

Resident Review is published periodically by the Accreditation Council for Graduate Medical Education. Opinions stated in the newsletter do not necessarily reflect the policies of the ACGME. Comments and suggestions should be sent to Julie Jacob, manager of communications, juliej@acgme.org.

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rounds

In December 2008 the Institute of Medicine released a report with recommendations on modifying the ACGME's duty hour standards. The ACGME's Council of Review Committee Residents discussed the report at its February 2009 meeting and developed the following consensus statement.

In recognition of the five-year mark of the common duty hour standards, the ACGME has convened a duty hour task force, which will present its recommendations for possible refinements to the duty hour standards to the ACGME Board of Directors and Committee on Requirements next year.

The IOM report can be read here:
<http://www.iom.edu/CMS/3809/48553/60449.aspx>

The ACGME's statement on the IOM report can be read here:
http://www.acgme.org/acWebsite/newsReleases/newsRel_12_2_08.asp

Dr. Nasca's open letter to the graduate medical education community about the process of reviewing the duty hour standards can be read here:
http://www.acgme.org/acWebsite/home/nascaletter_feb2009.pdf

CRCR Position Statement on IOM Report

The Council of Review Committee Residents (CRCR) is an advisory council for the ACGME. The council comprises 29 resident members representing 26 Residency Review Committees, Transitional Year Review Committee and the Institutional Review Committee.

The Institute of Medicine report was discussed at its meeting in February 2009 with the following consensus:

Your organization's formal position on the recommendations contained in the Institute of Medicine Report, including impact analysis, from your organization's perspective, on costs and impact of implementation.

- 1. Self-regulation.** The CRCR fully supports the concept of self-regulation within the profession of medicine and supports all efforts by the ACGME to maintain autonomy within the educational environment. There is virtually no support among residents for the notion that either the Centers for Medicare and Medicaid Services or the Joint Commission should assume oversight of resident duty hours. It is clear that residents want the oversight of duty hours to be regulated by the profession and any changes should be evidence-based.

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for more information, visit www.acgme.org

reminders

Upcoming Meetings

American College of Surgeons 2009 Annual Clinical Congress
Chicago, Illinois
October 15–19, 2009

Association of American Medical Colleges 2009 Annual Meeting
Boston, Massachusetts
November 6–11, 2009

2. **Ongoing research.** The CRCR recognizes the need for ongoing research into optimal training conditions and how these conditions affect patient safety.
 3. **Duty hour restrictions.** The IOM recommends numerous duty hour restrictions. The CRCR could not reach consensus on a set of common standards. However, the council supports a set of basic duty hour standards applicable to all programs, such as 80 hours per week maximum averaged over four weeks, and one day off in seven days averaged over four weeks. Subsequent rules should be specialty specific and they should be based on the settings and requirements for the specialty.
 4. **Supervision and appropriate transition to independent practice.** The CRCR acknowledges that all programs do not always provide supervision that is appropriate to the level of training and the competence of the trainee. There is agreement that some errors in training are due to inadequate supervision and that appropriate supervision may not necessarily be an attending physician; an appropriately trained upper-level resident would suffice at most times. Additionally, there is strong sentiment that not all programs provide adequate transition to independent practice. Trainees from ACGME programs are supposed to be capable of independent practice upon completion of their program; thus, there needs to be some time during training where much of the “direct supervision” is weaned.
 5. **Handoffs.** The CRCR recognizes that systems used for patient-care handoffs are generally poor. Systemic improvement is needed to improve continuity of care and decrease risk of medical errors.
 6. **Moonlighting.** The majority of the council felt that external moonlighting should not be regulated because regulating residents’ personal time would be unenforceable, requiring the program director to monitor hours that happen at outside institutions.
 7. **Dilution of education.** Current ACGME duty hour standards already pull residents from elective, educational and research rotations. Proposed IOM duty hour restrictions would place greater need to pull residents from these rotations, further diluting important aspects of residency training.
 8. **Service vs. education.** In many specialties, residents still spend a significant amount of time performing clerical tasks. Work hours could be improved with increased support services allowing trainees more time to participate in educational activities without compromising patient care. As mentioned in the IOM report, there will be a financial impact for increased support services.
- Your organization’s formal position on the current ACGME resident duty hour standards including impact analysis, from your organization’s perspective, on costs and impact of implementation.*
9. **One size does not fit all.** We believe that current ACGME duty hour standards should be changed from a “one-size fits all” policy to basic minimum duty hour standards for all residencies and other duty hour standard that are specific to each specialty, since each specialty has its own clinical and educational demands. Ideally, these specialty specific guidelines should be based on research into functioning/learning/safety of residents in their own unique settings.

