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rounds

Developing Interpersonal and Communication Skills Takes a Multi-pronged Approach

What can residents and fellows do to improve interpersonal and communication skills?

It is important to first understand that social interactions with friends and family do not constitute communication skills. Many residents make the error of thinking that being the life of the party equates to having excellent communication skills when it comes to patients and their families. Residents and fellows alike also tend to overestimate their communication skills, yet consistently lack confidence in performing essential skills such as delivering bad news or discussing unexpected outcomes. Keeping this in mind, let's discuss several strategies for residents to improve communication skills.

The process of developing good communication skills begins with **honest self-assessment and reflection**. Residents and fellows who want to improve, are willing to critically evaluate themselves on a regular basis, and reflect on encounters with patients and other health professionals will develop superb communication skills.

Reviewing 360-degree evaluations provided by residency programs is an excellent way to determine strengths and weaknesses, as well as provide measurable outcomes to gauge improvement.

Creating clearly defined and achievable learning goals and eliciting feedback allows the resident to focus efforts on specific skills.

Observing positive and negative role models provides the resident with an arsenal of different strategies and approaches for managing challenging situations and distressed patients.

Finally, all residents should approach **small-group sessions** on communication skills with an open and energetic mind.

Keys to Developing Good Communication Skills

- Practice honest self-assessment and reflection
- Review 360-degree assessments
- Create clearly defined and achievable learning goals
- Elicit feedback
- Observe positive and negative role models
- Attend and willingly participate in small-group sessions

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reminders

Upcoming Meetings

Accreditation Council for
Graduate Medical Education
Summer Board Meeting
Chicago, Illinois
June 15–16, 2009

American Academy
of Family Physicians
National Conference of
Family Medicine Residents
and Medical Students
Kansas City, Missouri
July 30–August 1, 2009

American Medical
Association Resident
and Fellow Section
Chicago, Illinois
June 11–13, 2009

How information is conveyed to patients and family members can have a significant impact on their understanding of illness, relationships with clinicians, and both patient and physician satisfaction. It is for these reasons that interpersonal and communication skills are highlighted as a core competency by the ACGME in the training of physicians.

Additional information and resources can be found on the ACGME website at: www.acgme.org/outcome/implement/interpercomskills.pdf

Written by Jason N. Itri, MD, PhD, a second-year radiology resident at the University of Pennsylvania

Office of Resident Services Provides Safe Place to Air Concerns, Learn About Resolution Strategies

The ACGME has created the new Office of Resident Services so that residents, fellows, faculty and others have a safe place to voice concerns related to residency education and the learning environment without the fear of intimidation and retaliation. Before contacting the office, the person with a concern should first use all the resources available in the program and institution, unless he or she has a valid reason for not using these resources. For example, if a resident's concern involves the program director and designated institutional official, and the resident feels that the existing channels of communication or dispute resolution have proven unsatisfactory, the resident may want to contact Resident Services first.

Resident Services will review concerns in an impartial and objective manner, and make recommendations to the

ACGME and its Board regarding needed changes in requirements, policies and procedures. Resident Services is not an advocate for individuals but rather an advocate for fair process. Moreover, Resident Services cannot impose solutions, but will identify options and strategies for resolution in order to accomplish the expeditious settlement of individual concerns outside formal channels. Talking with the staff of Resident Services does not constitute notice to the institution or the ACGME. Because Resident Services does not advocate for any one side in a conflict, and does not participate in any formal investigation, hearing, or process, concerns can be submitted confidentially. The staff of Resident Services listens, discusses, answers questions, provides information, and helps develop options for resolving a situation. When possible, Resident Services will help people develop new ways to solve problems themselves.

Resident Services operates independently and separately from the accreditation and formal complaint processes so that it can work openly and honestly with the designated institutional official in resolving concerns. Resident Services provides a safe and objective environment in which individuals can air their concerns, receive appropriate referrals, be advised of pertinent policies and procedures and discuss informal and formal options for addressing concerns, which may include information on how to submit a formal complaint to the ACGME.

Concerns and formal complaints are distinguished as follows:

Concern(s): A concern is a care, trouble, or distress someone has about a residency program or its institution that creates uncertainty and apprehension. Examples include an inability to access one's file, fear and intimidation in the program or institution, resident

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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

well-being issues, untimely verification of residency training, inability to obtain a date for a grievance hearing, vacation and leave of absence issues, injustices, and abuses of power or discretion. (The above examples could also be grounds for a formal complaint rather than a concern. For example, chronic and routine non-compliance with the ACGME requirement regarding access to the resident file could be a violation. The key is *routine* and *chronic* occurrences and not a single instance.)

