

Residency Review Committee for Surgery
NEWSLETTER
Summer 2003

ELECTION OF NEW CHAIR AND VICE-CHAIR TO THE RRC FOR SURGERY

Kirby Bland, M.D. was elected incoming Chair (replacing Lazar Greenfield, M.D.) and L.D. Britt, M.D., elected Vice-Chair, each with two-year terms beginning July 1, 2003.

PROGRAM REQUIREMENTS FOR SURGERY

Programs undergoing a site visit after July 1, 2003 will be expected to demonstrate compliance with the:

- 1) ACGME Common Requirements which incorporates the new duty hours standard,
- 2) Duty hours language specific for the specialty,
- 3) Specialty-specific program requirements effective July 1, 2003.

Please call or e-mail the RRC office if you need assistance with an interpretation of these standards.

DUTY HOURS UPDATE

At the June 22-24, 2003 meeting of the ACGME, provisions to use a specialty-specific definition for the “new patient” were approved and have been incorporated into the program requirements. The Program Requirements for Surgery including that revision are available www.acgme.org. The specific additions (underlined) follow:

Program Requirements IV. F 3c:

No new patients may be accepted after 24 hours of continuous duty. A new patient is defined as any patient for whom the surgery service or department has not previously provided care. The resident should evaluate the patient before participating in surgery.

Restated positively, this statement may be interpreted to mean: Any patient that has been seen by a member of the surgery (pediatric, hand, vascular) service or department is NOT considered new, and a resident may perform surgery on these patients during the “up to 6 additional hours” post in-house call IF they evaluate that patient prior to surgery.

DUTY HOUR QUESTIONS AND ANSWERS

The following is a sample of questions you have been asking (kindly note the caps):

1. Can we average the resident’s vacation week into a 4-week period to decrease the overall average duty hours for that 4-week period?

NO, this does not meet either the intent or the spirit of the standard. The implication inherent in this question is that the residents could be overworked for 3 weeks then given a week to rest.

2. If a resident on pager call is called in from home and she or he works most of the night, must I give that resident 10 hours off?

Strictly speaking, the answer is NO. HOWEVER, you are required to evaluate your residents for fatigue. If that resident has been up all night and needs rest, you are responsible for ensuring that she or he is relieved for their own well-being and for patient well-being.

3. If a resident is scheduled for in-house call and is up most of the night, must I give the resident 10 hours off before she or he comes back to work a shift or a regular day of duty?

YES, no matter how many or how few hours a resident works during an in-house call, 10 hours of rest are required. The 10 hours of rest also must be provided after a regular shift or regular duty day. NB: By contrast, 10 hours of rest are not required after pager call (also see #2 above).

4. Please explain the interpretation of the “should” in this sentence: 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.

The ACGME and the RRCs define “should” as a term used to designate requirements so important that their absence must be justified. A program is at risk if it is not in compliance with a “should.”

The ACGME changed the “should” from “must” to provide programs with flexibility. In other words, occasionally a resident may only receive 8 hours of rest between duty periods and after an in-house call. However, please do not interpret this to mean that all programs may provide only an 8-hour rest period consistently.

5. An example of an inappropriate rationale for the 80-hour exception: Our program needs this exception because we do very long cases and our residents need to stay past noon post in-house call 2 or 3 days each week to finish these cases.

The exception should be denied because the following criteria in the duty hour standard are immutable and not subject to the exception policy: working up to an additional 6 hours after in-house call for continuity of care and academic activities; in-house call no more frequently than every 3 days; continuous on-site duty may not exceed 24 hours; 1 in 7 days free averaged over 4 weeks.

In other words, do not request an exception to the parts of the standard listed above; only the 80-hour criterion is subject to the extension.

6. Our residents really don't want their critical care (or trauma) assignment to be changed. They like working 24 hours on and off for that 8-week assignment. If we revise the schedule to give them an 8- week assignment scheduled as 24 hours on and 24 hours off for 5 days, yet meet all

other criteria, will we be cited by the RRC for noncompliance?

