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Council of Review Committee Residents Creates Its Own Standing Committees

The Council of Review Committee Residents (CRCR) is a relatively new body, as it was only in 1999 that the Accreditation Council for Graduate Medical Education (ACGME) made the pivotal move requiring one resident to serve as a member of each Review Committee. An invitational planning meeting was held during a meeting of the ACGME Board of Directors in June 1999, with residents from the ACGME, the American Medical Association (AMA), the Association of American Medical Colleges (AAMC), and the Council of Medical Specialties (CMS), which focused on how the ACGME could help residents and how residents could help the ACGME. While there were only eight ACGME resident members present that day, the CRCR was born. Its mission: to advise the ACGME about graduate medical education, accreditation, and resident issues.

The CRCR has come a long way in its early history; however, it was only this year that the CRCR defined itself as an expert panel of young physicians who bring resident issues to the forefront of important discussions. While CRCR members have previously served on the ACGME's standing committees, and the chair is a resident director serving on the ACGME Board, this year the CRCR additionally formed its own standing committees:



CRCR Photo

First row, left to right: *William Huang, MD; Michael Swaby, MD; Adeline Deladisma, MD (vice chair); Rupa Dainer, MD (chair); Hannah Zimmerman, MD; Nastaran Safdarian, MD.* Second row, left to right: *Steffanie Campbell, MD; Kari Wanat, MD; Meridith Runke, MD; Charles Scales, MD; Adam Roise, MD; Eilean Myer, MD; Jordon Lubahn, MD; Erin Grady, MD; Matthew Patterson, MD; Anna Gaines, MD.* Third row, left to right: *Vinai Gondi, MD; Noel Jabbour, MD; Jeffrey Kozlow, MD; Alex Khalessi, MD; Jason Itri, MD; Tom Christensen, MD; Tom Nguyen, MD; Paris Butler, MD; Audrey Woerner, MD.*

- the Data and Information Technology Committee will contribute ideas to the ACGME website and Case Log System;
- the Communications Committee will focus on increasing awareness among residents about the ACGME;

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reminders

Upcoming Meetings

American Academy
of Allergy, Asthma,
and Immunology
San Francisco
March 18–22

American Academy
of Dermatology
New Orleans
February 4–8

American Academy of
Orthopaedic Surgeons
San Diego
February 15–19

American College
of Cardiology
New Orleans
April 2–5

American College of
Obstetrics and Gynecology
Washington, DC
April 30–May 4

American College
of Physicians
San Diego
April 5–9

- the Leadership Committee will actively identify, recruit, cultivate and promote future leaders in graduate medical education; and,
- the Education Committee will address issues related to program and institutional requirements.

Other CRCR activities have included forming an ad hoc Orientation Committee to create a program for new CRCR members; serving on the ACGME's Task Force on Quality Care and Professionalism and forming its own Quality Care and Professional subcommittee to review and make recommendations to the ACGME regarding the new duty hours and related requirement changes; and serving on the specialty Milestone Working Groups to develop milestones and identify assessment tools. CRCR members have worked with DeWitt (Bud) Baldwin, MD, the ACGME's scholar-in-residence, on his renowned resident survey, which captures important dimensions of the learning environment and is used to better inform the ACGME on such matters. Lastly, a resident member serves on the American Board of Medical Specialties Task Force on Leave of Absence advocating that all boards have the same leave of absence policy.

If you are interested in becoming a member of this prestigious group of residents, please visit the ACGME website at www.acgme.org, click on "Review Committees," select your specialty's page, and then select the link to "Appointment Process for ACGME Review Committee Members," or contact the executive director of the Review Committee for your specialty. You will find contact information on the ACGME website under "About ACGME" > "Staff Listings" > "Department of Accreditation Committees," as well as on your specialty Review Committee's individual web page. As each of the specialties has its own variation on the process for soliciting resident members, you may want to contact

the staff of the ACGME Office of Resident Services (ORS), who can also connect you with the right person to answer your questions. Contact information for ORS can also be found by clicking the "Resident Services" tab at the top of the ACGME home page. ■

Written by Marsha Miller, MA, associate vice president, resident services, at the ACGME.