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resources

Useful Websites

Association of American Medical Colleges

www.aamc.org/members/orr

American Medical Association Section on Residents and Fellows

www.ama-assn.org/go/rfs

Educational Commission on Foreign Medical Graduates

www.ecfm.org

National Resident Matching Program

www.nrmp.org

10. Enforcement. Greater oversight and enforcement of resident duty hours are needed. This is important for maintaining our authority and credibility for self-regulation. While most residents do not feel that they have been forced to work over their assigned hours, there are exceptions.

Your organization's formal recommendations regarding dimensions of resident duty hour standards, and justification (wherever possible) for this position with evidence.

We make no formal recommendation here. There is considerable disagreement among resident physicians about the necessity for long duty hours and whether long periods on duty constitute abuse, or whether long duty hours are necessary in order to prepare for medical practice. There are residents who feel that the current system of duty hours is impinging on their ability to adequately prepare for independent practice, while others believe that the current system optimally balances the need for rest and the need to learn to function in adverse environments; many believe that the current system is an anachronism best done away with. Much of the disagreement comes across specialty lines.

We believe that all reform must keep in mind the following points:

Patient safety. Interventions must demonstrate that they improve patient safety, not compromise patient safety.

Resident education. All interventions should consider the effects on the residents' ability to eventually gain independence and function within our medical system after the completion of training.

Resident well-being. All interventions should consider the physical and mental health of trainees and how the intervention might improve or worsen this health overall.

Feasibility. Interventions should be fiscally responsible and should not impose undue burdens on already-stressed trainees and teaching hospitals.

Your organization's formal recommendations regarding standards governing key aspects of the learning environment, and justification (wherever possible) for this position with evidence.

Residents should be allowed to get sufficient rest and sleep; however this must be balanced with the realities of our profession. When unique (non-routine) training opportunities arise, residents should be allowed the opportunity to voluntarily exceed duty hour limitations. If this occurs, there should be sufficient justification, documentation and supervision to prevent abuse and maintain adequate supervision. ■

ACGME Duty Hour Task Force Reviewing Duty Hour Standards, Will Recommend Refinements to Board Next Year

I entered my third year of medical school in 2003, right as the ACGME introduced the common duty hour standards. By the time I started my pediatrics internship in 2005, most specialties had made significant changes to their schedules due to the duty hour rules. I have never known doctoring without the limitations of the 80-hour work week.

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reference

ACGME Definitions**Rotation**

An educational experience of planned activities in selected settings, over a specific time period, developed to meet goals and objectives of the program.

Scholarly Activity

An opportunity for residents/fellows and faculty to participate in research, as well as organized clinical discussions, rounds, journal clubs, and conferences. In addition, some members of the faculty should also demonstrate scholarship through one or more of the following: peer-reviewed funding; publication of original research or review articles in peer-reviewed journals or chapters in textbooks; publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or participation in national committees or educational organizations.

Duty hour regulations were created for several reasons, most notably protecting residents from abuse and protecting patients from overly fatigued residents. When the standards were instituted, the ACGME promised that resident work hours would be readdressed in five years. The ACGME has kept that promise, starting with the Duty Hour Symposium in March 2009 and continuing with the selection of the Duty Hour Task Force. The Task Force consists of representatives from almost every specialty and includes three residents. Its first meeting took place at the Duty Hour Congress, which was held in June in Chicago.

The Duty Hour Congress was a two-day conference, during which the graduate medical education community was invited to comment on the current duty hour standards and to make recommendations for the next set of standards. The speakers included residents, program directors, and hospital administrators from 27 specialties. I admit that I had expected the discussion to degrade into specialty specific arguments, but the congress was remarkable. Although each specialty had its own thoughts, there were several common themes.

First, a significant majority suggested that the new standards must be specialty and level specific. Second, almost everyone stated that the ACGME should maintain its responsibility for monitoring and enforcement of standards. Third, all those present agreed that residents must no longer be forced to choose between following the rules and doing what is best for their patients.

Over the next 12 months, the task force will meet every six weeks to hear from additional experts and draft the next set of standards. We hope to release the standards in June 2010, with implementation to occur in July 2011. ■

Written by Meredith Riebschleger, MD, a first-year fellow in the pediatric rheumatology program at the University of Michigan and a resident member of the RRC for Pediatrics and the ACGME Duty Hour Task Force.