No, as long as you adhere to these criteria:

1) no resident can work longer than a 24-hour duty period (NB: the distinction here is that this assignment as outlined as a 24-hour work day, not a call period; provision for relief and report must begin earlier to ensure that residents go off duty in 24 hours);

2) because of the 80-hour rule, care must be taken to ensure strict adherence to the rest periods and 1/7 days free, averaged over 4 weeks. (NB: The other work periods in this type of schedule are generally covered by float or weekend call staff.)

WEB DATA COLLECTION SYSTEM

The original information sent to all programs addressing the required **Surgical Critical Care** documentation **is printed again for your information:**

Beginning in July 2001, the documentation of surgical critical care management will include:

- 1) a description in the Program Information Forms of the educational assignments by which residents gain experience in surgical critical care;
- 2) a log identifying a list of sample “index” cases of critical care patient management that will be kept by the residents.

The CPT code for surgical critical care in the on-line system is 99292. This code is different from other codes, as it will map to all 7 critical care categories. The Critical Care Index Cases (CCIC) log was developed to provide documentation of resident management of a broad scope of critical care patients as follows:

- 1) Each resident will develop a log of *at least twenty* critical care patients who represent the **broad scope** of critical care index management. (NB: do not submit 20 of the same conditions)
- 2) Each of the patients listed in the log should include the management of at least 2 of the 7 categories listed in #4 below.
- 3) The completed logs should include experience, **with at least one patient in all seven** of the categories.
- 4) The categories are:
 - 8410 - Ventilatory Management (>24 hours on a ventilator)
 - 8420 - Bleeding (a non trauma patient requiring more than 3 units of blood/products and monitoring in ICU settings)
 - 8430 - Hemodynamic Instability (requiring inotropic/pressor support)
 - 8440 - Organ Dysfunction/Failure (etiology/mode of management, ie, renal, hepatic, cardiac failure)
 - 8450 - Dysrhythmias (requiring drug management)
 - 8460 - Invasive Line Management and Monitoring (Swan-Ganz, A-lines, etc)
 - 8470 - Parenteral/Enteral Nutrition

The residents are to maintain their own logs. Blank copies of the logs, with sign-off boxes for the resident and program director, are available on the ACGME website. The program director

must sign off on the completed logs and maintain a copy for review by the ACGME field staff representative at the time of the site visit.

The American Board of Surgery will also require completed logs for candidates applying to take the examinations. **NB:** I was reminded to amend a recent Newsletter comment. The ABS does not require the paper grid if the operative log is filled out in the critical care section and is adequate; if the operative log is not filled out, the ABS will accept the Index Grid as an alternative.

MAJOR ORGAN TRAUMA, NO OPERATION REQUIRED (MOTNOR)

The original information is being reprinted from the August 2002 Newsletter for your information.

The CPT code for recording nonoperative trauma in the online system is 99199. It may not be intuitive to find this code using the search mechanism because it is listed under the heading “patient care, not for major credit,” and the subheading is “nonoperative trauma.” As you may recall, this coding has been available for some time; the only change we have made is to ensure that it now counts in the “trauma” defined category.

Monitoring of this classification became effective July 1, 2002. The Committee approved previously an increase in the minimum number of cases in the Trauma category from **16 to 30**. Of the **30** required cases, **10** is the minimum number of operative trauma cases; **20** is the minimum number of nonoperative cases. Graduates should document compliance with these data in their June 30, 2003 logs.

Guidelines include:

- 1) The category, major organ trauma, no operation required, refers to a patient with major organ trauma who was admitted to a critical care unit in the hospital, ie, SICU, CCU, Burn Unit, etc.
- 2) The most senior resident on the trauma service should claim credit for the MOTNOR case. In the instance where there is no trauma service, a fourth or fifth year general surgery resident may claim credit.
- 3) If the patient subsequently requires a general surgery operative procedure that may be claimed in the defined category “trauma, operative,” then this case should not be recorded as MOTNOR.