Graduate Medical Education Committees Focus on Policies and Procedures for Residency Programs

No residency program is an island at a sponsoring institution. Although a program director runs each residency program, a designated institutional official (DIO) and a graduate medical education committee (GMEC) are responsible for the oversight of graduate medical education at a sponsoring institution. The DIO is the person responsible for all ACGME-accredited residency programs at a given institution. (The responsibilities of the DIO were discussed in an article in the fall 2009 issue of *Resident Review*.) The ACGME Institutional Requirements state that every sponsoring institution must have a GMEC as well, which develops and puts into practice policies and procedures for graduate medical education. The GMEC addresses, among other issues, the following matters:

- resident stipends, benefits, and funding;
- communication between program directors and the committee;
- written policies and procedures to ensure compliance with duty hour standards;

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reference

ACGME Definitions

Sponsoring Institution

The organization (or entity) that assumes the ultimate financial and academic responsibility for a program of GME. The sponsoring institution has the primary purpose of providing educational programs and/or health care services (e.g., a university, a medical school, a hospital, a school of public health, a health department, a public health agency, an organized health care delivery system, a medical examiner's office, a consortium, an educational foundation).

Clarification: When the sponsoring institution is a non-rotation site the major associated hospital is the participating rotation site. Additionally, for multiple ambulatory medical sites under separate ownership from the sponsoring institution one central or corporate site (and address) must represent the satellite clinics (that are located within 10 miles of the main site).

- communication with medical staff regarding quality and safety of patient care;
- review of program curriculum and evaluation systems to ensure that they comply with ACGME requirements on the general competencies;
- review of ACGME program accreditation letters and monitoring of plans to correct citations;
- review of institutional accreditation letters and monitoring to correct citations;
- oversight of program changes, including changes in resident complement, program structure, and appointment of new program directors;
- internal reviews of programs.

The GMEC must include the DIO, program directors, administrators and residents, and it must meet at least four times per academic year.

Jason Itri, MD, PhD, chief resident in radiology at University of Pennsylvania Hospital System in Philadelphia, serves on that institution's GMEC. He attends the committee's monthly meetings, providing the residents' perspective.



Issues discussed at the meetings cover a spectrum of topics: education and work environment, resident stipends, duty hours, internal reviews, and resident supervision.

"During a recent meeting," said Dr. Itri, "the committee discussed providing and monitoring progressive house staff responsibilities by PGY level to demonstrate progression; increasing house staff salaries by three percent; downtime

procedures for written paper orders in the event that online computerized ordering is unavailable; comments regarding the ACGME duty hour revisions; duty hour violations for various programs; specific ACGME accreditation letters; program reports to the ACGME; and responses to learning climate surveys resulting in improved food availability and options at an affiliated hospital, replaced mattresses in call rooms, and increased security at parking lots during off hours."

During the time he's served on the committee, Dr. Itri said he's been struck by the wealth of experience of the program directors and faculty members who serve on the GMEC, as well as the efficient way in which the committee is run. The members share a passion for and commitment to graduate medical education, he said.

Noted Dr. Itri, "It was clear from the first meeting that the 20-plus residency programs at our institution work together to solve problems and have a common interest in improving resident education and the work environment."

At some institutions, house staff associations or resident forums nominate members to the committee, but a resident who wants to serve on a GMEC should start by consulting with the program director to find out the procedure for nominating residents to the committee. ■

Written by Julie A. Jacob, communications manager for the ACGME.

Subspecialty Program

A structured educational experience following completion of a prerequisite specialty program in GME designed to conform to the Program Requirements of a particular subspecialty.