Caution is the Word to Remember with For-Profit Residency ‘Placement’ Services

If it sounds too good to be true, it probably is.

Residents and medical school graduates seeking a residency position, or wishing to switch to another program, are wise to keep that axiom in mind when they see advertisements for companies offering to place residents in vacant residency slots.

Recently, the ACGME Office of Resident Services has been alerted about two such services.

The first company lists residency programs with vacant slots. The slots are pulled from the institutions' websites, as well as websites that advertise open residency slots. The service also pays a fee to residents enrolled in its service who alert the company to unfilled residency slots in their program.

For a fee, the company will send e-mail or text message alerts of vacant residency slots to residents and prospective residents who sign up for this service. It markets its service to unmatched medical school graduates looking for open program slots, couples seeking residency slots in the same area, or residents wishing to “swap” positions with residents in other program.

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Short Call

Responsibility for admitting patients to the teaching service during the early part of the day. Residents begin call in the morning, admit patients until some designated time in the afternoon or late morning and do not stay in the hospital overnight.

Should

A term used to designate requirements so important that their absence must be justified. A program or institution may be cited for failing to comply with a requirement that includes the term “should.”

Definitions are from the ACGME Glossary. The entire glossary is posted online at http://www.acgme.org/acWebsite/about/ab_acgmeGlossary07_05.pdf

Although the ACME Office of Resident Services has not received any specific complaints about this particular service, residents and prospective residents should keep in mind that just because a residency program has an open slot, that does not necessarily guarantee that the resident will be qualified for that position. Prospective residents must meet the eligibility requirements for that institution and program and may be competing with other candidates for that slot.

The Office of Resident Service has also been alerted of various companies that purport to help medical school graduates – especially graduates of international medical schools – find slots in residency programs in exchange for “placement fees” of \$75,000 or more.

However, residency slots cannot be bought, and medical school graduates seeking a slot in a residency program should work through the National Resident Matching Program, which was established in 1952 to provide “an impartial venue for matching applicants' and programs' preferences for each other consistently,” according to the NRMP website.

“There are many services that claim to be able to find GME positions,” said Mona Simpson, executive director of the NRMP. “The bottom line is that the NRMP does not cooperate with any of those services, and certainly does not share unfilled program information. Unmatched applicants' best opportunity for finding a position is to use ERAS; to send applications to the unfilled programs on the list that is posted in the NRMP secure web application; to use Find a Resident, an Association of American Medical Colleges (AMMC) service.”

The bottom line is that, as when purchasing any goods or services, medical school graduates and residents should use caution and common sense when they see advertisements for companies that claim they can place residents in programs for a fee. ■

Interacting with Residents the Best Part of Job Say DIOs

At every teaching hospital or medical school that sponsors residency programs, there's a person called the designated institutional official (DIO), who is responsible for supervising all the residency programs at that institution in conjunction with the institution's graduate medical education committee. You may know the DIO simply as the person who welcomes new residents at the annual orientation session and periodically meets with your program director.

However, the DIO is not just a remote administrator. He or she has a hands-on job of making sure that all the residency programs comply with ACGME institutional and program requirements. The DIO is also a resource person for program directors, faculty, and residents.

Two DIOs, both recipients of the ACGME's Courage to Lead Award, recently talked with *Resident Review* about the responsibilities, joys, and challenges of being the one in charge of a hospital's residency programs.

Douglas B. Dorner, MD, is the DIO, senior vice president for medical education and research, and director of medical education at Iowa Health – Des Moines. He has been a DIO for 16 years. Diane Hartmann, MD, is DIO and

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senior associate dean for graduate medical education at the University of Rochester Medical Center in Rochester, N.Y. She has served as DIO for eight years.

Although Dr. Dorner and Dr. Hartmann say that there is no one typical day, their workdays often includes lots of meetings – meetings with the institution’s graduate medical education committee, program directors, hospital administrators, and residents. They also participate in the internal reviews of residency programs, review budgets, sign paperwork, keep up to date on changes in Medicare regulations, and do the 101 other things that DIOs must do to keep their institution’s graduate medical education programs running smoothly.

Dr. Dorner says the best part of his job is talking to residents and watching them change from interns into graduates prepared to begin independent practice.

Dr. Dorner stresses to the incoming residents that they need to be “owners of the program, not renters – I want them to consider the program to be their program and to realize that they can make a difference.”

Dr. Hartmann says she enjoys dealing with the variety of knotty problems that she has to untangle every day.

