



Focusing
on a review
process that
works



ACGME

Accreditation Council for Graduate Medical Education

P R O G R E S S I V E

Looking back on the ACGME's first decade of operation, we are pleased to report that it has been a decade of progress. Through the unwavering dedication of our Council members, our staff and our volunteers, we have fulfilled our goal of establishing a process that not just preserves, but improves the quality of graduate medical education.

During that time, we refined our system of review to obtain a more precise description of programs to enhance the accuracy of our evaluations. We developed a professional, experienced staff to shepherd applicants through the process and expedite accreditation. We secured the partici-

pation of hundreds of distinguished volunteers to elevate the caliber of our decision making and we designed internal training for these volunteers and outreach workshops for program directors.

Overall, it has been a decade in which the ACGME acted as a catalyst in bringing together knowledgeable, concerned individuals and institutions to address and resolve critical issues facing graduate medical education.

The ACGME's scope of influence continues to widen. We now accredit in excess of 6,600 programs, 24 major specialties and 49 other training areas. Every day, we directly affect the professional development of more than 90,000 residents in 1,500 institutions across the country.

We approach the future committed to build on these achievements, to ensure the objectivity and effectiveness of our work. We are developing requirements for new subspecialties to keep pace with medical progress and to impact the delivery of care. We are entering the final approval phase of our complete revision of General Requirements to reflect current trends in medicine and to guarantee the educational support of physicians. And, we have restructured our agreement with the American Medical Association to assume

fiscal self-management to better control our resources.

We are encouraged by the preliminary results of our recent survey of the varied constituencies we serve. They have responded overwhelmingly in endorsing the value of our work. We thank them and our member organizations, which have created a climate conducive to the broad acceptance of our process.

Looking forward, the ACGME can promise the same uncompromising commitment that characterized the decade behind us: to provide a framework for graduate medical education that meets the expanding requirements of science and the changing needs of society.



John C. Gienapp, Ph.D., ACGME executive secretary since 1981, and a chairman selected on a rotating basis from the council's five member organizations provide the capable leadership that guides operations and development.

O B J E C T I V E

ACGME's impact on graduate medical education takes many forms. We establish general procedures, policy and requirements for review. We evaluate and accredit programs. Conduct research. Maintain program records. Act as liaison among our 24 Residency Review Committees. Coordinate expert volunteer activities. Plan conferences and participate in medical forums. Most importantly, we continually communicate with thousands of program directors across the country.

Throughout these ongoing activities, we strive to maintain complete objectivity. The credibility of the ACGME rests on its ability to act as an independent review body free

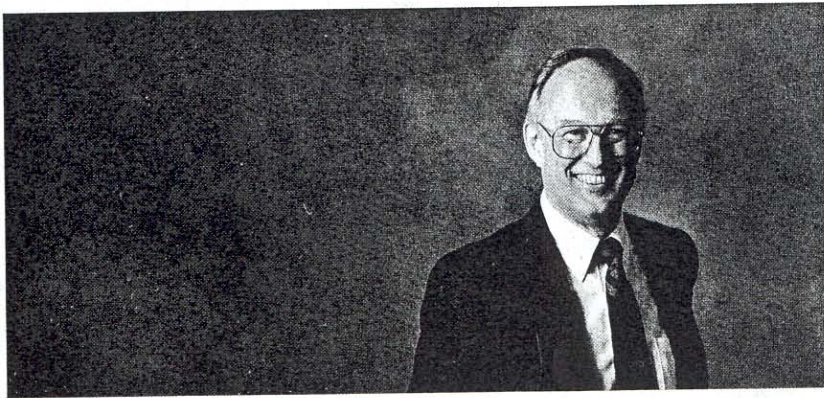
of self-interest. Although the ACGME is sponsored by five medical organizations, we function autonomously, managing our own operations. As a nonprofit organization, we have no financial stake in the outcome of an accreditation decision. We pursue our work solely as an advocate for quality standards in graduate medical education.

Our system of peer review further ensures that accreditation decisions are fair and impartial. This approach reflects our belief that the more knowledgeable the reviewer, the more equitable the outcome. The volunteers who give so generously of their time and talent to participate in our RRCs come from all walks of medicine and education. They possess the specialized expertise necessary to make informed decisions and are given the freedom to follow their judgment.

