Review Committee Membership Changes
The Review Committee welcomed two new members on July 1, 2010. Paris Butler, MD, MPH began a two-year term as the Committee’s resident member, and Ronald L. Dalman, MD, began a six-year term. The addition of Dr. Dalman’s position increases the Committee’s size from 13 to 14 members.

The Committee congratulates Adeline Deladisma, MD, MPH for her three years of service, wishes her every success as she completes her residency, and thanks her program director for his support of her Review Committee activities.

New Vice Chair Begins Term
Mark Malangoni, MD, began a two-year term as vice chair of the Review Committee on July 1, 2010.

The Committee is most grateful to J. Patrick O’Leary, MD for his leadership as vice chair from July 1, 2008 through June 30, 2010.

Update on Case Logs
The Review Committee expects that residents will enter all cases performed during their residency education into the ACGME Case Log System. Program directors are expected to ensure that complete and accurate information is entered in the case logs. The Review Committee relies on case log information when considering a request for an increase in complement (both permanent and temporary). Increasingly, more hospitals are using case log data to determine privileges for new attending physicians.

Programs must provide residents with operative experiences in the defined categories to satisfy the minimum required number of cases. Residents and program directors are reminded that the minimum for GI endoscopy is 85 cases. At least 35 of the minimum 85 cases must be upper-endoscopic, and 50 of the 85 cases must be colonoscopic. The minimum case requirement prior to completion of general surgery residency remains at 750 major cases, with 150 of those as a chief resident (during the last twelve months of residency).

Updates for the Defined Category Resident Summary reports were implemented. The pediatrics sub-categories of pediatric hernia and pediatric appendectomy are no longer shown on the reports. Residents must perform a minimum of 20 cases in the defined category of pediatric surgery.

Links to documents describing the recent changes in defined category minimums are listed below:

Pediatric Surgery: www.acgme.org/acWebsite/RRC_440/440_pedMinNumbers.pdf
Credit Roles for Surgery Residents
For multi-procedure operations, residents must record all procedures performed and indicate which procedure is primary.

When more than one resident is involved in a same-day/same-operation/same-procedure situation, a senior resident may take credit as surgeon, while another resident may take credit as a First Assistant; or, a senior resident may take credit as a Teaching Assistant, while a more junior resident takes credit as surgeon. If two residents perform different procedures on the same patient (different CPT codes), then each may take credit as surgeon.

Definition of Credit Roles
SC = Surgeon Chief Year; only cases credited as surgeon during 12 months of Chief Year
SJ = Surgeon Junior Years; all cases credited as surgeon prior to Chief Year
TA = Teaching Assistant; more senior resident working with junior resident who takes credit as surgeon
FA = First Assistant; any instance in which a resident assists at an operation with another surgeon—an attending or more senior resident—responsible for the operation (not credited towards total number of major cases)

The ACGME’s Task Force on Quality Care and Professionalism Proposes New Duty Hour Recommendations
In response to the Institute of Medicine’s (IOM) recommendation to change the current duty hour standards as described in our prior newsletters, the ACGME’s Task Force on Quality Care and Professionalism, which includes members of the Board of Directors, several Review Committee chairs and Review Committee resident members, has prepared and presented a draft of new duty hour requirements.

In his June 23, 2010 letter to the GME community, Thomas J. Nasca, MD, MACP, chief executive officer of the ACGME, presented the goals of the revised program requirements:

1. To assure the safety and quality of care rendered to patients in our teaching hospitals today;
2. To assure the safety and quality of care rendered to patients of our current residents in their future independent clinical practice; and
3. To assure the provision of a safe and humanistic educational environment for our residents to learn and demonstrate professionalism and effacement of self interest.

While the total of 80 hours per week remains intact, multiple changes regarding how those hours can be apportioned are being recommended.

The Proposed Common Program Requirements, inclusive of the new duty hour recommendations, can be read in their entirety at the following site: http://acgme-2010standards.org/pdf/Proposed_Standards.pdf.

The Task Force is in the process of considering the many comments received during the ‘Review and Comment’ period, and will make its final recommendation to the ACGME’s Board of Directors. Additional information about the effective date of implementation will be announced on the ACGME’s website.

The Council of Review Committee Residents (CRCR) is an advisory council for the ACGME. It includes 28 resident members representing 26 Residency Review Committees, the Transitional Year Review Committee and the Institutional Review Committee.

