

Summer 2004

Resident Duty Hours: Interpretation of a Key Requirement

The ACGME policy in duty hours states, in part, that adequate time for rest and personal activities must be provided. This **should** consist of a 10-hour time period provided between all daily duty periods and after in-house call. Programs are expected to provide 10 hours between duty periods. However, in exceptional cases of urgent patient care requirements, or for other substantive purposes, programs are granted flexibility. Although programs should be organized to provide 10 hours between duty periods, occasional exceptions are permissible to maintain continuity of patient care.

Resident Duty Hours: the 10% Exemption

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities. Programs may request an exception to the 80 hours based on a sound rationale. The RRC requires the following supporting documentation: 1.) approval of the institution's Graduate Medical Education Committee, 2.) corrective responses to any previous citations concerning duty hours, 3.) statement of educational rationale distinct from service requirements, and 4.) evidence of a monitoring program for resident fatigue

and a plan for relief of resident duties in the case of fatigue. The RRC reviews requests upon receipt.

To date, 40 programs have requested an exception and 34 have been granted.

Actions from the June 2004 RRC Meeting

The RRC confirmed proposed actions to withhold accreditation of two new program applications. Eleven programs were reviewed and approved for continued accreditation. Four programs requested an increase in resident complement. Two were approved. The RRC identified three deficiencies with program reviews that all programs should monitor: 1.) finishing residents must be evaluated regarding ability to practice competently and independently and this should be documented in resident files, 2.) operative volume is critical to resident training and should be maintained at levels to provide residents with progressive and meaningful experience, and 3.) integration of competencies with program goals and objectives, along with tools to measure resident performance, should be developed.

Neurosurgery Competencies and Assessment Tools

Competency assessment tools have been developed by Dr. Edward Benzel and Dr. Deborah Benzil. They have proposed a study to evaluate the usefulness of the tools and presented a proposed pilot during the May meeting of the Society of Neurological

Surgeons. Of the 27 programs that volunteered to participate in the pilot, 19 have completed the initial phase of pilot testing. It is clear that sponsoring institutions are committed to competency measurements and supportive of programs to demonstrate significant activity in this area. The pilot may be a valuable effort in helping programs to meet institutional and RRC expectations. The RRC is aware that other programs have developed tools to measure ACGME competencies and extends an invitation to programs to share their progress with the committee and the neurosurgical community.

The ACGME Competencies

Those responsible for the academic leadership of the program are reminded that the residency program must require its residents to obtain competence in the six areas listed below to the level expected of a new practitioner. Programs must define the specific knowledge, skills, behaviors and attitudes required, and provide educational experiences as needed in order for their residents to demonstrate the following:

1. *Patient care* that is compassionate, appropriate and effective for the treatment of health programs and the promotion of health;
2. *Medical knowledge* about established and evolving biomedical, clinical and cognate sciences, as well as the application of this knowledge to patient care;
3. *Practice-based learning and improvement* that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence and improvements in patient care;
4. *Interpersonal and communication skills* that result in effective

exchange of information and collaboration with patients, their families and other health professionals;

5. *Professionalism as manifested* through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds;
6. *Systems-based practice*, as manifested by actions that demonstrate an awareness of and responsiveness to the large context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

When programs are reviewed, implementation of the competencies and utilization of appropriate assessment tools will be a major factor in the accreditation decision.

Future RRC Meetings

Jan. 28-29, 2005.

Agenda closing date: Dec. 6, 2004

June 17-18, 2005

Agenda closing date: April 18, 2005

Residency Review Committee Membership

Dr. Lawrence Marshall, chair and program director of the University of California, San Diego completed six years of service at the close of the June 2004 meeting. Dr. Marshall's knowledge of neurosurgery and residency training is invaluable and will be missed. Dr. Robert Ratcheson joined the RRC succeeding Dr. Marshall.

Dr. William Shucart completed his term as RRC chair. Dr. Donald Quest was elected chair and Dr. Williams Shucart was elected vice chair.

Composition

Donald O. Quest, MD, chair

William Shucart, MD, vice-chair

Steven L. Giannotta, MD

Dennis Spencer, MD

Estrada J. Bernard, MD

Robert Ratcheson, MD

Vishal C. Gala, MD, resident member

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