2001 ANNUAL REPORT

Accreditation Council for Graduate Medical Education
The Accreditation Council for Graduate Medical Education is responsible for evaluating and accrediting residency programs in the United States. We are a private-sector council operating under the aegis of five medical organizations.

Most importantly we act as a catalyst, bringing together knowledgeable healthcare practitioners, educators and administrators to resolve critical issues concerning graduate medical training.

The volunteers who participate in our Residency Review Committees are key to the efficacy of our process. Through their work we directly influence the quality of graduate medical education, the quality of healthcare institutions and, ultimately, the quality of medicine in America. Because of them the ACGME is improving the pattern of medical education and the course of patient care.
MISSION AND VISION STATEMENT

ACGME Mission Statement
The mission of the ACGME is to improve the quality of health care in the United States by ensuring and improving the quality of graduate medical education experiences for physicians in training. The ACGME establishes national standards for graduate medical education by which it approves and continually assesses educational programs under its aegis. It uses the most effective methods available to evaluate the quality of graduate medical education programs. It strives to improve evaluation methods and processes that are valid, fair, open and ethical.

In carrying out these activities the ACGME is responsive to change and innovation in education and current practice, promotes the use of effective measurement tools to assess resident physician competency, and encourages educational improvement.

ACGME Vision Statement
The ACGME will:

• Be a source of inspiration, encouragement, support and assistance to all who strive for educational excellence;

• Incorporate educational outcomes into accreditation decisions;

• Be data and evidence driven;

• Encourage the development of core competencies across all disciplines, including knowledge of quality improvement;

• Explore a more comprehensive role in GME policy;

• Become a world leader in accreditation efforts;

• Maintain objectivity and independence while continuing its interorganizational relationships;

• Develop a consultative role and encourage innovation.

• Be the spokesperson for GME
MESSAGE FROM THE CHAIR

Perhaps a harbinger of this awakened interest was the controversial and challenging report issued by the Institute of Medicine on the safety of patient care in America. This report not only gave rise to generic concerns about the performance of our nation’s health-care system, but also challenged the very credentials of those whom society has asked to care for them. This sentinel report was followed shortly by the National Labor Relations Board determination that resident physicians in private hospitals were subject to NLRB regulations and thus are to be seen more as employees than as learners.

Most recently federal legislation has now surfaced that is intended to limit or restrict residents’ duty hours. This initiative, if enacted as proposed, would doubtless have wide-sweeping implications not only for the clinical experience of our trainees, but also for the very core and fabric of Graduate Medical Education and the institutions that sponsor this training.

Viewed in the collective, our public accountability and indeed, our very esteem are being questioned in unprecedented ways, demanding a swift and decisive response from Academic Medicine. In fact, all of us engaged in the provision, coordination or oversight of Graduate Medical Education shoulder a shared responsibility to critically reexamine associated structures, processes and communications to assure that the expectations and ideals of the various publics we serve are fully accommodated.

As we embrace this challenge, it is incumbent upon those of us who are ultimately accountable for Graduate Medical Education to be truly versed in the commitments necessary to assure high-quality GME in the training of tomorrow’s health-care professionals. Development of such knowledge simply cannot be delegated. Today’s leaders of teaching institutions must, more than ever, be fully cognizant of the requirements and obligations of Graduate Medical Education.

Lastly, and perhaps most importantly, we must cast a beacon on the support given to those engaged in Graduate Medical Education. By this statement, I am not simply referencing our repeated call for enhanced federal funding. But rather, available resources must be effectively deployed to support, recognize, and advance Graduate Medical Education within our home institutions. Our residency program directors must be valued for their critical contributions to our training programs and our rank and file clinician educators must be rewarded for their service as role models for the next generation of aspiring physicians.

Certainly, these institutional commitments are not facile. However, it is imperative that academic medicine cast off the perceived complacency and arrogance that has cloaked our ivory towers and be visibly responsive to these public obligations. Without such dedicated action, on a collective front, I fear that the self-governance and self-regulation of our Graduate Medical Education programs may, in fact, perish from our landscape just as certainly as the twin towers of New York exist now only as a memory.

