

rounds

ACGME complaint process investigates violations, helps improve resident education

ACGME requirements that are violated, reported to the program director and/or designated institutional official, and then go uncorrected may be brought to the attention of the ACGME through its complaint process. Anyone with knowledge of noncompliance of ACGME requirements may submit a complaint.

In order for a complaint to be processed, violations must have occurred within the current or immediately prior academic year. The complaint must be written and reference the ACGME requirements that have been violated, and include examples of how they were violated. Unsigned and email complaints will not be processed.

Upon receipt of the complaint, the ACGME complaint officer will write to the program director outlining the allegations and request a response that is due in one month. The response must be reviewed and signed by the designated institutional official. The designated institutional official is the person in graduate medical education who oversees all the institution's residency programs. Once the response is received, the complaint officer and the appropriate review committee executive director will review all elements of the complaint and decide the next steps.

Next steps include:

1. an immediate site visit;
2. review by the relevant review committee (RC) or RC Chair;
3. acceptance of the response and a request for a progress report;
4. monitor concerns at the time of the next site visit;
5. consider the complaint egregious and forward it to the ACGME executive director for handling;
6. dismiss the complaint because of lack of evidence.

When submitting a complaint, residents often fear retaliation and are, therefore, concerned about anonymity. The ACGME will do its best to protect the complainant's identity; however, there is the rare chance of a legal action between the ACGME and the program/institution that may require that the complainant's name be known. As noted above, this is extremely rare and, in fact, has never happened, but residents should be aware of the possibility.

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reminders

Upcoming Meetings

Accreditation Council for
Graduate Medical Education
Fall Board of Directors Meeting
Rosemont, Illinois
September 10–12

Royal College of Physicians
and Surgeons of Canada
Annual Conference
Ottawa, Canada
September 28–30

Association of American
Medical Colleges 2006
Annual Meeting
Seattle, Washington
October 27–November 1

American Medical Association
RFS Interim Assembly Meeting
Las Vegas, Nevada
November 10–11

In complaints concerning lack of due process, the complainant's name is known to the program director and designated institutional official because the ACGME is inquiring whether due process was followed for a particular resident. Often residents do not understand due process or how to start the process. Due process is the institution's policy and procedures for addressing grievances which may range from contract and credit issues, dismissal, remediation, probation, evaluations, professionalism, patient care issues, etc. Due process policies and procedures vary among institutions but usually involve several stages that allow the resident the opportunity to be heard before an impartial committee(s). The program director, residency coordinator, or designated institutional official can be helpful in obtaining the program/institution's policies and procedures for due process.

With that said, it is important to note that the ACGME does not adjudicate disputes between the program director and resident. The ACGME is not an arbitrator, mediator, or judge. The ACGME does not address contract, credit, discrimination, probation, or dismissal issues. The ACGME cannot help the resident retain their position or find another. What the ACGME does do is affect the program/institution's accreditation and/or cite the program/institution for violation of its requirements. Lack of due process would be an example of a violation.

It is the ACGME's mission to: *improve health care by assessing and advancing the quality of resident physicians' education through accreditation.* The ACGME's complaint process is a tool to improve the resident physician's education and learning environment. You might ask: If the ACGME can't help me, why would I file a complaint? Answer: To improve your education and learning environment and that of the residents who will follow.

For more information about the ACGME complaint process, please visit the ACGME Web site at www.acgme.org and click "Resident Information." You may also contact the ACGME complaint officer, Marsha Miller, by email at mmiller@acgme.org or by phone at 312.755.5041.

Written by Marsha Miller, ACGME complaint officer and staff liaison for the Council of Review Committee Residents

response

ACGME Contacts

Case Logs assistance
helpdesk@acgme.org

Resident Review feedback
juliej@acgme.org

Questions about the
 general competencies
outcomes@acgme.org

Resident complaints
mmiller@acgme.org

Resident Survey questions
ressurvey@acgme.org

**Frequently Asked Questions
 on the ACGME Case Log System**

If you are a resident in one of 36 specialties or subspecialties, you are required to enter procedural codes into the ACGME Case Log System. Following are answers to commonly asked questions about the Case Log System.

What is the ACGME's Case Log System?

Case logs are documentations of residents' patient encounters during their education. Generally, the residents enter their patient encounter information by using CPT and/or ICD9 codes. The appropriate review committee identifies the procedure/diagnosis categories that they want to capture and determine which codes count within each category.

Why did the ACGME develop the Case Log System?

The ACGME started the Case Log System in July 2000 because of the need for the review committees to collect accurate, verifiable information. A number of review committees have specific minimum number of procedures/encounters they expect residents to obtain, and even if they don't have specific minimum numbers, they look at the data to determine if the residents receive adequate experience at the program. The ACGME developed the Case Log System as a way to easily capture the data. In addition, using CPT/ICD codes provided common accepted classifications for procedures/diagnoses.

How do residents enter patient encounters into the Case Log System?

Residents complete case logs by entering their patient encounters into the system. They enter basic information, such as the date of the procedure/encounter, the institution,

attending physician, rotation, and then one or more CPT/ICD9 codes to reflect the procedure and/or diagnosis. If they keep this up to date, they will have a record of all their encounters when they complete their education. We ask the programs to send us a signed summary report when they finish.