“I never know what’s going to walk in my door,” said Dr. Hartmann. “A lot of it is problem solving ... you diagnose and treat problems.”

Both Dr. Dorner and Dr. Hartmann often talk with residents who are struggling with problems, either in the program or in their personal lives. They stress that while they are always there as a resource for the residents, residents should first talk to their program directors. In most cases, they say, a frank talk between the program director and the resident resolves the issue.

If it does not, then the DIO is there to listen and work with the resident and program director to find a solution.

In those cases, it’s usually just a matter of working with the resident and program director to improve communication.

“I’m blessed with a supportive administration and good infrastructure so there are not a lot of issues for residents,” said Dr. Dorner. “Almost always, it’s just a breakdown in communication. My job is to be sure that the channels of communication are open and effective and impartial.”

Dr. Hartmann said when residents come to her with problems, she tries to come up with a workable compromise.

“It’s hearing both sides of the story and determining the most fair and reasonable course of action,” said Dr. Hartmann. “That’s always the most challenging – to have both parties feel that they have been heard and coming up with a solution they both can live with.”

The least enjoyable part of the job, both DIOs noted, is dealing with the piles of paperwork.

The best part of the job, on the other hand, is working on behalf of young doctors preparing for their careers.

Said Dr. Hartmann, “You are dealing with bright, committed young people. They want to take good care of people and it is my job to make sure they work in a system where they learn how to take good care of people. There’s always this new regeneration every year. You train them well and you send them out. And they go to someplace else. It is that regeneration that keeps us all young and enthusiastic about what we do.” ■

Written by Julie Jacob, manager of communications at the ACGME.

Office of Resident Services Protects Confidentiality of Residents, Works to Create Fair Solutions to Problems

"I'm having a problem in my residency, but I'm afraid to tell you my name or where I'm calling from."

"I want to file a complaint, but I'm afraid of retaliation."

The issue of confidentiality is one the staff of the Office of Resident Services hears every day. The staff at the Office of Resident Services treats all inquiries—whether by phone, email, fax, or mail – as confidential. The Office of Resident Services staff fields questions and concerns from everyone. In addition to residents and fellows, Office of Resident Services staff members speak to family members, faculty, and program administrators – and everyone's confidentiality is protected.

Formal complaints must be submitted in writing and signed. However, the complainant's name is kept confidential unless the complainant gives the Office of Resident Services written permission to use their name. When writing a letter to the program to investigate the complaint, we do everything we can to protect the complainant's identity by removing potential identifiers while giving as much information about the alleged violation(s) as we can.

When handling concerns, Resident Services staff will only use a name if the question or concern relates to that individual, e.g., a program director is not providing verification of a resident's education. In that case, we would need to reveal the identity of the complainant in order to solve the problem. If, however, a concern comes in (by e-mail or phone) about something that is happening in the program

that is unclear or worrisome to the resident, we can generalize the concern as "residents report" when enlisting the DIO to help solve the problem or answer the question.

Our goal is to create a fair process in solving the problem by giving both sides (complainant and the program) due process. Ultimately, our process works because we provide confidentiality to all parties. Communication between programs and the ACGME is protected; we cannot reveal to complainants the content of letters between the ACGME and programs. We can only reveal what is public information about a program – the information found on our website.

If you need to call the ACGME one day to ask a question about our process or share a concern or complaint, please know that our goal is a fair process for all – and confidentiality is a key component of that process. ■

Written by Emily Vasiliou, special project manager in the Office of the CEO. Emily previously served as a resident services associate.

Become Active, Speak Up, Says New Chair of CRCR

Hello, everyone. Welcome to another exciting year here at the ACGME! I am truly honored to be serving as your new chair of the Council of Review Committee Residents. I come to you all as a recently graduated pediatric anesthesiology fellow, and the most recent resident member of the Institutional Review Committee (IRC). I take the reins from outgoing chair Karen Hsu Blatman, MD, a former resident member of the RRC for Internal Medicine, who, during her tenure, was instrumental in increasing the visibility and the voice of the residents within the ACGME.

I can imagine that for those of you not actively involved in the ACGME your thoughts might be “who are you?” and “I don’t remember voting for you!” Understandable, especially as the organization of the ACGME becomes more complex. As a brief recap – the accreditation work of the ACGME is accomplished mostly through its committees called the Review Committees (RCs). Each RC has a resident member who, in addition to shouldering their share of the regular committee work, helps remind the “higher-ups” of those of us in the trenches – a kind of “reality check” for everyone. All 26 Residency Review Committees, plus the Transitional Year Review Committee (TYRC) and the Institutional Review Committee (IRC) have a resident member with a full voice and a full vote, and all those residents come together to share experiences and ideas, and to work on a resident-specific agenda in the Council of Review Committee Residents (CRCR). Those residents, your representatives, have given me the privilege of leading us (the CRCR) through the next two years.