Of the hundreds of programs the ACGME evaluates each year, rarely is an opinion of our RRCs questioned. But it does occur. For that reason, since the early days of the council, we have had an appeals process open to any program. Again, in the interest of fairness, every appeals panel is composed of independent experts in the pertinent specialty.

In 1986, however, a teaching hospital sought recourse beyond the checks and balances within the ACGME, using the legal system to challenge our right to enforce graduate medical education standards. Recently, after thorough scrutiny, the court affirmed the legitimacy of our work, stating that ACGME standards and procedures comported with constitutional standards of due process and common law standards of fairness.

Objectivity is the only way to safeguard the ACGME process and to guarantee that we continue to serve everyone touched by medicine. Residents can be confident in their abilities, knowing that the training they receive familiarizes them with both common and rare medical problems and incorporates the latest technology and procedures. Institutions with graduate medical education programs know they can deliver consistent, quality patient care. And, although most people do not know the ACGME, they nonetheless benefit from our work every time they consult a physician.



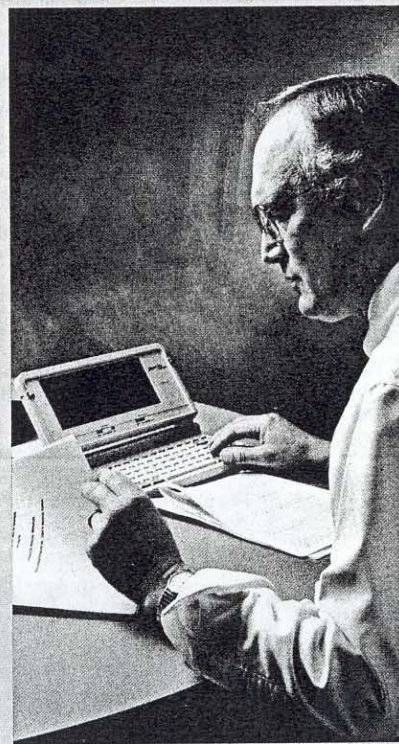
David Schramm, Ph.D. is one of 14 field surveyors on the road for the ACGME, visiting the 1,500 hospitals, ambulatory facilities, family practice centers and health agencies that form the nucleus of graduate medical training.



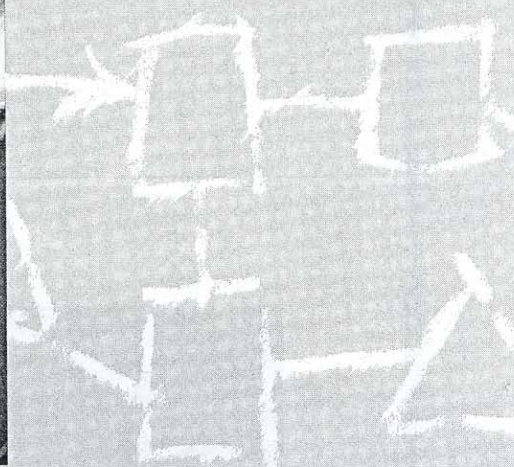
Schramm's assignment: Verify program information first-hand, a responsibility that includes interviewing program directors, administrators, key faculty and residents.



Talking with residents is the most rewarding part of Schramm's job: "They're the point of everything we do. Our process at heart is to make sure residents receive the best possible education."



His site survey report clarifies and elaborates on the program's information forms to give the appropriate RRC a complete and accurate body of data on which to base its accreditation decision.



R E S P O N S I V E

Much of the ACGME's work takes place behind the scenes. In addition to our RRC volunteers, we rely on 55 full-time professionals and support staff at our headquarters office. Their backgrounds run the gamut — as educators, administrators, healthcare advisors and communications directors. They come to us from universities, hospitals, associations and government health organizations. Our field survey team consists of five Ph.D.s and nine M.D.s stationed around the country. All contribute to keeping our process responsive to the constituencies we serve.

The staff works closely with graduate education providers to facilitate a smooth

transition from phase to phase of the accreditation process. Upon receipt of application documents, the appropriate RRC executive secretary sets the wheels in motion. The director of field staff assigns a site survey date and an ACGME surveyor visits the institution. The surveyor's report is directed to the RRC executive secretary who prepares all materials for review by the committee charged with that specialty. After thoughtful, thorough deliberation, the members arrive at their decision. The executive secretary then conveys the result to the program director and other institutional officials.