Dependent Subspecialty Program: A program that is required to function in conjunction with an accredited specialty/core program, usually reviewed conjointly with the specialty program, usually sponsored by the same sponsoring institution, and geographically proximate. The continued accreditation of the subspecialty program is dependent on the specialty program maintaining its accreditation.

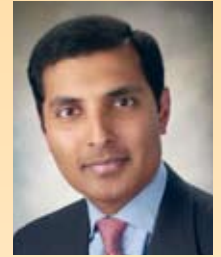
Independent Subspecialty Program: A program that is not directly related to, or dependent upon, the accreditation status of a specialty program.

Residency, Then and Now: The Times They are A-Changing

When I started my general surgery internship in 1995, I spent about a third of my year on call every other night, and with usually just one day off each month. The concept of every-other-night call in the hospital is probably hard for most residents to conceive of today, especially for periods lasting for up to eight weeks. Essentially, it meant I was working, at a minimum, about 125 hours, seven days a week, with no days free of some sort of clinical duty.

Fortunately, this changed rapidly over the next year, and by my second year of residency, *all* call was changed to every third night, and most weeks averaged about 100 working hours (unfortunately, days off still usually totaled about one or two a month). This all changed even more dramatically by my chief resident year, when our institution chose to implement the ACGME's duty hour standards one year prior to their mandated effective date. Eighty hours a week and one day off *each* week was like going on a holiday break! The implementation of this change, particularly in the surgical specialties, was, at best, challenging and, at worst, either derided or ignored. The challenges continued as I started my cardiothoracic residency; the rollout of work hour limits began to impact radically the way in which call would be taken and how critically ill patients would be treated.

The new and expanded standards approved this year by the ACGME Board of Directors are part of the continuum that began during my residency and fellowship years. As I approach status as a mid-career faculty member, my views on duty hours and competencies have evolved. As a faculty member, I think my focus should be on the elements that go into the crucible of graduate medical education, which produce competent, effective, and safe physicians. The distribution of and adherence to work hour limits, I believe, should be broadly defined and enforced by the departments and institutions in which we work and teach, but should be largely left to the residents to manage and regulate. As a post-graduate learner, I truly believe that individuals should have both autonomy and responsibility to manage their individual learning. Faculty members should focus on competency-based, rather than time-based, education. To date, residency education is still primarily defined by the amount of time (typically years) or the number of rotations completed, and board certification is based on qualifying and certifying examinations. We should seek to evolve to a system in which the learner can potentially dictate the time he or she spends in the program by way of demonstrating competency and mastery of certain knowledge and skills. For some learners, it may take more than 80 hours in a week; for others, the same may be accomplished in 55 hours. Efficiency and competency need not be linked strictly to time. Furthermore, certain procedure-based specialties may require "deliberate practice" – that is, the repetition needed to become both safe and proficient. Of course, patient care and practical needs will still require a minimum number of hours for clinical activities, but the overall length of education could be more flexible if learners are able to master certain didactic components "offline" and outside of the mandated duty hours.



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reference (continued)

Suggested

A term along with its companion “strongly suggested,” used to indicate that something is distinctly urged rather than required. An institution or program will not be cited for failing to do something that is suggested or strongly suggested.

Definitions are from the ACGME Glossary. The entire glossary is posted online at http://www.acgme.org/acWebsite/about/ab_acgmeGlossary.pdf