Do residents need a handheld computer to enter data into the Case Log System?

Residents do not need a handheld computer. For the specialties that use the Case Log System, we provide the Web version for free. However, given the prevalence of handheld computers and the request to enter data immediately on these, we developed a version of the software for handhelds. It is not required; it is available as an option for residents who wish to use it. It is only for the entry of their encounters; they still have to transfer the data to the Web site so they can run reports and their program can monitor their experience.

Do residents in all specialties need to enter procedure/diagnosis codes into the Case Log System?

No. It is up to each review committee to decide which specialties need to use the Case Log System. Right now 36 specialties and subspecialties use the system. A complete list can be found on our Web site at <http://www.acgme.org/residentdatacollection/documentation/codelist.asp>.

Information provided by Tom Richter, systems manager in the ACGME Department of Operations and Data Analysis

resources

Web sites of Interest

Association of American
Medical Colleges

▶ www.aamc.org/members/orr

American Medical
Association Section on
Residents and Fellows

▶ www.ama-assn.org/ama/pub/category/15.html

Educational Commission on
Foreign Medical Graduates

▶ www.ecfm.org

National Resident
Matching Program

▶ www.nrmp.org

ACGME Committee on Innovation in the Learning Environment seeks resident input

The ACGME Committee on Innovation in the Learning Environment (CILE) was created in the fall of 2004 after the sunset of the ACGME Subcommittee on Duty Hours. CILE was formed to broaden the focus from duty hours to the many factors that contribute to the learning environment; explore the effect of duty hour limits; and collect, interpret, and disseminate information on innovative ways to create an optimal learning environment for residents and fellows.

CILE has a broad membership base including program directors, residents and fellows, researchers who focus on medical education research, representatives from the Residency Review Committees (RRCs) and ACGME Board of Directors, and public representatives. The chair of the committee is Dr. Howard, the Vice President of Academic Affairs at Washington Hospital Center in Washington, DC, who is a member of the ACGME Board of Directors. The committee is staffed by Ms. Ingrid Philibert and Dr. Jeanne Heard. Both have done extensive work on the learning environment.

CILE first met in April 2005 in Chicago with an initial task of defining the optimal resident learning environment. The committee created a list of tasks to explore the resident clinical-education interface, out of which four subcommittees were formed to address these tasks. These subcommittees have met over the past 16 months, and the committee as a whole has met several times to analyze the progress of the subcommittees, review innovative approaches from programs and institutions across the country, and explore the role of the ACGME in enhancing the resident learning environment.

One of the CILE subcommittees has been investigating the learning environment from the resident perspective by holding focus groups with residents and fellows from across the country. Focus groups have been held thus far with the resident representatives on the residency review committees, the members of the Association of American Medical Colleges' Organization of Resident Representatives, and the Resident and Fellows Section of the American Medical Association. The purpose of these focus groups has been to explore aspects of the learning environment most important to residents and to gather innovative ideas for improving the learning environment, including creative solutions utilized to comply with duty hour standards. It is not surprising that residents have a lot of good ideas about what works and what doesn't work within a residency training program. The committee is using data from an analysis of residents' reports of their programs' strengths and opportunities for improvement that the ACGME field representatives collect during the accreditation site visit. Finally, the committee is planning to conduct a brief survey to collect information from a broad group of residents and, potentially, program directors.

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reference

Important Definitions**Categorical Resident**

A resident who enters a program with the objective of completing the entire program.

Certification

A process to provide assurance to the public that a certified medical specialist has successfully completed an approved educational program and an evaluation, including an examination process designed to assess the knowledge, experience and skills requisite to the provision of high quality care in that specialty.

Chief Resident

Typically, a position in the final year of the residency (e.g., surgery) or in the year after the residency is completed (e.g., internal medicine and pediatrics).

Definitions are taken from the ACGME Glossary which is posted online at http://www.acgme.org/acWebsite/about/ab_ACGMEglossary07_05.pdf

The ACGME is sponsoring an educational design conference in Chicago on September 8–10, 2006, *Designing Tomorrow's Learning Environment: A Collaborative Design Conference to Move Physician Education Toward the Future*. This conference will provide a setting where graduate medical educators will be able to meet and discuss the attributes of an ideal learning environment for residents, with a goal of developing specific recommendations for improving residency education and disseminating best practice ideas.

As one of the resident members on CILE, I would like to encourage any resident/fellow who has ideas related to the following questions to contact me at: mmeridet@mail.nih.gov.

- 1. What innovations or improvements have been implemented in your learning environment since you started your training program?**
- 2. What innovations or improvements would you like to see implemented in your learning environment?**
- 3. What barriers do you perceive to implementation of innovative practices within your training program or institution?**
- 4. What is the most intriguing idea for innovation in the learning environment that you have heard about?**

Residents and fellows have quite a unique perspective and are vital in this discussion of how to make tomorrow's learning environment better for residents and fellows.

Written by Melissa Merideth, MD, MPH, resident member of the ACGME Board of Directors