Over the years, the ACGME has progressed from manual tracking of volumes of paperwork to a sophisticated computer program for record-keeping and proper channeling of documentation. In this way, any program director or RRC member seeking to verify information or check the status of an application is assured a timely, accurate response. Currently, we are in the final stages of planning our next generation of computer support to ensure our capabilities match the needs of future operations.

At each stage of our process, the ACGME staff is readily available by telephone to answer questions and give program direc-

tors assistance in completing applications. The RRCs also provide valuable feedback; their comments help institutions make improvements to satisfy accreditation requirements.

To further communication with hospital administrators, program directors and others responsible for graduate medical education, we conduct our annual Mastering the Accreditation Process workshop. The goal is to acquaint newcomers with the work of the ACGME, introduce them to the staff members who administer the process and provide specific guidelines for gaining accreditation. The concentrated day-long seminar features problem-solving sessions and tackles topics from how to prepare for an ACGME site visit to what to do about an adverse accreditation decision.

Program directors tell us that direct contact with the ACGME allows them to obtain the information they need in the way they know best — by listening. To satisfy demand — an average of 200 registrants attend each session — we offered the workshop twice in 1990.



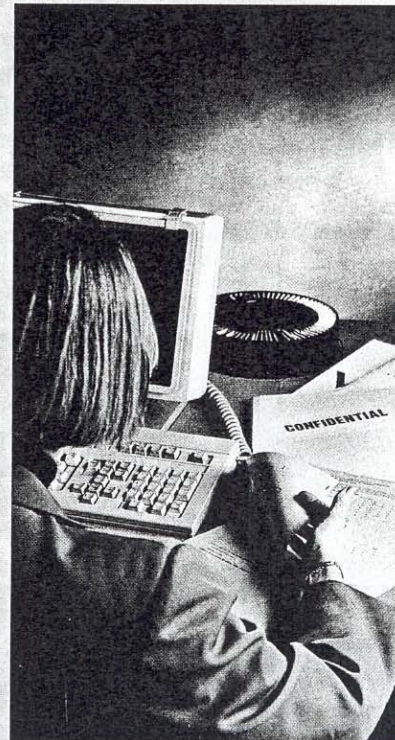
RRC executive secretary Paul O'Connor, Ph.D., coordinator Sheila Hart, senior secretary Allean Holmes and dozens of other professional and support staffers, working in teams, keep each stage of the ACGME process running smoothly.



Helping those responsible for graduate medical education learn more about accreditation is the goal of the ACGME's annual day-long Mastering the Accreditation Process workshop.



Seminar presentations walk attendees through the ACGME process, addressing specific questions such as how to complete the application, the best way to prepare for a site visit and how to appeal an adverse decision.



Evaluating feedback from each session enhances the ACGME's ability to keep the workshop responsive to the needs of our constituency.

Change is a staple of ACGME operations. Breakthroughs in technology and techniques accelerate the capabilities of medicine every day. External influences such as financial and societal patterns restructure the delivery of healthcare just as rapidly. The ACGME operates within this dynamic environment and adapts its process to reflect the times.

As medicine introduces new procedures, our RRCs evaluate whether these advances should become required practice. The ACGME also examines emerging subspecialties and develops guidelines for integrating them into resident training. Within the last 12 months, we have released first-

time educational standards in five subspecialties: neuroradiology, pediatric radiology, pediatric urology, diagnostic laboratory immunology and orthopaedic surgery of the spine.

Naturally, as medicine changes, new issues arise. A major concern has been reconciling the desire for the best in graduate medical education with realistic demands on residents. After a comprehensive review of resident hours, the ACGME revised the relevant requirements. For most specialties, our deliberations led to a limitation of the frequency of night call, set a maximum number of hours that a resident may work each week, provided for assigned days off and placed specific responsibility on the program director to see that these stipulations are enforced.

Right now, along with the entire medical community, we are grappling with equally important concerns such as how to provide optimal training given the diminishing resources available to institutions, how to effect substantive education in an ambulatory setting and how to prepare for an increase in the aging population.

To stay attuned to all of the factors impacting our work, the ACGME draws on our network of volunteers and colleagues.

Our RRCs alert us to changes they experience in their practices. We talk with program directors and hospital administrators, attend symposia and government forums, and listen to the observations of our field surveyors.

The ACGME dissects new issues at our thrice-yearly plenary sessions and concurrent meetings with our RRC chairs. With so many changes affecting both new and existing programs, our RRCs understandably keep full agendas. Committees generally meet two times annually, though many convene more frequently to accommodate their review load. Each year, at least 3,000 programs are on RRC agendas. In a 12-month period, a committee often reexamines half of all the programs it oversees. The RRC with the largest number of programs – internal medicine – is responsible for 428 core programs and more than 1,500 subspecialty programs.



