveness as an accrediting organization. The goal is to facilitate ongoing assessment of effectiveness and identification of opportunities for improvement. The conversations will involve the members of the ACGME Executive Committee and Board of Directors, RRC Chairs and selected RRC members, executive staff of member and appointing organizations, representatives for the ACGME's constituents (program directors, designated institutional officials, teaching hospital leaders, deans, residents, prospective residents and the public), and ACGME staff. The focus groups involve seeking answers to five simple questions, shown in ***Exhibit 1***. The responses will be aggregated and used to develop a "dashboard of strategic indicators" to assist in guiding strategic activities, operations and improvement efforts.

Exhibit 1
Questions for the Focus Group Process

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

Election of Officers

The ACGME Board of Directors approved the nominations of the following individuals to serve as its officers for 2004: Charles Rice, MD, Chair; Emmanuel G. Cassimatis, MD, Chair-Elect; Wm. James Howard, MD, Treasurer; Carol Berkowitz, MD; and William H. Hartmann, MD as a new Executive Committee member, representing the American Board of Medical Specialties (ABMS).

Changes in ACGME Directors

The ACGME elected as new members of its Board of Directors Edward T. Bope, MD, as a representative for the ABMS, and Mr. Roger Plummer, as a Public Director. The Council re-elected Carol Berkowitz, MD; L. Maximilian Buja, MD; William H. Hartmann, MD; Wm. Jim Howard, MD; Mr. Duncan L. McDonald; Sheldon Miller, MD; and Sandra Olson, MD, to the ACGME Board of Directors for additional three-year terms.

ACGME Approves Program Requirements

The ACGME approved the Program Requirements for Pediatric Anesthesiology, without modification. The Council also approved the program requirements for seven subspecialties of Pathology: Blood Banking/Transfusion Medicine, Chemical Pathology, Cytopathology, Forensic Pathology, Medical Microbiology, Neuropathology, and Pediatric Pathology. All newly approved program requirements will become effective on July 1, 2004.

Ad Hoc Committee on Duty Hours Issues First Report

The Board of Directors approved the first report of the ACGME Ad Hoc Committee on Resident Duty Hours. The committee functions in an advisory capacity to the Board during the initial implementation of the ACGME's duty hour standards. The report addressed data collection on duty hours; data evaluation procedures; interviews and review of information during the accreditation site visit; provisions for confidential reporting of violations of the duty hour standards; innovative approaches to address duty hours; reporting of duty hour data; and ACGME's internal monitoring procedures. The report outlines recommendations for each of these areas, and also includes an algorithm for compliance monitoring. It can be found on the ACGME Web site under the Resident Duty Hours menu.

ACGME Establishes Accreditation Fees for 2003-04 and 2004-05 Academic Years

John Nylen

At its September meeting, the ACGME Board of Directors established the fees for accredited programs for academic years 2003-2004 and 2004-2005. Fees for the current academic year, which will be invoiced in January 2004, will remain the same as the fees for 2002-2003 (see ***Table 1***). The ACGME is proud that its cost containment efforts have made this the fifth consecutive year the accreditation fees have remained constant.

The Board also approved the fees for the 2004-2005 academic year, which will be invoiced in January of 2005. After five years of stable fees, the growing cost of providing accreditation services makes it necessary to increase fees. The fees are also shown in ***Table 1***. The ACGME pledges to keep these fees constant for at least 3 years. In 1999, ACGME pledged to freeze fees for three years and was able to extend this for two additional years. The ACGME believes it better serves institutions by raising fees as needed only once every few years, instead of annually increasing them by smaller amounts.

Table 1 - ACGME Accreditation Fees for 2003-04 and 2004-05

	2003-2004	2004-2005
Programs with 6 Residents or More	$ 2,500	$ 3,500
Programs with 5 Residents or Less	$ 2,000	$ 2,750
Application Fee	$ 3,000	$ 4,000
Appeals Fee (Plus Incurred Expenses)	$ 10,000	$ 10,000
Cancelled Site Visit Fee	$ 2,000	$ 2,750
Inactive Program Fee	$ 2,000	$ 2,750
Palm Pilot Fee (Academic Year Billed in July)	$ 25/User	$ 25/User
Finance Charge (after Payment is 45 Days Late)	1.5%/month	1.5%/month

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Dr. Rice presented awards to recognize the service to two ACGME directors completing their terms: Mark L. Dyken, MD, who completed his term as the ABMS representative to the ACGME; Rebecca M. Minter, MD, who completed her term as the RRC Resident Council Representative to the ACGME. He also recognized Edward Langston, MD, who resigned his position due to other obligations.

