



Spring/Summer 2008

ACGME Learning Portfolio

A number of resources are available for programs that want to become more familiar with the ACGME Learning Portfolio (ALP).

http://www.acgme.org/acWebsite/portfolio/cbpac_faq.pdf: The Frequently Asked

Questions (FAQs) (updated April 2008) include a description of the portfolio and its benefits to both residents and program directors, in addition to common concerns about using an online portfolio system. An updated timeline for development provides additional information on the alpha and beta testing phases.

http://www.acgme.org/acWebsite/portfolio/cbpac_revisedtimeline.pdf. A narrated

demonstration of the portfolio can be found at

<http://www.acgme.org/acWebsite/portfolio/AlphaDemonstration.wmv>.

More information is available on the ACGME Learning Portfolio website:

http://www.acgme.org/acwebsite/portfolio/learn_cbpac.asp

A total of 4 programs have been enrolled in Alpha-2 testing. This newsletter will feature additional information from the beta phase as it becomes available. More information is available on the ACGME Learning Portfolio website:

http://www.acgme.org/acwebsite/portfolio/learn_cbpac.asp

Updating the Anesthesiology Program Information Form

by Kathleen Holt, PhD

An RRC subcommittee has been editing the Program Information Form (PIF) during the past year. As part of this process, they have eliminated open-ended or free text items, checked that PIF questions parallel the program requirements, and reframed questions to be more outcomes-based. ACGME programmers are now converting the PIF questions into a web-based environment so that it may be completed by program directors just as annual updates and common PIFs are done now. The new electronic PIF is expected to be available by midsummer.

Having a fully electronic PIF (e-PIF) is a crucial step towards meeting the ACGME's goal of a fully Electronic Accreditation System (EASy). EASy will allow all parts of the program review (PIF completion, SV interviews and report, review by the committee, and program notification) to be completed and available within the ACGME's web-based system.

Since the new web-based PIF and the new program requirements will go into effect during the same timeframe, the ACGME will not schedule site visits for programs due for a survey in the second half of 2008 until after October 1st. This should give program directors and coordinators time to fully complete the new e-PIF.

Program Review

The RRC meets twice a year, usually in the spring and in the fall to review programs. These meetings are about six months apart. Before each meeting, two RRC members are assigned to review each program. The paperwork is distributed over a two to three month period prior to the RRC meeting, and RRC members are expected to complete their reviews within 30 days of receiving a program. All reviews must be received in the ACGME office eight weeks prior to the meeting to allow incorporation into the reviewer book. The reviewer book is sent to the RRC members before the meeting so that RRC members may read all the reviews, and compare the two reviews for each program.

After the RRC meeting, the ACGME staff prepare the notification letters for the program directors regarding the accreditation decisions reached by the RRC. Before these are posted on ADS, however, the chair of the RRC has to review each communication and compare it with a worksheet generated during the RRC meeting, make corrections as necessary, and then certify the entire process by signature. The purpose of this review is to make absolutely certain the citations and final accreditation decisions reflect the decisions of the RRC.

Because of this process, some survey results completed in the month or so just before an RRC meeting will likely not be reviewed at that meeting, but will be delayed until the next RRC meeting six months later.

The RRC asks program directors to be mindful of this somewhat lengthy interval between a site visit and the receipt of a final accreditation decision.

Pain Medicine Advisory Group

The [Multidisciplinary Pain Medicine requirements](#) became effective on July 1,

2007. Many of the changes in these requirements are intended to ensure that program curricula have a multidisciplinary scope.

To ensure that the program review process emphasizes multidisciplinary concepts, the ACGME has recommended a pre-review process by the Pain Medicine Advisory Committee. This review occurs prior to scheduling programs for review and a final accreditation decision by the respective RRC. This Advisory Committee includes four members, each of whom represent one of the four participating disciplines: Anesthesiology, Neurology, Physical Medicine & Rehabilitation and Psychiatry. Advisory Committee members are not sitting members of an RRC; however, each was selected by an RRC as a recognized expert in Pain Medicine.

Due to these changes, the time period from a site visit to an accreditation decision will be lengthened somewhat to allow for both a pre-review by the Advisory Committee and an accreditation review and final decision by the RRC.

Program directors should contact [ACGME staff](#) to confirm when their program will be scheduled on an RRC agenda.

“Red Flags” Help Programs Recognize Potential Issues

In the February 2008 issue of the [ACGME e-Bulletin](#), an article entitled “*Nine ‘Red Flags’ in Accreditation Site Visits and Reviews*” by members of the ACGME Field Staff provides observations that may raise questions about program quality and compliance with program and institutional requirements. This may be of particular interest to programs preparing for upcoming site visits.

Frequently Asked Questions

Anesthesiology Education Abroad

Q: Can a resident participate in a rotation at a facility abroad in order to obtain experience in providing anesthesia in austere conditions and/or other environments?