R. Edward Howell
Chair
Accreditation Council for Graduate Medical Education
Two thousand and one was an important year for the ACGME. Many academic health centers are doing more with less. Recognition of this fact led the ACGME to freeze its fees for the third consecutive year; to establish the Parker J. Palmer "Courage to Teach Award," an award designed to acknowledge acts of courage on the part of program directors who are true to their values and who maintain quality educational programs in a very harsh environment; and to continue to pursue an accreditation system based more on educational outcomes and less on process and structure measures. The need for program flexibility is apparent and can be better accommodated in an outcome-based system. Additionally, the ACGME and Residency Review Committees (RRCs) solicited and responded to over 70 "RFPs," Requests for Permission from programs seeking permission to conduct innovative educational experiments and to enable a deeper understanding of "Good Learning for Good Health Care." This initiative, supported by the Commonwealth Fund, has resulted in several interesting opportunities to enhance learning.

The ACGME engaged several graduate students at the Dartmouth Medical School's Center for Evaluative Clinical Sciences to assist the ACGME in its attempts to improve its work with the forty organizations that appoint to the Residency Review Committees. The results, published under the title "Six Competencies in Search of a Community: Reports from the Appointing Organizations" reviews the various appointment processes, identifies the common and diverse purposes designed to support GME, and identifies opportunities for the ACGME to enhance dialogue with the very broad community of talented and individuals and organizations committed to GME.

For the second consecutive year the ACGME published the frequency of citations related to work hour violations. This issue is symptomatic of three related phenomena: there is more work to be done; in less time; and with less help. Hospitalized patients are sicker, are discharged sooner, and hospitals are experiencing shortages of other types of health care professionals and financial resources. There is no quick fix to the problem. Fundamental redesign of the way work is done will need to be developed. However, the ACGME will be inexorable in its attempts to focus on educational approaches that maximize good education and safe patient care. Programs that consistently violate accreditation standards will sustain adverse accreditation actions. A work group on Duty Hours and the Learning Environment was established in September and will clarify ACGME’s responsibilities, identify opportunities to collaborate with other organizations in the medical community, and develop a generic template for ACGME requirements that will address this problem.

The Accreditation Data System (ADS) became fully functional in 2001. This system gathers data over the internet for accreditation purposes, clearly identifies the Designated Institutional Official (DIO) accountable for the accredited programs in a given sponsoring institution, allows for e-mail communication between RRCs and programs, preloads institutional data as part of the accreditation process, and supports comparisons that can build knowledge about good GME. A public site on www.acgme.org identifies accredited programs, their accreditation status and cycle length.

The ACGME Outcome and Competency Initiative has entered its first operational phase: Forming the Initial Response. This one-year phase is designed to allow RRCs and programs to respond to the challenge of using assessment of six general competencies: patient care; medical knowledge; practice-based learning and improvement; interpersonal and communication skills, professionalism; and system-based practice as a measure of a program's success at teaching its residents. The larger community has been very supportive of this effort. Some of the boards have developed global assessment instruments that are being applied to all residents in their discipline; portfolios are being developed to record a resident's clinical experience, focused observations of clinical skills are being offered, and many programs are beginning to use some form of 360 degree evaluation to capture the perceptions of peers, patients and colleagues of a given resident.

Program directors are at the heart of good learning. Their efforts have long gone unrecognized. The ACGME has this year established the Parker J. Palmer "Courage to Teach" Award offering public acknowledgment of the power of effective teaching in a harsh environment. Each of the awardees has demonstrated unusual commitment and talent in the education of residents. They offer all of us a model of the power of aligning internal values and external behaviors. A retreat supported by the Pitzer Institute in Kalamazoo and facilitated by Parker J. Palmer himself will explore this in greater depth. Stay tuned.

The ACGME attracts some of the best physicians in America to serve as volunteers on its RRCs and on the ACGME itself. The strength of the organization is dependent on this talent and their ability and willingness to create standards, review programs in their discipline, and make judgments about compliance with these standards. This is a lot of work. The ACGME remains a private, voluntary, accreditation system. It is the profession’s best attempt to regulate its own GME programs. The ACGME and the public owes these individuals a great debt.