First Reading of Proposal Regarding Voting Privileges for Second Resident Representative

Approximately two years ago, the ACGME approved the appointment of a second resident to sit on the Board of Directors with voice but without vote. The second resident is the Chair of the RRC Resident Council and is appointed by that group. Due to the importance of resident input into ACGME activities, the Council has been debating the benefit of giving voting privileges to the second resident member. In September, the Board of Directors received for first reading revisions in the Bylaws that will give the second Resident Director voting privileges.

Enduring Tribute to Marvin Dunn, MD

The Chair requested that the ACGME consider establishing an enduring tribute to Marvin Dunn, M.D. whose untimely death has caused a great void in the ACGME. The Board of Directors agreed to an enduring tribute to Dr. Dunn by establishing a lectureship in his honor.

ACGME Selects Ten Programs Directors for Parker J. Palmer Award

The ACGME selected 10 residency program directors to receive the 2004 Parker J. Palmer "Courage to Teach Award." This marks the third time the Parker Palmer Award has been presented.

The recipients will be honored at the reception and dinner in conjunction with the February 2004 meeting of the ACGME.

William L. Bockenek, MD
Program Director for Physical Medicine and Rehabilitation Charlotte Institute of Rehabilitation

Carol Carraccio, MD
Program Director for Pediatrics University of Maryland Medical System

Carlyle H. Chan, MD
Program Director for Psychiatry Medical College of Wisconsin

Paul H. Gerst, MD
Program Director for General Surgery Bronx-Lebanon Hospital Center

DuPont Guerry, IV, MD
Program Director for Hematology-Oncology University of Pennsylvania

J. Peter Harris, MD
Program Director for Pediatric Cardiology Golisano Children's Hospital at Strong University at Rochester

John B. Jeffers, MD
Program Director for Ophthalmology Wills Eye Hospital

Catherine K. Lineberger, MD
Program Director for Anesthesiology Duke University Medical Center

Gordon E. Schutze, MD
Program Director for Pediatrics Arkansas Children's Hospital

Eric Walsh, MD
Program Director for Family Practice Oregon Health & Science University

Marvin Dunn, MD – A Tribute

When Dr. Dunn died suddenly and unexpectedly on July 29, 2003, he left behind friends and colleagues across the nation. A memorial service in the first days of August celebrated his life and his accomplishments, and evidenced the loyalty, love and respect he commanded in life. His colleagues continue to miss him, and selected comments, taken from a book of memories, are tribute to someone who is still missed.

Marvin had courage, fortitude and vast knowledge; most of all he was kind, modest and loved a good laugh. As the soul animates the body, he animated the ACGME. *~David C. Leach, MD*

His vitality was inspiring; his humor contagious; his demeanor above reproach. *~Ron Stephansen, Computer Consultant, ACGME*

Marvin Dunn was a trusted advisor, a font of knowledge and wisdom, a leader in American Medicine, and a true advocate for excellence in medical education. *~Thomas Nasca, MD, Dean Jefferson Medical College and Chair, Residency Review Committee for Internal Medicine*

Marvin was the perfect mentor with wonderful listening skills and an uncanny ability to make you look good in a difficult situation. *~Patricia Levenberg, PhD, ACGME Staff*

Marvin Dunn has been one of the most effective leaders in graduate medical education we have had. He was informed, thoughtful, fair and able to bridge many conflicting opinions and have everyone's respect. *~Harold Fallon, MD, Institute of Medicine*

You always knew when Marvin called or came into your office, there would be a great anecdote. I learned so much from him over the past years - he was always willing to share his knowledge in a non-intimidating way. *~Debra Dooley, ACGME Staff*

Though his presence will be missed, his impact will continue. *~Susan Day, MD, Director, Ophthalmology Residency Program, California Pacific Medical Center and Chair, Residency Review Committee for Ophthalmology*

In some elemental way, his ways of doing things were at the heart of where our work should be, consistently focused on improving residency education and the working lives of residents. *~Ingrid Philibert, ACGME Staff*

What may be missed most is his capacity to see goodness in all of us. Dr. Dunn is survived by two daughters and two sons, a sister, and six grandchildren.

David Schramm, PhD, Retires

After nearly 15 years on the ACGME field staff, David Schramm, PhD, is retiring at the end of December. Over his career Dr. Schramm conducted site visits of more than 1,900 programs. After retiring from travel for the ACGME, he will spend more time at his home near Portland, Oregon, with his wife Beth.

Duty Hour Implementation Update

A duty hour implementation update will be featured in most issues of the ACGME Bulletin over the coming year. The goal is to offer succinct information on issue relevant to implementing the standards to assist programs and their sponsoring institutions.