Judith S. Armbruster, Ph.D., executive secretary for three RRCs, has lent her expertise and organizational skills to the ACGME for more than a decade.



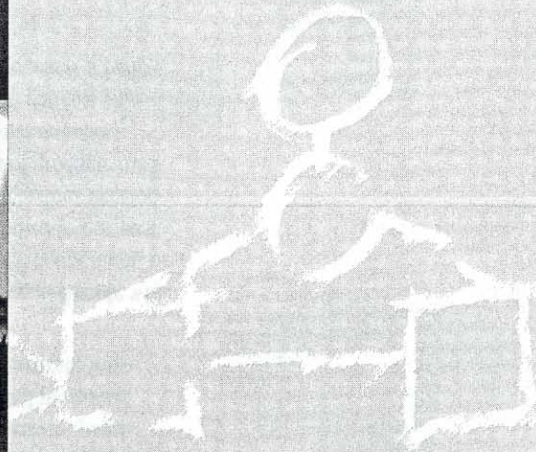
Among the major issues that have arisen during Armbruster's tenure: "The proliferation of subspecialty programs has raised questions about how narrow or broad a new area should be before it is considered for accreditation."



As liaison between the RRCs and program directors, she prepares committee agendas and travels around the country to participate in RRC meetings.



Communicating the results of an RRC decision to relevant programs is an integral part of the continuum of the review process.



R E S P O N S I B L E

The ACGME shoulders a concrete responsibility for excellence in graduate medical education. To uphold this important duty, we must ensure our objectivity, respond to the needs of those who rely on our process and adapt to reflect the dynamics of medicine. Only then can we continue to advance the level of physician training.

Our responsibility extends well beyond initial accreditation. We reevaluate all 6,600 accredited programs on an average of every three-and-a-half years. That means that at least once during a resident's training, the program in which he or she participates will be carefully examined for its performance against established standards.

The ACGME has an ongoing commitment to preserve the caliber of its staff and its volunteer force. We have an ongoing commitment to serve our many constituencies. And, we have an ongoing commitment to the certifying boards and licensing agencies that depend on us to ensure physicians completing accredited programs have been trained commensurate with ACGME requirements.

We begin the ACGME's second decade with resolve. With the continued cooperation of everyone who has contributed to our past accomplishments, we will further develop and refine our standards of graduate medical education to benefit the residents, healthcare institutions and patients who place their trust in our process – a review process that works.



ACGME Executive Committee members (left to right) James N. Sussex, M.D.; Robert M. Dickler; chairman Jay S. Sanford, M.D.; George T. Lukemeyer, M.D. and Ronald B. Berggren, M.D. (not shown) are among nearly 250 volunteers who contribute more than 38,000 hours each year to ensure our process continues to enhance the quality of graduate medical education.

M I L E S T O N E S F O R 1 9 9 0

Program Activity

The primary activity of the ACGME is the review and evaluation of residency programs. One of the most important measures of activity, therefore, is the number of programs reviewed. Of the 6664 programs accredited by the end of 1990, 3467 appeared on Residency Review Committee agendas during the year, and regular accreditation status reviews were made on 2223. Thus, 52% of the programs were looked at, and regular accreditation actions were taken on 33% of the programs.

The ACGME field staff surveyed 855 programs in the basic disciplines and 529 subspecialty programs. In addition, volunteer physician specialists conducted 338 surveys.

During regular accreditation reviews, Residency Review Committees evaluated 295 programs or 12% adversely. These decisions comprised 114 instances of withholding accreditation upon application, 60 instances of withdrawal and 121 instances of probation.

Programs have the opportunity to have adverse decisions reviewed. Residency Review Committees reconsidered 161 decisions during the year and the ACGME considered 13 appeals after formal hearings by specially constituted Boards of Appeal.

1990 ACGME Activity

Total agenda items	3467
Regular reviews for status	2223
Adverse decisions	295
Withhold	114
Withdraw	60
Probation	121
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Reconsiderations	161
Sustained	94
Reversed	67
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Appeals	13
Sustained	8
Reversed	5

Number of accredited programs: 6664

Number of Residents: 90,000

Another way to view the ACGME activity is to consider the people and tasks necessary to accomplish this vital quality control. A full-time staff of surveyors spent approximately 490 weeks on the road. Volunteer surveyors made 338 trips to visit programs. Residency Review Committees held 54 meetings and the ACGME met three times. Appeals brought nearly 40 physicians to Chicago for one-day hearings. All told, volunteer physicians and administrators contributed an estimated 38,000 hours to ACGME accreditation activities. The ACGME staff of 55 full-time employees supported these efforts.