A: Accredited programs are encouraged to develop longitudinal relationships with specific programs in overseas locations that are capable of providing optimal educational experiences for residents wishing to spend a portion of their residency training in these locations. Programs are encouraged to incorporate specific overseas experiences as an elective rotation that is made available to all trainees in the program on an ongoing basis and to describe this (these) rotation(s) as a part of the PIF and receive prospective approval from the RRC.

Applications to the RRC for Anesthesiology for overseas rotations should be submitted by the program director to the Executive Director of the RRC for Anesthesiology and should include the following:

- A detailed description of the proposed overseas rotation, including the duration, location, proposed faculty members, and the training and experience of the faculty available on site to support resident education during the rotation.
- Specific goals and objectives for the overseas rotation that have been designed in collaboration with the faculty who will be on site to support resident education during the rotation.
- A description of how resident performance will be evaluated during the overseas rotation.
- A description of how the rotation will be evaluated by participating residents.
- A letter from the DIO of the program's participating institution signaling that the proposed rotation has been reviewed and approved by the GMEC at the program's institution.

Prospective approval from the RRC for ongoing overseas rotations is preferable to case-by-case requests for overseas rotations for individual residents. Once such

a rotation is approved by the RRC, it is considered a part of the program's approved educational curriculum, and no further approval is needed for individual residents to participate in such approved overseas rotations. Trainees must be in good standing in their program, and the total number of months away from the core program, including rotations abroad, must not exceed 6 months in the CA 1-3 years. In general, experiences in anesthesia education abroad should not exceed one month.

However, if the rotation has not been prospectively approved by the RRC, the program director must obtain prospective approval from the ABA Credentials Committee for any individual trainee before such elective rotations can take place.

Requests for overseas rotations must be directed to the ABA Credentials Committees at least four months in advance of the proposed rotation under the following circumstances:

- If the overseas rotation has not received prospective approval from the RRC for Anesthesiology to be incorporated as an ongoing component of the program's educational curriculum that is offered to all residents in the program.
- If the rotation is scheduled to occur within the final 3-month period of an individual's CA-3 year. This is the final evaluation period for residents completing residency in anesthesiology, and final reports to the ABA regarding an individual resident's performance are formulated during this period, thus overseas rotations during this period are generally not approved.
- If the rotation is scheduled to occur within the first 12 months of training in anesthesiology (CA-1 year). As overseas rotations place the resident in unfamiliar surroundings where supervision of clinical care may differ from that within the training program's educational program offered at participating and affiliated institutions, such rotations should generally

be reserved for residents in the CA-2 and CA-3 years who have already gained significant training in anesthesiology.

Integrated and Non-Integrated Participating Sites

Q: What is the difference between an integrated and non-integrated participating site?

A: One sponsoring institution assumes ultimate responsibility for the program and all participating sites.

Participating sites may be integrated or non-integrated.

In an integrated site, the core program director (PD) has authority over the educational program including the appointments of all teaching faculty and residents. Rotations to integrated sites are not limited. Integrated sites should be in geographic proximity to the parent institution to allow residents to attend joint conferences.

A non-integrated site provides the core program with limited rotations that complement or enhance the clinical experiences available in the parent institution. Assignments to the non-integrated site must be made for educational purposes only and limited in time and number. Specifically, a resident cannot be assigned for more than 12 months over 3 years of clinical anesthesia and no rotation should exceed 6 months duration.

For example, a program may wish to enhance resident rotations in pediatrics by establishing an affiliation with a children's hospital. To do this, the hospital will create an affiliation agreement with the specialty hospital that defines the number of months the resident will spend at the children's hospital during each clinical anesthesia

year.

In either arrangement, the Program Director must maintain effective communication with the site directors at each participating site to maintain proper oversight of residents' clinical experiences, duty hours, and other aspects of their training.

Faculty Scholarly Activity

Q: What is an appropriate level of faculty scholarly activity?

A: The Program Requirements have very specific requirements for faculty scholarly activity as follows:

“The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.

a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.

b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

(1) peer-reviewed funding;

(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;

(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,

(4) participation in national committees or educational organizations.”

The RRC considers all forms of scholarly activity to be important. The RRC has found that successful programs usually have at least half of their faculty involved in various forms of scholarship.

The RRC considers a number of factors when

deciding if an individual program's faculty has satisfactorily created an environment of inquiry and scholarship.

As a general rule, it is reasonable to expect that a program would have at least 10% of their clinical faculty as authors of peer-reviewed publications (with PUBMED numbers attached) with authorship in the first, second or last position.

As an example, what would be the expectation of a program with fifty clinical faculty? It seems reasonable to expect that at least five papers a year would come from the faculty (in total) in which they are either first, second or last author.