Home Call

The ACGME still receives questions about home call, including how many consecutive days a resident may take call from home, as programs are restructuring and senior residents take home more call. The answer is that the requirement that one day in seven be free of patient care responsibilities would generally prohibit a resident from being assigned straight home call for an entire month. Assignment of a partial month (more than six days but less than 24 days) is possible, but programs need to check with their relevant RRC, since some RRCs have a firm requirement that home call must comply with the "one day off in seven" requirement.

Research Rotations

Another frequent question pertains to how the duty hour standards pertain to research activities. The answer is that the standards pertain to all required hours in the residency program (the only exceptions are reading/self-learning and time on home call not spent in the hospital). When research occurs during the accredited years of the program, research or any combination of research and patient care must comply with the weekly limit and other pertinent duty hour standards. There are only two situations when the ACGME duty hour standards do not apply. The first is an additional research year that is not part of the accredited program; the second occurs when residents conduct research on their own time, which makes these hours identical to other personal pursuits. There is an emerging "gray area" where programs assign residents on research rotations to cover clinical services. Where this is done, the combined hours must comply with the weekly limit and other duty hour standards. Programs should be aware that RRCs may have concerns that this practice may dilute residents' research experience.

Advice on Monitoring Duty Hours

We have received many questions on how duty hours should be monitored. It is important to note that ACGME does not mandate a specific monitoring approach, since the ideal approach should be tailored to the program and its sponsoring institution, and the approach best suited for neurological surgery will be different from the one most appropriate for preventive medicine or dermatology. The only required activity is that all accredited programs must complete a short (six-question) duty hour survey on the ACGME's Web Accreditation Database (WebADS) and that this information needs to be endorsed by their Designated Institutional Official (DIO). A number of approaches exist for monitoring hours, from resident self-reporting to swipe cards and other electronic measures. All have some advantages and some drawbacks, with none clearly being superior in every way and in all settings. Programs and institutions may benefit from hearing what has worked in settings similar to theirs, and should involve their residents and faculty in deciding on how to monitor, since their acceptance of the approach will be critical to its success.

ACGME Collects Information on Problematic Aspects of the Standards

In its first report, the Ad Hoc Committee on Duty Hours called attention to aspects of the standards early reports from the field have identified as being problematic. The Committee suggested that what is needed is a comprehensive list of standards that have been difficult to implement, or that may be counterproductive to the goals of ensuring good learning, safe patient care and resident well-being. The Board of Directors requested the assistance of the RRC Chairs in identifying these aspects of the standards, and plans to address them at a joint meeting of the RRC Council of Chairs and the Committee, tentatively scheduled for May or June of 2004.

Briefly: National and International News About Residency Education

Puerto Rico Passes Resident Duty Hour Legislation

The Puerto Rico Legislature approved a bill that limits duty hours for residents in Puerto Rico by statute. The new law went into effect on July 1, 2003. The provisions largely mirror the ACGME's common duty hour standards, with the exception that residents are limited to 24 hours of continuous duty time, without being allowed to remian for the transfer of patient care or participation in didactic activities at the end of the call period.

AAMC Revises Definition of "Underrepresented minorities"

The AAMC recently released the following revised definition of underrepresented minorities (URM): "Underrepresented in medicine means those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population." The Association stated a benefit of the new definition is that it allows individual medical schools to determine which groups in its geographic areas are "underrepresented in medicine." The AAMC has developed a document entitled, "Frequently Asked Questions and Answers About the New Underrepresented in Medicine Definition. It can be accessed from the AAMC's Web site under: http://www.aamc.org/meded/urm/start.htm

European Working Time Directive Extends to British Doctors in Training by 2004

The European Working Time Directive (EWTD) is on a trajectory of reducing maximum weekly work hours for all health and social care staff from 58 hours in 2004 to 48 hours by 2009. In Great Britain, it applies to all health personnel with the exception of physicians in training and plans call for extending it to this group in August 2004. It has been noted that this will present a challenge for the British health care system. Also, the European Court of Justice established that time on call in the hospital counts as work hours (previously many European nations considered in-house call as a separate category and did not count it toward the weekly limit). The UK Department of Health and other stakeholders are exploring options for dealing with the restriction in hours: (1) replacement with other providers; (2) emergency night teams to provide cross-hospital coverage; and (3) fewer levels of coverage linked with new working patterns. Pilot projects are being set up to test these approaches.