Complaint(s): A complaint pertains to chronic and routine non-compliance with ACGME Institutional and Program Requirements.

You can find more information about Resident Services at www.acgme.org. Marsha Miller and Emily Vasiliou, Resident Services staff, may be reached at residentservices@acgme.org.

Written by Marsha Miller, Associate Vice President, Office of Resident Services

ACGME Seeking Residents, Resident Teams for New David C. Leach, MD, Award

The Accreditation Council for Graduate Medical Education is accepting nominations for the David C. Leach, MD, Award. This new annual award, which will recognize residents and resident teams for improving graduate medical education, is named in honor of the ACGME's former chief executive officer, David C. Leach, MD, who retired in 2007.

The award will be given to residents or resident teams (residents, fellows, faculty, program coordinators, allied health professionals) who have developed a project or activity that improves graduate medical education in one or more of the following areas:

- fostering innovation and improvement in the learning environment;
- increasing the program's emphasis on educational outcomes;
- increasing efficiency and reducing non-educational burden
- improving communication and collaboration in education and patient care within the program or institution;
- advancing humanism in patient care and among health care professionals.

Five awards will be given to residents or resident teams; each resident or team will receive \$2,500 and a plaque. The awards will be presented to the recipients at the ACGME's Annual Educational Conference in March 2010.

Residents and teams may be nominated by program directors, designated institutional officials, program coordinators, ACGME Review Committees, or chief executive officers of teaching hospitals. Nominations are due July 1, 2009, and must include a completed application form (posted on the ACGME website) and three recommendation letters. The application and supporting materials should be sent to Emily Vasiliou at evasiliou@acgme.org.

reference

ACGME Definitions**Program**

A structured educational experience in graduate medical education designed to conform to the Program Requirements of a particular specialty/subspecialty, the satisfactory completion of which may result in eligibility for board certification.

Program Director

The one physician designated with authority and accountability for the operation of the residency/fellowship program.

Program Evaluation

Systematic collection and analysis of information related to the design, implementation, and outcomes of a resident education program, for the purpose of monitoring and improving the quality and effectiveness of the program.

Council of Review Committee Residents

The Council of Review Committee Residents (CRCR) is composed of physicians in-training, and their unique perspective makes them invaluable members of the 28 Residency Review Committees to which they belong.

The CRCR meets in February and September, and provides advice and feedback to the ACGME Board through its chair, Karen Hsu Blatman, MD. Dr. Hsu Blatman is one of two ACGME resident directors of the ACGME Board of Directors (the AMA appoints a resident director from its Resident and Fellow Section), and she also serves on the ACGME Committee on Requirements. Adeline Deladisma, MD, vice chair, serves on the ACGME Monitoring Committee.

In recent years, the CRCR has provided feedback on the redesign of the ACGME resident survey and has also recommended a change in the Institutional Requirements to allow for a fairer grievance process when the designated institutional official is also the program director. In addition, the CRCR has voiced concerns with the Federation of State Medical Boards about its “unusual circumstance” question on the verification credentialing form.

Written by Kavitha Reinhold, an editor at the ACGME



Back row, left to right: *Miriam D. Post, MD, Pathology; Meredith Riebschleger, MD, Pediatrics; Monica E. Rho, MD, Physical Medicine and Rehabilitation; Jeffrey H. Kozlow, MD, Plastic Surgery; Samuel Seiden, MD, Anesthesiology; Kayla Pope, MD, Psychiatry; Todd J. Mondzelewski, MD, Ophthalmology.* Middle row: *Matthew M. Poppe, MD, Radiation Oncology; Ruth Ann Vleugels, MD, Dermatology; Brian Lane, MD, PhD, Urology; Michael L. DiLuna, MD, Neurological Surgery; Adeline Deladisma, MD, Surgery; Joanna R. Fair, MD, Nuclear Medicine.* Front row: *Esther J. Cheung, MD, Otolaryngology; Rupa J. Dainer, MD, Institutional Review Committee; Karen Hsu Blatman, MD, Internal Medicine (and baby Penelope); Jaime Lynn Bohl, MD, Colon and Rectal Surgery; Gretchen Glaser, MD, Obstetrics and Gynecology.* Not pictured: *Jose A. Carillo, MD, Neurology, Molly Cohen-Osher, Family Medicine, Brian P. Freeman, MD, Internal Medicine, James Huang, MD, Thoracic Surgery, Shauna Lawless, MD, Preventive Medicine, Keri A. Reese, MD, Orthopaedic Surgery, Jessica B. Robbins, MD, Diagnostic Radiology, Benjamin P. Soule, MD, Allergy and Immunology, Sarah Taylor, MD, Transitional Year, Michael J. Tocci, MD, Emergency Medicine, Audrey C. Woerner, MD, Medical Genetics.*

reference (continued)

Program Information Form (PIF)

The PIF is the document completed by the program director in preparation for a site-visit. The document is a compilation of requested information that reflects the current status of the educational program. The PIF is organized in two parts: the Common PIF, which addresses the program's compliance with the Common Program Requirements, and the specialty or subspecialty specific PIF, which addresses compliance with the specialty or subspecialty specific program requirements. The Common PIF is electronically generated through the Accreditation Data System.