Financial Facts

Naturally, looking at financial facts is another way of understanding the ACGME activity of 1990.

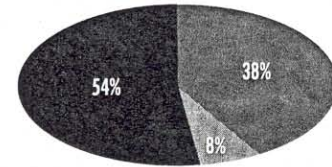
The ACGME's budget for the year was projected at \$7.4 million. Revenues for this operation came primarily from fees charged to programs, although some money was contributed directly by the member organizations.

Revenues

Site visit and application fees	\$4,256,815
Annual resident fees	2,968,536
Interest	257,350
Member organization contributions	100,000
Miscellaneous	257,309
Total	\$7,840,010

Revenues

Site visit and application fees	54%
Resident fees	38%
Other	8%

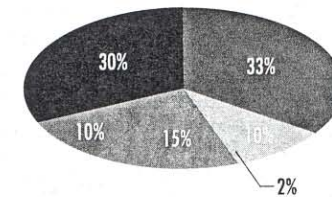


Expenses

Site visits	\$2,094,082
Residency Review Committee activities	2,256,146
Secretariat operations, including ACGME meetings	706,884
Appeals and litigation	160,228
Research and administration	1,008,480
Rent and office services	655,379
Total	\$6,881,199

Expenses

Site visits	30%
RRC activities	33%
ACGME activities	10%
Appeals and litigation	15%
Research and administration	10%
Rent and office services	2%



Year-end cash and investments \$3,428,370

A MESSAGE FROM THE CHAIR

I am pleased to present the accompanying report, which is addressed to the ACGME's many constituencies. To those who are less familiar with the ACGME and its activities, I hope this report will help you understand its organization and functions. To those already quite knowledgeable about the ACGME, I hope it will provide useful information on the scope of activities during the past year and extend a "thank you" to the many qualified professionals who have volunteered their time to support and improve graduate medical education.

The end of 1990 coincided with the end of the decade of accreditation activities under the auspices of the ACGME. The ACGME was formed by agreement of its five member organizations in December, 1980 and held its first meeting in February, 1981. The ACGME was chartered to continue the task of evaluating graduate medical education programs that was begun early in the century and gradually broadened and changed over subsequent years. The reorganization in 1980 was intended to improve the administrative structure for accreditation and establish a solid financial basis to accomplish its goals.

After a decade, it is appropriate for the ACGME to ask how well it has done. That is one of the activities we undertook during the past year. The ACGME commissioned the

survey research laboratory of the University of Illinois to conduct a survey of ACGME's constituencies to determine if and how well the ACGME is meeting its goals.

As I write this, returns are still being compiled, but the number of responses is already adequate to suggest the patterns of the final conclusions. Preliminary results suggest that residency program directors have quite favorable opinions of the ACGME, its associated Residency Review Committees and the accreditation services provided. The ACGME's overall goals, its general organizational characteristics and the functioning of its staff are all endorsed by respondents. Residency Review Committees are seen as carrying out their responsibilities in an effective, fair and professional manner. The accreditation of graduate medical education programs is viewed as having contributed favorably to the quality of residency training in the United States.

These positive responses are gratifying to the ACGME, its staff and especially to the many professionals who have volunteered considerable time and effort to accreditation. I particularly wish to commend those whose names appear in this report as having participated on the ACGME and the Residency Review Committees during the past year. This list encompasses nearly 250 medical education professionals who,

together with specialist site visitors and volunteers serving on ACGME appeals panels, have collectively volunteered more than 38,000 hours during the year. American medicine and American society both are richer for their generous activity.

Assessing the past even if positive does not mean that the ACGME can rest on its laurels. Not all past problems have been resolved. Furthermore, each year brings new challenges as graduate medical education responds to changes in both medicine and society. I and the other members of the ACGME are committed to see to it that the ACGME remains dynamic and responsive to the challenges of the coming years.

What remains unchanged is our goal – to assure the profession and society that physicians completing their formal education are better prepared than ever for the evolving practice of medicine and are ready to stand with those who have contributed so much in the years past.



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