Editor's Occasional Column:

80 Hours, 120 Days: What have we learned?

Ingrid Philibert

What we have learned since July 1

On July 1, 2003, the ACGME instituted common duty hour limits for all accredited programs. The reasons have been stated many times. They include scientific evidence that sleep loss negatively affects performance, learning and well-being. Medicine continues to be dependent on cognition, memory,

vigilance, and until recently, relatively little attention had been focused on system safeguards. Other reasons concern significant changes in the clinical environment, including higher acuity, growth in scientific knowledge, and availability of new technologies and modalities of care. Shortages in many health professions, a large number of un- and underinsured Americans, and a mounting crisis in the health care system have also increased clinical demands on residents. Academic medical centers' support systems have not kept up. A political environment in which groups pursued federal regulatory or legislative intervention also framed the duty hour l imits, and interpretations of the information from the field need to be aware that resident hours continue to be as much a "political" matter as they are a scientific and educational concern.

A substantial share of the comments since July 1 have related to the negative effects of the new standards. Many are from residents. Does this mean residents oppose the new standards? Or, worse, have residents who previously supported the limits changed their mind after seeing the effect? It is helpful to explore the timing and context of the comments. Prior to formulating the duty hour standards, the ACGME heard from residents who favored limits and expressed their views during the deliberations. Today, the ACGME still hears from residents who appreciate the limits, but a larger number of comments are from residents who always had concerns that the standards would have a negative effect. Assuming that the ACGME has heard from several thousand residents on each side of the issue, given the nearly 100,000 residents in training, most residents have not weighed in on the debate. It is noteworthy

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that the majority of comments about negative effects are from residents in surgical disciplines, and that the ACGME takes their concerns seriously in its effort to refine the standards.

Faculty has commented on a loss of residents' professionalism under the duty hour limits, reporting that residents have adopted a "shift work mentality," and do not demonstrate the same commitment to patients as previous generations of physicians. ACGME also hears from residents who state they are conflicted about leaving their patients, especially at the end of the post-call period.

The Good, the Bad and the Ugly - Revisited

New York State instituted duty hour regulations in 1989. The findings on the effect of the New York regulations are remarkably similar to comments received in the early days of the national implementation of duty hour limits. They encompass "the good, the bad and the ugly." In the realm of "the good," several New York studies found that limits on duty hours improved residents' welfare and allowed more time for reading and self-study. Others findings corroborated the "bad" – that residents are highly motivated and skilled providers of care, and that replacements are difficult to find, are more costly, and may be unwilling to work some of the less desirable periods traditionally covered by residents. In the category of "the ugly" are efforts at compliance that meet the letter of the standard but violate the intent, often resulting in a pattern of residents spread so thin that it can compromise education and patient care. Patterns of inappropriate compliance may have contributed to the finding that New York's regulation of duty hours diminished the quality of care in teaching institutions.

"In surgical specialties, after residents have spent 80 hours, the most meaningful learning modality–added operative experience–is curtailed by the duty hour limits."

Overall, the findings initially appear equivocal on the effect of the standards on patient care and learning. However, when the New York reports and the comments received in the past 120 days are disaggregated by specialty, a pattern emerges. It suggests that the consequences are different in medical and surgical disciplines. After 80 hours per week spent on patient care and didactics, residents in medical disciplines may use the added free time for reading and self-study. This may result in improved performance on exams of medical knowledge. In surgical specialties, after residents have spent 80 hours, the most meaningful learning modality – added operative experience – is curtailed by the duty hour limits. The surgical community has expressed concern that this will ultimately translate in reduced surgical skills. An unintended and undesirable consequence of duty hour limits thus could be reduced operative skills for a cohort of surgeons trained in this initial period, when the clinical and education systems are still adapting to the new duty hour standards.

The observation that some residents do not want to leave their patients merits further exploration. It could be evidence they are acculturating to their professional responsibilities, or it could be a sign residents are clinically overburdened and lack the support to complete assigned care tasks within the allotted hours. Faculty observations regarding residents' diminished professionalism and "shift work mentality" could suggest that residents have adapted "too well," or it could signal that faculty equates professionalism with the sheer number of hours spent. Conversations with clinical leaders, educators and faculty suggest there are unmet expectations and a sense of loss on the part of faculty, including a feeling that they do not receive the level of support from residents they provided to faculty during their residency." Duty hour limits are thus perceived as halting an inter-generational transfer of support that faculty expected, perhaps unconsciously, when they chose academic careers. These perceptions are accentuated where the faculty complement has increased, but the number of residents has remained stable.

Sensitive to the observation that duty hour limits may negatively affect the attainment of competency in surgical disciplines, the ACGME Board of Directors charged the chairs of the surgical

RRCs to explore how to refine the common duty hour standards for the final accredited year in surgical specialties. The intent is to ensure that surgical residents in their last year of training have adequate surgical experience and enhanced continuity, to complete their professionalism preparation for independent practice and leadership of the surgical team.