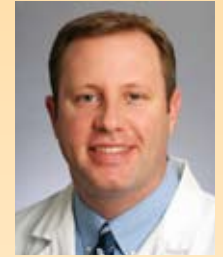
Resident fatigue, patient management errors, and the service needs for large teaching institutions are all still relevant issues. It is difficult to tightly correlate reductions in work hours with improvements in these factors. In general, duty hour restrictions create a positive guidepost to reduce resident labor abuses and focus some institutions more keenly on education rather than service. In other instances, however, these limits create new needs and new requirements with night float coverage and improvements to the safe hand-off and transition of care of patients. The other challenge is teaching physicians or imbuing them with a staunch commitment to individual patients or their families' care when shifts are constantly changing and major portions of patient care are occurring on their time away from the hospitals or clinics. Given that lengths of hospital stay are shorter today, even for major index admissions like pneumonia, myocardial infarction, or coronary artery bypass, duty hour limits may mean a resident is absent for up to 50 percent of a given patient's care. Thus, these new challenges will need to be met with continued innovation in educational approaches and techniques. Web-based learning, simulation, and resident self-study may be some ways in which competency can be acquired while adhering to work hour limits. Sanctioned, tightly regulated and monitored rotations, during which longer work hours are permitted and combined with learning new fatigue reduction and work stamina skills would also be useful for real-world situations and might be considered.

In conclusion, the evolution of medical education will continue, and work hours will always be a component of the discussion, but my hope is that the focus will be on competencies, outcomes, and patient- and family-centered care above all. Keeping our focus on the patient will help us further evolve our system of residency education so that it improves our future care of those same patients and families. ■

Written by Seenu Reddy, MD, MBA, FACS, associate professor of surgery and associate program director for the thoracic surgery residency program at the University of Texas Health Science Center at San Antonio.

The New Recommendations on Duty Hours: An Anesthesiology Resident's Perspective

For many years, there has been much debate among both the medical and non-medical communities over resident duty hours. This past summer, the ACGME Task Force on Quality Care and Professionalism published new standards on duty hours, professionalism, and supervision, which serve as an update from the standards enacted in 2003.



These new recommendations will likely impact some specialties more than others, and will likely have a greater impact on smaller programs. At this point one can only hypothesize how these proposed recommendations will affect anesthesiology residents. Under the new recommendations, residents may not accept new patients, including new cases, after 24 hours on duty, but there can be a transfer of care period of up to an additional four hours. The transfer of care period seems most applicable to anesthesia residents on critical care rotations. Therefore, under the new recommendations the maximum call period would now be 28 hours instead of 30 hours.

Secondly, the language describing that a resident “should” have 10 hours but “must” have eight hours free of duty between work periods could be a source of confusion, and both program directors and residents could be unclear on how many hours they should expect to have off between work periods. Additionally, some anesthesiology programs incorporate up to six months of anesthesiology experience in the PGY-1 year. Therefore, the more stringent rules for PGY-1 residents could directly impact anesthesia education at these programs. Finally, at some programs, residents are accustomed to moonlighting and they may not feel that time spent moonlighting negatively impacts their education. However, the new recommendations may lead to revisions of the moonlighting policies of some programs, as all external moonlighting will now count towards the 80-hour work week.

Although resident duty hour restriction is the area that has received the most attention, the new recommendations also address supervision, outlining a graded level of expected supervision based on the resident's level of education. This ranges from direct supervision or immediate on-site availability for a PGY-1 resident to the supervising physician reviewing the encounter after the care has been delivered for more experienced upper-level residents. Ultimately, all residents must become independent clinicians by the end of their programs, and patient safety must always be preserved. Therefore, the ACGME's proposed recommendations address this balance by allowing residents to be more independent as they gain experience.

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These proposed guidelines were reviewed by each of the Residency Review Committees and had a 45-day period for public comment. The implications will be significant for resident education. The goal of the requirements is to improve the educational experience for all residents and to provide appropriate supervision as well as personal decision-making to allow a resident to transition from the educational program to independent practice. The new standards will be put into effect in July 2011, so there will be changes in residency education in the future. The Residency Review Committees and ACGME will monitor the impact of these changes on every residency program to ensure that the desirable goals do not have unintended consequences that undermine resident education. ■

Written by Matthew Patterson, MD, resident member of the Residency Review Committee for Anesthesiology and a resident in the anesthesiology program at Emory University School of Medicine in Atlanta.