David C. Leach, MD
Executive Director,
Accreditation Council for Graduate
Medical Education
MILESTONES FOR 2001

The primary responsibility of the ACGME is accreditation of residency programs. One of the most important measures of annual activity, therefore, is the number of programs reviewed. Of the 7,805 programs accredited by the end of 2001, a full 3,555 appeared on Residency Review Committee agendas during the year, including 2,151 that were scheduled for regular accreditation status reviews. In addition, the ACGME processed 162 applications for new programs.

As a result, 45.5 percent of all programs were examined and 24.6 were subject to routine accreditation actions.

SCOPE OF RESPONSIBILITY

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<th>ACGME-accredited programs</th>
<th>7,805</th>
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<tr>
<td>ACGME-accredited training areas</td>
<td>83</td>
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<tr>
<td>Residents affected by ACGME accreditation</td>
<td>99,761</td>
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ACGME field staff conducted 1,708 surveys, including 86 institutional surveys, 787 surveys of programs in the basic disciplines, and 835 surveys of sub-specialty programs. Volunteer physician specialists conducted an additional 110 surveys.

During regular accreditation reviews, RRCs proposed adverse evaluations for 119 programs, or 6.7 percent. Accreditation was withheld upon application in 13 cases and withdrawn in 15 cases. Sixty one programs were placed on probation, and one reduction in resident complement were mandated. Six programs were administratively withdrawn, and 84 programs withdrew voluntarily.

The ACGME considered 7 appeals after formal hearings by specially constituted Boards of Appeals.

Another indicator of ACGME's 2001 activity is the number of people and tasks necessary to accomplish this vital process. The staff of ACGME surveyors spent approximately 570 weeks on the road. In addition, volunteer surveyors made 110 trips to visit programs; RRCs held 60 meetings; the Institutional Review Committee met two times; and the entire ACGME council met three times.

All told, volunteer physicians and administrators contributed an estimated 40,000 hours in 2001. The ACGME staff of 76 employees supported their invaluable work.

EVALUATION ACTIVITY

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<th>Total agenda items</th>
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<td>Regular accreditation status reviews</td>
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<td>Adverse actions</td>
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<td>Withheld</td>
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<td>Probation</td>
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2001 Financial Highlights

The ACGME's 2001 fees came primarily from annual fees charged to all accredited programs. Programs with more than 4 residents are charged $2,500 annually and programs with fewer than 5 residents are charged $2,000. The current rates have been frozen since the 2000-2001 academic year. ACGME reserves, defined as cash and investments, totaled $16 million at year end.

Revenues

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<td>Workshops &amp; Miscellaneous Income</td>
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<td>Application Fees</td>
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<td>Investment Revenue</td>
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<td>Rent Revenue</td>
<td>$327,099</td>
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<td>Total</td>
<td>$19,148,190</td>
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Expenses

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<td>ACGME Activities</td>
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<td>RRC Activities</td>
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<td>Rent and Contracted Support Services</td>
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<td>Field Staff Activities</td>
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<td>Appeals and Legal Services</td>
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<td>Administration and Research</td>
<td>$1,557,158</td>
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<td>Total</td>
<td>$16,318,638</td>
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Each of the 26 Residency Review Committees is sponsored by the two or three organizations listed below. The sponsoring organizations are the medical specialty boards, the American Medical Association (AMA), and in many instances an appropriate major specialty organization. Members of the Residency Review Committees, which vary in size from six to 15 persons, are appointed in equal numbers by the sponsoring organizations. In addition to the specialty area which forms the name of the committee, other specialized training areas accredited by the committee are also indicated.

In addition to programs in these areas, the ACGME accredits special one-year general clinical programs called Transitional Year Programs. The ACGME also provides for an Institutional Review Committee, which evaluates sponsoring institutions for compliance with the ACGME Institutional Requirements.

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<th>Accrediting Organizations</th>
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<td>• Pediatric Anesthesiology</td>
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<td>Transitional Year</td>
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<td>• ACGME Standing Committee</td>
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