Sense-Making

At this time, we lack "hard data" on the effect of the duty hour limits, in part because only four months have elapsed since standards were instituted, and in part because assessing interventions in the field is difficult. The multi-factorial nature of outcomes and the sheer size of the "experiment" are daunting. Evaluations of the effect of duty hour limits in New York and Europe used studies with small samples or cross-sectional surveys that gathered the perceptions of affected individuals. In some areas, they relied almost entirely on anecdotal information. The distinguished scholar Karl Weick advocates for "sense-making," which he defines as giving meaning to an activity by focusing on the identity of the thinker(s), extracted cues, and plausibility rather than accuracy.[1,2] In the absence of hard data, a sense-making approach could guide the assessment and refinement of the common duty hour standards. This is not the familiar approach for the medical community, who likes to rely on controlled trials and quantitative studies that meet established reliability and validity standards. Still, "plausible" data could greatly enrich our understanding by revealing why people respond to the duty hour limits the way they do and how they think the standards impact on their work and lives.

"...one could envision change that is both radical and orthodox, radical in the degree to which significant revisions were made to decouple the systems for patient care and education and reassemble them in a new way, and orthodox by returning resident education to its ultimate goal."

Radical and Orthodox Change

The implementation of duty hour limits has focused attention on adapting the clinical delivery system. The resulting changes affect residents and, perhaps even more, faculty. Resident and faculty buy-in is critical to the successful application of the standards, and to avoiding situations where residents must choose between complying with the standards or meeting the expectations of their faculty and mentors. The medical education community is aware that education is key to enhancing patient adherence to the treatment regimen. It may benefit from adapting this wisdom, and educate residents and faculty about the goals and benefits of the duty hour limits. Program and institutional leaders also must address hidden curriculum, including faculty comments about, "what residents will miss" or statements about "reduced professionalism." Because duty hour limits have created major changes in the system, programs need to re-conceptualize their definitions of professionalism to adapt them to constrained hours, and address the attitudinal aspects of the change.

At present only a few institutions and a national joint effort of the Association of American Medical Colleges and the Institute for Healthcare Improvement seek to radically redesign the clinical delivery system in teaching institutions. When these efforts come to fruiting and expand to a larger number of institutions, one could envision change that is both radical and orthodox, radical in the degree to which significant revisions will be made to decouple the systems for patient care and education and reassemble them in new ways, and orthodox by returning resident education to its ultimate goal – seeing residents as learners who are completing their professional preparation for independent practice in their chosen specialty. This echoes the comments by David Leach, MD, in the lead article in this issue, reminding us that residents are foremost students. We also need to assist residents in making the most of the time that has been freed by reducing their hours. At a recent conference, David Nahrwold, MD, senior academic surgeon and Chair of the American Board of Medical Specialties, suggested that surgical residents could use the added time resulting from limits on duty hours to explore how they could enhance their capacity to care for their patients, viewing their professional work not through a technical but an intellectual and emotional lense.[3]

The ACGME realizes it needs to explore refinements to the standards, using the flexibility of the accreditation approach that is one of its strengths. The refinements will focus on areas where the Council has received what Weick has termed "plausible information." To facilitate this, the ACGME has requested that all RRCs collect data on the problematic areas of the standards to be evaluated in late spring of 2004. At the same time, implementation of the standards and the necessary changes in patient care and education need to go on. Having learned that the effect of sleep loss is not related to intelligence, motivation or professionalism, the community now needs to come to terms with the fact that health care continues to be a 24/7 industry. It merely can no longer depend on the services of residents to the extent it did prior to July 2003. Among other things, this will require faculty to abstain from commenting that duty hour limits have destroyed continuity of care. It may be disquieting to our public to learn that the only barrier between patients and lack of continuity of care in the nation's finest medical institutions was residents working more than 100 hours per week. Development of new group models of continuity and improving the systems for patient hand-off will be critical areas for advancing our knowledge.

Dealing with the duty hour limits in the next 120 days will likely be as complex and consuming as the first 120 days, but it will contribute to allowing residents to function as learners, not as the "the glue in the cracks of the broken health care system.[4]"

(1) Weick, K. (1995). Sense-making in organizations. Thousand Oaks, CA: Sage

(2) Weick KE. The reduction of medical errors through mindful interdependence. In medical error: What do we know? What do we do? Rosenthal, et al., Eds.; JosseyBass, 2002.

(3) Nahrwold, D. Lecture at the ABMS/ACGME Conference on Professionalism, Chicago IL, September 19, 2003.

(4) Quote by Paul Patalden, MD.