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

Physicians Should Control the Education of Physicians

"...I will impart a knowledge of the art to my own sons, and those of my teachers, and to students bound by this contract and having sworn this Oath to the law of medicine, but to no others."¹

"The Centers for Medicare and Medicaid Services should assess the reliability of ACGME procedures and data and should sponsor periodic independent reviews of ACGME's duty hour monitoring to determine the characteristics of and reasons for violations."²

The training of medical professionals is currently unregulated beyond the eligibility for obtaining a medical license, which includes passing a series of standardized exams (the USMLE) and completing a period of post-graduate medical training.³ To date, the profession has largely been self-regulated in the United States; we are able to control the content and quality of both our undergraduate, graduate, and continuing professional development. We are able to make changes in our own training based on what our profession sees as needed to provide the best possible service to the public. We, as physicians, are able to do so based on the evidence as it develops, and we are able to do so collectively in discussion.⁴

The basis for this freedom lies in our sworn professional duty to care for the sick as well as to pass on this knowledge to the next generation of physicians who have similarly sworn to do so; the profession is founded on the notion that our patients' well-being comes first.⁵

Over the past forty years there has been considerable debate within the physician community about how we should train our physicians, and whether or not we should place limits on our training in order to both avoid abuse of residents and to avoid placing fatigued physicians in direct patient care. As we all know, the ACGME began implementation of duty hour limitations in 2003 as an initial attempt to address these questions. In 2007 Congress asked the Institute of Medicine (IOM) to address the question of resident fatigue and resident scheduling; the report made recommendations regarding patient handoffs, resident supervision, resident fatigue, and oversight of the monitoring of duty hours. Specifically, the IOM called for the Centers for Medicare and Medicaid Services (CMS), a government payer for services, to oversee the ACGME's duty hour regulation and to regularly audit the ACGME. Although this recommendation would not result in the direct intervention of CMS into resident training, it would likely be a first step in doing so.

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The ACGME was criticized for our initial implementation of the common duty hour requirements, which were rushed into place to fend off attempts at external regulation. We are now reassessing, in consultation with the medical educational community (residents, program directors, teachers, patients, and organized medicine), our initial, awkward rules. The involvement of CMS, or any other government entity in the process would remove the physician community's ability to change the rules to best suit the evidence available. We would no longer be able to decide for ourselves the best training methods for physicians, but would have to appeal to bureaucrats who have the interests of their political masters in mind, rather than that of patients and trainees. The current ACGME strategy is to use the processes of continuous quality improvement (plan, do, study, act),⁶ but at a national scale – as applied to over 100,000 residents across the nation. If our institutions had to appeal to a government agency or through our Congress to change our rules, political pressure would lead change rather than best practices for resident education and well-being and patient safety.

We must keep the training of future physicians in the control of physicians and physician organizations; we have sworn to maintain excellence in our training, and in keeping our patients safe. Handing this responsibility over to any other entity would be an abrogation of that sworn duty.

Written by William Walsh, MD, a second year fellow in pulmonary and critical care medicine at the University of Utah

¹ Translated by Michael North, "Greek Medicine | Hippocrates | The Oath," National Library of Medicine, http://www.nlm.nih.gov/hmd/greek/greek_oath.html.

² Committee on Optimizing Graduate Medical Trainee (Resident) Hours and Work Schedules to Improve Patient Safety, *Resident Duty Hours: Enhancing Sleep, Supervision, and Safety* (Washington, D.C.: National Academies Press, 2008), http://books.nap.edu/openbook.php?record_id=12508&page=R1.

³ American Medical Association, *State Medical Licensure Requirements and Statistics 2006* (Chicago, IL: American Medical Association, 2006).

⁴ D.A. Kendel, "Professional Autonomy in Medicine Response," *Canadian Family Physician* 36 (September 1990): 1464.

⁵ Sox, H.C., "The Ethical Foundations of Professionalism: a sociologic history," *Chest* 131, no. 5 (May 2007): 1532-40.

⁶ G. Kuperman et al., "Continuous quality improvement applied to medical care: experiences at LDS hospital," *Medical Decision Making: An International Journal of the Society for Medical Decision Making* 11, no. 4 Suppl: S60-5.