The recommendations proposed by the ACGME’s Task Force on Quality Care and Professionalism were discussed at a special meeting of the CRCR, and after a consensus was reached, the following response was submitted for consideration:

• The CRCR strongly supports the principle of balancing the demands of resident education with patient safety and quality of care. Additionally, the CRCR applauds the Task Force for the manner in which the proposed standards encompass all of the important general principles of residency education and patient care without removing the ability of varying specialties to design systems that work for their own residents/fellows, teachers, and patients.

• Two aspects of concern for the CRCR:

  1. **Loss of the opportunity to average every third night call.**

     Removing the ability to average call frequency will make it so that some residents, especially those in smaller programs, will likely be unable to spend an entire weekend free from clinical responsibilities. The CRCR believes that the negative impact on resident quality of life by removing call averaging will not be commensurate with an improvement in patient quality of care. Thus, the CRCR asks that call every third night with averaging be permitted.
2. Limiting the duty period for PGY-1’s to 16 hours will negatively impact the educational experiences of many first year residents. Particularly for certain programs, interns are exposed to very short but crucial periods of education in which their “24 hour on call” experience is the key to their exposure and growth as physicians. Additionally under the proposed duty hour requirements, it is possible that many will spend half of the first year in a night float capacity missing out on educational lectures/didactic and elective procedures that only occur during the course of the day light hours. The CRCR asks that this 16-hour duty hour limitation for PGY-1 residents be reconsidered by the ACGME’s Task Force.

Resident/Fellow Survey 2010
The ACGME’s Resident/Fellow Survey is one method used by the Review Committee to monitor graduate medical clinical education and to provide early warning of potential non-compliance with ACGME accreditation standards. Currently, all core specialty programs (regardless of size) and subspecialty programs (with four or more fellows) are surveyed every year between January and June. Aggregate reports will be made available to programs with four or more residents if a 70% response rate is reached.

The survey is administered annually, and the information gathered is used at the time of the program’s site visit. The ACGME will notify programs directly when their participation is required. This notification will include detailed information on accessing the survey, as well as a deadline for completion. Residents and fellows will have four weeks to complete the survey.

The survey, and additional information about it, can be accessed via the following link: www.acgme.org/acWebsite/resident_survey/res_index.asp.

Office of Resident Services
In 2009, the ACGME established the Office of Resident Services to help physicians in graduate medical education (GME) receive fair solutions to concerns and formal complaints related to residency education. When a concern (which is different from a formal complaint (see Procedures for Addressing Complaints against Residency Programs and Sponsoring Institutions), is submitted, it has no impact on accreditation. While concerns submitted do not, complaints may impact an institution’s and/or program’s accreditation status. When the existing channels of communication or dispute resolution have proven unsatisfactory, the ACGME’s Office of Resident Services confidentially investigates specific concerns brought to its attention by physicians in GME (residents, fellows, and faculty members).

ACGME-accredited programs and their sponsoring institutions are expected to comply with the ACGME’s Institutional and Program Requirements. Anyone having evidence of non-compliance with these standards by a program or institution may submit a formal complaint to the ACGME. Such complaints must be submitted in writing and bear the signature and mailing address of the complainant(s).

Anonymous complaints or complaints submitted solely by e-mail will not be considered. Complaints addressing subject matter, the entirety of which occurred during the residency year preceding the current residency year, are discouraged.

ACGME Review Committees address only matters regarding compliance with the published standards and do not adjudicate individual disputes between persons and residency programs or sponsoring institutions. Nevertheless, sponsoring institutions and programs must provide an educational and work environment in which residents may raise and resolve issues without fear of intimidation or retaliation.

Additional information is available at the following link: www.acgme.org/acWebsite/resInfo/ri_welcome.asp.

Selected Accreditation Terms

Accreditation: A voluntary process of evaluation and review based on published standards, and following a prescribed process, performed by a non-governmental agency of peers.

Competencies: Specific knowledge, skills, behaviors and attitudes and the appropriate educational experiences required of residents to complete GME programs.

Program Information Form (PIF): The PIF is the document completed by the program director in preparation for a site visit. It compiles requested information reflecting the current status of the program. The PIF is organized in two parts: the Common PIF, which addresses the program’s compliance with the Common Program Requirements, and the specialty- or subspecialty-specific PIF, which addresses compliance with the specialty- or subspecialty-specific program requirements.