This year, the CRCR has a full plate – there are the obvious things, such as the immediate issues surrounding the ACGME’s review of the duty hour standards at the five-year mark. But the CRCR is uniquely positioned to tackle other, more subtle, issues facing trainees today. Because every core specialty is represented on the CRCR, we have tremendous strength in our consensus. We are using that leverage to work on issues surrounding extended medical leave among the various specialties – currently each field has a different set of rules and consequences when extended medical leave is required, some of which may be quite detrimental to trainees without necessarily increasing the educational benefit. Additionally we are looking for new ways to reach out to our constantly shifting demographic – the 100,000-plus residents, a significant percentage of whom are starting or graduating every year.

This year will be full of exciting changes to our educational environment, and the voices of the residents within the ACGME must be clear and strong. To that end, I welcome and expect input from any resident, whether or not you are currently active within the ACGME, through our new Office of Resident Services. Everyone’s ideas are important and can contribute to improving resident education and, by extension, the quality of medicine as a whole. From the duty hour issue, we are learning that “one size” doesn’t necessarily fit all. We are strong because of our diversity – in opinions, as well as needs. But our deepest strength comes in our unity, our ability to build consensus and speak with one voice for the future of medical education. ■

Written by Rupa Dainer, MD, chair of the CRCR, a former resident member of the Institutional Review Committee, and a recent graduate of the pediatric anesthesiology program at the Children’s National Medical Center.

The Lack of Leadership in Medicine

There is a crisis facing medicine today. Our profession has been transformed into the “health care industry,” with Wall Street investors, insurance giants, and companies like Wal-Mart developing business models that maximize profits for shareholders rather than ensure high quality care for patients. Significant political barriers to tort reform encourage spiraling professional liability insurance costs and Powerball-type jury verdicts. Managed health care organizations control costs by limiting coverage and seeking retroactive cancellation of policies. Big pharmaceutical companies spend tremendous amounts of money on marketing campaigns for drugs that have no proven efficacy because they believe the market can be “grown” for huge profits. Medicare continues to slash physician reimbursements without making any real efforts to address the underlying drivers of overutilization. Despite the apparent complexity of these issues, the problem is actually a simple one: the most important medical decisions are made by those responsible for profits and cost control rather than those responsible for the patients’ health. How do we fix a system that appears to be beyond repair?

“In adversity lies opportunity.”

Albert Einstein

Despite the ominous tone of the preceding introduction, we are entering a time of tremendous opportunity in medicine. There will be opportunities to improve an inefficient and disjointed system, take a more active role in patient and physician advocacy, expand access and coverage for health care services across the country, and revert the “health care industry” back into the “practice of medicine.” Yet in order to take advantage of these opportunities, we need more young leaders with strong voices to ensure that physicians are responsible for making the important decisions regarding our patients’ health. We can no longer afford to let those responsible for making profits and controlling costs determine how we practice medicine. Where do we find these future leaders?

“Leaders aren't born, they are made. And they are made just like anything else, through hard work.”

Vince Lombardi

Residency and fellowship programs are charged with the vital task of teaching us how to be good clinicians, not how to be leaders. There is no formal curriculum on developing leadership skills, no textbook or manual that gives us the tools we need. As residents and fellows, we are the future of our respective specialties. We need to take an active interest in the future of our profession and take advantage of the leadership opportunities that already exist. Start by understanding the issues that threaten to take the practice of medicine out of our hands. An unending supply of newsletters, articles, web-based resources and discussion forums are only a few mouse clicks away. Once you understand the issues, get involved.

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Every major specialty organization has opportunities for residents and fellows to get involved in advocacy, health service policy issues and leadership. We are all part of a national community with more than just our livelihoods at stake. It's up to us to make a difference.

“Nobody can do everything, but everyone can do something.”

Unknown.

In response to the demand from residents and fellows for a focused approach to leadership skills development, the ACGME will hold its first Leadership Development Workshop in March 2010 at the Gaylord Opryland Resort Hotel in Nashville, Tennessee. ■

Written by Jason Itri, MD, PhD, a third-year radiology resident at the University of Pennsylvania Hospital and the resident member of the RRC for Diagnostic Radiology.