VASCULAR SURGERY OPERATIVE LOGS

The original information is being reprinted from the August 2002 Newsletter for your information.

The Committee approved the revised mapping and minimum case designations effective July 1, 2002. Vascular surgery programs will be reviewed based upon the new data generated during the 2002-2003 academic year and comments for improvement will be noted. Note that programs **will be cited** for deficiencies based upon these data beginning July 1, 2004.

Program Directors should carefully review their aggregate operative data when it is received and call if they have any questions about their program/resident data set.

DUTY HOURS EXCEPTIONS

To date, the RRC for Surgery has received 13 requests for duty hours exceptions (none for any subspecialty program). If you are considering such a request, please ensure that the checklist for exceptions (www.acgme.org - RRCs - surgery) is complete and that a letter of institutional support is included. NB: The RRC staff will not process incomplete requests; they will be returned.

COMPETENCIES UPDATE

To assist you with implementing general competencies in your own program, the RRC has begun to identify programs that have submitted innovative and practical approaches to implementing the general competencies. Once those programs have been identified and they have indicated their permission for us to publish their information, we will share their concepts with you.

Don't be shy: do you have something to share with your colleagues? Send it to: das@acgme.org

REVISED PROGRAM INFORMATION FORMS (PIF)

The PIF for general surgery have been reorganized and computerized. You are now requested to review and revise Part 1 of the PIF that has been electronically populated from data provided annually by programs and sponsoring institutions in the ACGME Accreditation Data System. After Part 1 is updated and complete, proceed to complete Part 2, a word processing document, that can be found under the Program Information Form Section on the ACGME website (www.acgme.org).

The PIF also have been streamlined to omit extraneous data, to simplify data tables, and to add a new faculty CV form that reflects the "real world" of medicine and your accomplishments.

Of course, we always appreciate hearing from you - let us know what works for you.

ACGME WEB ACCREDITATION DATA SYSTEM

A reminder: It is mandatory for all accredited programs to annually update the program information in the ACGME Web Accreditation Data System (ADS). Every program director should have a username and password as well as a manual. The online system consists of two parts: the program identifying information, and information for all residents enrolled in the program. Since this system serves as our accreditation data base, please comply in a timely manner.

Lost your information/have questions about ADS? Contact: jtruesdale@acgme.org

EARLY SPECIALIZATION PROJECT (ESP)

The RRC-Surgery voted to consider applications for the Early Specialization Project as a pilot project. Institutions having a pediatric surgery and/or a vascular surgery program and a general surgery programs sponsored by the same institution are eligible to apply for participation in the Early Specialization Program (ESP). The application criteria and required documentation follow:

- 1) A letter of support from both the program director of the surgery residency program and the pediatric/vascular surgery program, and
- 2) A letter of support from the designated institutional official (DIO).
- 3) Both the surgery and the subspecialty programs must be in substantial compliance with the Program Requirements as judged by the RRC, ie, the program accreditation history, the program's ability to correct areas cited on the last program review, and the breadth of operative experience available for education including the defined category data will be evaluated and addressed.
- 4) Both programs' passing rates on the Qualifying and Certifying Examinations must meet or exceed those listed in the Program Requirements.
- 5) The procedure outlining the resident selection process must be submitted.
- 6) The first 4 years of surgery education justifying resident preparation for ESP must be completely described. NB: Normally, no more than 4 months of the first 36 months of the surgery residency may be spent exclusively on the applicable subspecialty service, ie, the pediatric or vascular surgery service.
- 7) Operative data should be submitted and should reflect that the program can provide sufficient operative experience during the PG1-4 years in the principal (essential) content areas.
- 8) The program director must document sufficient resources to provide all other residents and subspecialty residents with a sufficient breadth and balance of operative experience in the principal (essential) content areas.
- 9) A block diagram of the proposed clinical assignments for the PG3, 4, and 5 years and the ESP 1 and 2 years in the applicable subspecialty must be submitted.
- 10) A narrative statement describing the implementation and sequencing of the chief resident experience is required. NB: The program will be required to track the resident's operative experience and provide the RRC with an annual progress report of these data. When the resident completes the ESP, the resident must meet or exceed these requirements: the defined category data, the chief year data, and the data in aggregate for the 4 years of general surgery experience.
- 11) Both program directors must stipulate in writing that she or he and the faculty will comply with the Program Requirements regarding resident evaluation, ie, documenting a written, semiannual evaluation; and a written, summative evaluation at the completion of each PG year, including the