This suggestion is based on data that suggests that the average amount of non-clinical time in academic departments is approximately 15%.

Innovative Projects

Q: How do programs get approval for innovative ways to teach and evaluate residents?

A: The ACGME is very receptive to developing new and better methods. The approval process is discussed in Section VII of the Common Program Requirements.

Additional information is available on the ACGME Anesthesiology RRC website in the section labeled "Proposal for Program Experimentation and Innovation."

Particularly pertinent to the approval process is the timeline because proposals which include requests for a waiver, variation and/or suspension of Common Program or Institutional Requirements require ACGME approval. The proposal will be reviewed by ACGME prior to consideration by the RRC. This process may delay the response time from the RRC. Program Directors should therefore estimate six to nine months for a decision

from the RRC.

Innovative programs that would not comply with the ABA Booklet of Information should also have prospective ABA approval.

ACGME Resident Survey

Every two years, all programs with four or more residents complete the ACGME Resident Survey. Results of this survey are made available to the program and the DIO for programs with a 70% or greater response rate. Programs with less than 70% response rates are resurveyed the following year.

The Resident Survey is used by the site visitor to spotlight key areas of concern as well as program strengths that the residents identified; the site visitor also uses the Resident Survey to help determine serious non-compliance with duty hour standards. Increasingly, compliance with duty hours, adequate supervision, and limiting excessive service are noted as key factors that contribute to a high-quality learning environment for residents.

The RRC has requested that site visitors provide more detailed information regarding the verification of negative comments made in the numerical or comment sections of the Resident Survey, specifically, when the site visitor records that a concern is "not an issue" or "could not be verified."

Results of resident surveys can be used as heuristic tools by program directors to improve the quality of residency education. National averages of resident surveys can be viewed on the ACGME website www.acgme.org, within the ADS section, and should be reviewed by individual programs during annual and mid-cycle internal reviews so that resident issues are identified and addressed in a timely manner.

Innovation and Experimentation at the Program Level

Program directors may wish to implement an

innovative project. The [Program Experimentation and Innovative Projects Proposal Form](#) is located on the Anesthesiology website. The DIO must sign the proposal indicating review and approval of the sponsoring institution's Graduate Medical Education Committee. Proposals should not exceed five pages in length; attach additional documents as numbered appendices. One copy of the proposal should be sent via standard mail to the Executive Director of the RRC for Anesthesiology, Missy Fleming, PhD.

Accreditation Data System

The ACGME's online ADS alerts the RRC to changes in programs. Program directors must update ADS to:

- Notify the RRC of any changes in their program (i.e., new program director or adding or deleting a site)
- Request a change which needs RRC approval (i.e., an increase in resident complement). The request for a permanent increase in the resident complement must include a copy of the institutional data for all participating sites. Only one academic or one calendar year of data is necessary.
- Submit the academic year "Annual Update" (ADS staff will e-mail the deadline for updating faculty and resident rosters)
- Prepare for an upcoming site visit (the ADS will populate many sections of the PIF with the data entered)

Address your questions or concerns about ADS to the ADS representative for Anesthesiology, Timothy Goldberg at 312/755-7111, tgoldberg@acgme.org.

Description of a DIO

DIO refers to the Designated Institutional Official. This individual has the authority and

responsibility for all ACGME-accredited GME programs. The DIO signs the PIF and also receives a copy of the program's accreditation status. The DIO is required to co-sign most correspondence between the institution and the ACGME.

Our Social Responsibility*

By Orin F. Guidry, MD

My postgraduate medical education began 36 years ago as a general surgery resident.

Mortality and morbidity (M&M) conferences were a major part of the teaching program, and they were presented in a consistent pattern: the presentation began with a seemingly minor error, omission, or failure that inexorably led to a bad outcome. Residents, then and now, may leave these conferences feeling as though they could have made those same mistakes; I remember feeling that way.



However, when mistakes are made or ethical codes are breached, it is our responsibility to be honest about those situations. The following legal story depicts the consequences of seemingly minor omissions. All of these facts are readily available in public documents.

An anesthesiology group at a private suburban hospital in Louisiana fired an anesthesiologist because he failed to answer his pager, was found asleep on duty, and was suspected of stealing meperidine. The group's letter of termination said, in part, "As we have discussed on several occasions, you have reported to work in an impaired physical, mental, and emotional state. Your impaired condition has prevented you from properly performing your duties and puts our patients at significant risk." The suspected substance abuse was not reported. He was allowed to voluntarily resign from the hospital staff.

The terminated anesthesiologist began work at a second hospital in a small town in eastern Washington State. He was granted staff privileges based on letters of recommendation written by two members of the original anesthesiology group. One of the letters includes: "He is an excellent anesthesiologist with a pleasant personality. I am sure that he will be an asset to your anesthesia service." No mention is made of the substance abuse issue. These letters could be interpreted as an effort to help a colleague.

