

Residency Review Committee for Thoracic Surgery
NEWSLETTER
Fall 2003

DUTY HOURS REVISIONS EFFECTIVE JULY 1, 2003

When policy changes occur at the ACGME and we need to contact you with important information quickly, we will send you an e-mail. Such was the case this past summer when small but significant changes were made to the last draft of the Duty Hours.

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

Restated positively, this may be interpreted to mean: Any patient that has been seen by a member of the thoracic surgery 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.

ADMINISTRATIVE/POLICY UPDATES

Call for resident nominations for the RRC: Since Dr. Ronson's last meeting is July 2004, the RRC will select the new resident member to ensure their attendance at the February 8, 2004 ACGME Orientation session and to attend the July RRC meeting also for orientation.

The deadline for submission is January 1, 2004. Please refer to the qualifications and procedures at www.acgme.org – Residency Review Committees – Thoracic Surgery – Information.

Reminder: Program Directors are ultimately responsible to recruit only those residents that meet the prerequisites for admission. The Program Requirements for Thoracic Surgery state: The resident must complete a general surgery residency program accredited by either the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada before beginning training in thoracic surgery. Program directors may not admit residents to ACGME approved positions who do not meet this criterion.

Not only is such a program director placing the program at risk, but also is placing the institution at risk.

Failure to comply with this criterion may result in an adverse accreditation action.

Reminder: Program Directors are responsible to provide and oversee resident education and to evaluate each resident's ability and progression in the program. Those residents that do not progress should be evaluated in writing, a plan for improvement should be developed, and a timeline for meeting remediation goals should be established. Residents should be informed of their options during the period of remediation that may include being relieved of their position.

To knowingly or unknowingly write that a graduating resident has met graduation criteria when such is not the case, also may result in an adverse accreditation action. In particular, we would recommend that a program director evaluate the resident's operative experience at the time of the 6-month evaluations to ensure technical progression and meeting minimums

Reminder: Resident complement changes of any duration must be prior approved by the RRC. For example: residents who begin their education on any date except July 1, any period of resident or new graduate remediation, extensive leave time that requires make-up time to meet the 24 month requirement, etc. Programs must comply with the approved resident complement; other learners who impact the current thoracic surgery resident education must be monitored.

Failure to request prior approval may result in an adverse accreditation action

Administrative withdrawal policy without prejudice: ACGME policy requires the RRC staff to at least annually identify those programs that have not filled resident positions for 2 years. If this is the case, an RRC may administratively withdraw a program, without prejudice. The rationale is that programs not filling for 2 years simply do not have an updated and ongoing educational and teaching program, ie, good educational policy.

Any program that fails to recruit residents for 2 years should proactively notify the RRC with an action plan or call the Executive Director for advice about the program options.

NB: When this policy was discussed with the current RRC leadership, there was concern expressed because this RRC never needed to use this policy. However, all Thoracic Surgery Program Directors need to understand that this policy has been operant and actively used by other RRCs – **it is not new**. What is new is that thoracic programs are not filling and the RRC is now required to protect residents who may enter programs that are not compliant and current – that are the objective.

DUTY HOUR QUESTIONS AND ANSWERS

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

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 and for the patient's 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.

DUTY HOURS EXCEPTIONS

To date, the RRC for Thoracic Surgery has received 9 requests for duty hours exceptions. If you are considering such a request, please ensure that the checklist for exceptions (www.acgme.org – Residency Review Committees - Thoracic 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.

The RRC will meet to make these decisions either by conference call or during a regular RRC meeting, whichever is expedient.

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

Have you checked the ACGME website lately (www.acgme.org)? Lots of great stuff for the taking, folks!

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 program sponsored by the same institution** are eligible to apply for participation in the Early Specialization Program. (NB: One vascular surgery program was approved at the October RRC meeting.)

At this time, a subcommittee of the RRC with program director representation has been charged to develop criteria on behalf of Thoracic Surgery. A report is expected for discussion at the January 16-17, 2004 RRC meeting. As soon as these deliberations are final, we will notify you.

Questions, comments, issues regarding these curricular revisions/policy changes may be directed to: Doris Stoll 312 755-5499 das@acgme.org

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

Please make sure your e-mail address is updated.

RRC MEMBERS

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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:

January 16-17, 2004 – Agenda materials deadline: November 30, 2003

July 8-11, 2004 – Agenda materials deadline: May 1, 2004

January 14-15, 2005 – Agenda materials deadline: November 30, 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.