PG4 and the ESP years.

12) The program may submit a proposal for only 1 position per subspecialty during the duration of the ESP pilot project. Early identification of residents interested in ESP is encouraged.

13) The program may, at its discretion, apply for a temporary increase in categorical positions per current RRC policy. However, the program is not encouraged to request approval for additional nondesignated preliminary positions.

Proposed Evaluation Process for the Early Specialization Program:

1) At each RRC review, the program must justify the volume and breadth of operative experience available for all residents in the program, including the ability to provide the ESP resident with sufficient cases in the essential content areas by completion of the PG4 year. Areas of insufficiency and noncompliance with the Program Requirements may be reason to discontinue the ESP.

2) The passing rate of candidates on both the QE and CE for surgery and the subspecialty examinations will serve as one evaluation measure.

3. The faculty evaluation of the educational quality of the program should play an integral role in the implementation and development of the program and this should be documented.

4. Employer and graduate evaluations of the quality of the graduate and the educational program should also prove helpful.

Submission date:

Applications may be submitted beginning October 2003 for those residents who wish to begin the early specialization program during their PG 4 year beginning July 1, 2004.

Questions regarding the application may be directed to:

Doris Stoll, Executive Director, RRC Surgery

312 766-5499 das@acgme.org

AAMC News

I received this information from the AAMC and thought it may be of interest to some institutions,

based upon how your residents are defined, ie, employees or students.

“Mayo owes no FICA for residents

On Aug. 4 the U.S. District Court for the District of Minnesota issued an opinion finding that medical residents at the Mayo Clinic are classified as students, enrolled in and regularly attending classes at Mayo Graduate School of Medicine (a division of Mayo Foundation) and that, therefore, no FICA taxes were owed on the stipends paid to the residents. The Internal Revenue Service was ordered to refund money paid by Mayo for the years involved in the litigation (1994-96), plus interest. It is not known whether the government will appeal this decision. The District Court is in the 8th Circuit, the same Circuit that rendered a favorable opinion to the University of Minnesota when it challenged the government's contention that taxes were owed on stipends it paid to residents.”

“Information: Go to <http://www.aamc.org/advocacy/library/teachosp/803ficaruling.pdf>”

CURRENT RRC MEMBERS

Kirby I. Bland, MD (Chair)
L.D. Britt, MD (Vice-Chair)
R. Phillip Burns, MD
Paul Colombani, MD
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Jerry Goldstone, MD
Donald L. Kaminski, MD
Col. A. Letch Kline, MD

David Richardson, MD
Linda Reilly, MD
Bradley Rodgers, MD
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DEADLINES

Please note that we must establish cut-off dates for each RRC meeting to ensure an orderly and efficient meeting. Please note these deadlines:

October 9-10, 2003	Agenda materials deadline: August 15, 2003
February 26-27, 2004	Agenda materials deadline: January 1, 2004
June 23-24, 2004	Agenda materials deadline: May, 3, 2004
October 28-29, 2004	Agenda materials deadline: September 10, 2004

We understand that emergencies occur and we will be sensitive to your needs in these situations.
However, routine agenda items will be held for the next meeting after these dates.

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We always invite your comments: das@acgme.org

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