In November 2002, there is a cardiac arrest during a general anesthetic for a simple procedure in a healthy patient. The patient remains in a persistent vegetative state. The anesthesiologist subsequently admitted to diverting narcotics.

The hospital settled a malpractice claim with the patient's family for \$7.5 million in May 2004.

The hospital and its insurance company then filed suit against the anesthesiologist who performed the anesthetic, the two anesthesiologists who wrote favorable letters and the first hospital that failed to fully respond to a credentialing request. In May 2006, the case was heard by a Louisiana federal court. The judge asked the jury to consider the following: "[Is there] a preponderance of the evidence that one or more of the defendants made a negligent misrepresentation to ... [the] Medical Center and that the defendant's negligent misrepresentation was a proximate cause of the damages to the plaintiffs?" The jury answered yes for both of the anesthesiologists who authored the letters of recommendation and assigned them responsibility for 5 percent and 20 percent of the \$8.2 million judgment.

The hospital that failed to disclose the adverse information has publicly said that it will appeal the verdict. The judge in this

case ultimately decreed: "When it comes to something as important as the physician who will be administering anesthesia in an operating room, it appears to me that we have the right to know if that physician previously had his privileges revoked by a hospital. We should have the right to know that a physician was terminated from his previous practice because of drug-related issues and other misconduct."

We may be concerned about hurting our colleagues' careers or being sued ourselves if we are forthcoming about negative information. But as difficult as it may be, we must protect patients by responding with factual and truthful information.

All of us recognize our responsibility for the individual patients under our care. This case emphasizes that society expects us to assume this responsibility in a broader and more complex context.

**For the unabridged version of this article, visit:*
http://www.asahq.org/Newsletters/2007/03-07/admin03_07.html

ACGME Educational Conference 2008 Recap

Each year, the ACGME Annual Educational Conference provides a venue for graduate medical educators to learn more about the accreditation process and ways to enhance residency program quality related to ACGME initiatives, such as general competencies, educational outcome assessment, and duty hours. This year's conference theme "Building Community, Improving Quality" emphasized how better education and better patient care can occur when individuals in diverse roles work together toward shared goals.

Post-conference information is available at:
http://www.acgme.org/acWebsite/meetings/meEducConf_08.asp

Save the date for the 2009 ACGME Annual Educational Conference, March 5-8, in

Grapevine, TX.

RRC Meeting and Agenda Closing Date

Meeting: October 2-3, 2008
Agenda Closing: August 22, 2008

Meeting: May 14-15, 2009
Agenda Closing: April 3, 2009

Mailing Address:
RRC for Anesthesiology
ACGME
515 North State St., Suite 2000
Chicago, IL 60654

We invite your comments:
m Fleming@acgme.org

Fond Farewell to Maggie Jeffries, MD

Maggie Jeffries, MD attended her last meeting of the RRC in May 2008. Dr. Jeffries began her tenure as a resident member of the RRC, and will now be leaving as a fellow. She has started her fellowship in Houston, TX. The RRC thanks her for her dedicated service and her contributions to the case log system.

RRC Welcomes Sam Seiden, MD

Sam Seiden, MD will be the new resident member of the RRC, beginning his term on July 1, 2008. Dr. Seiden is currently a resident at Stanford, and he is a graduate of The University of Chicago Medical School.

RRC Welcomes Douglas Coursin, MD

Douglas Coursin, MD from the University of Wisconsin School of Medicine in Madison joined the RRC in January of 2008. Dr. Coursin earned his medical degree from Albany Medical College in New York and completed his residency at the University of Wisconsin Hospitals and Clinics. Dr. Coursin is board certified in Anesthesiology,

Critical Care, and Internal Medicine. He is also the recipient of the 2006 ASCCA's Lifetime Achievement Award.

Residency Review Committee

Audrée A. Bendo, MD
Lois L. Bready, MD *Chair*
Neal H. Cohen, MD *Vice Chair*
Douglas Coursin, MD
Orin F. Guidry, MD
Jeffrey R. Kirsch, MD
Rita M. Patel, MD
James P. Rathmell, MD
Mark A. Rockoff, MD, *Ex Officio*
Sam Seiden, MD, *Resident*
Kenneth Tuman, MD

RRC Staff

Missy Fleming, PhD
Executive Director
312/755-5043
m Fleming@acgme.org

Linda Thorsen, MA
Associate Executive Director
312/755-5029
lmt@acgme.org

Norma R. de Yagcier
Senior Accreditation Administrator
312/755-5042
nrdeyagcier@acgme.org

Dyan Flores
Administrative Assistant
312/755-5490
dflores@acgme.org

Timothy Goldberg
ADS Anesthesiology Representative
312/755-7111
tgoldberg@acgme.org