

### Accreditation Council for Graduate Medical Education



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### Executive Director's Column:



David C. Leach, M.D.

### What's Up with the New ACGME Fee Structure?

Over the past months, we have received a number of questions from you about the new ACGME fee structure. The new fee structure was announced in the October 1999 *ACGME Bulletin*, and became effective on January 1 of this year. One of the most frequently asked questions concerns the reason the ACGME switched to annual fees. The answer is related to a significant extent to our emerging outcomes-based model for the accreditation of residency education programs. Many of you already know that our

accreditation system is shifting to a model based on educational outcomes in lieu of the process and structure measurements that make up the current system. The primary goal of the shift is to enhance the specificity of the accreditation process by focusing it on the success of the educational program in developing residents' knowledge and understanding and ability to practice independently. The current model, based on structure and process, can capture the potential of a graduate medical education (GME) program to educate residents, but cannot systematically document that residents are, in fact, being educated successfully. There are several implications of the new accreditation model, not the least of which are financial, for programs, their sponsoring institutions, and the ACGME itself. In this column, I will review and clarify concepts that prompted us to initiate the new fee structure.

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All program site visit fees, institutional site visit fees and resident head count fees have been discontinued as of January 1, 2000. They have been replaced by an annual program accreditation fee. This fee is \$2,500 for programs with more than five

residents and \$2,000 for programs with five or fewer residents. The previous program and institutional site visit fees were \$3,100 each, and institutions were billed annually \$52 for each resident. The new ACGME fee structure makes it possible to build an accreditation model that is not dependent on the site visit for its financing, and that supports necessary changes in operations to develop an outcomes-based approach.

Current accreditation activities depend to a very great extent on the site visit. It serves to clarify and verify information and report on the extent to which the program's self-study report in the program information form (PIF) reflects reality. The new model, once fully realized, will depend to a much greater degree on ongoing collection and analysis of data for all programs, and to a lesser extent on the site visit. ACGME operational support for data analysis, and other support activities related to accreditation will also be ongoing activities, and will not just occur at the time of the site visit. Eventually, all programs in a given discipline will be profiled annually by their Residency Review Committee (RRC). The profile will consist of data elements the RRC has identified as key indicators of educational outcomes in that discipline. These ele-

ments will be obtained from a variety of sources. Review of a GME program will occur by glancing at these indicators, rather than the many hours it currently takes to review a PIF and site visit report. This review will likely be done annually. Outliers found through this approach will trigger further review by the RRC, using methods that may or may not involve a site visit. The site visit and complete review of programs and sponsoring institutions will not disappear (I do not want you to get your hopes up), but will be less frequent.

At present, the ACGME is a long way from this model, but not as far away as one might think. Last year 3,650 programs — 47 percent of the 7,731 residency programs in the United States —

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were reviewed by the RRCs. Of these, 2,160 were classic accreditation status decisions, almost always associated with a complete PIF and full accreditation site visit. The remainder were reviews of progress reports, changes in resident complement, institutional affiliations, or other data.

This July, we hope to launch an Internet-based version of

common data elements that constitute the 'institutional and program demographics' section of the PIF. The fields will be pre-loaded with data the ACGME currently has for each program and institution, and the system will allow each program director and institutional official to review and, if necessary, correct this information. The data set will be limited to contain only key elements that are needed to make accreditation decisions. This will provide the RRCs with more accurate and better information (the sometimes extreme variability in the ways the PIFs are completed can contribute unnecessarily to the already very heavy work load of RRC members). The new data collection will also make life easier for program directors, as these data elements will be completed once by the sponsoring institution and applied to all programs at that sponsor. These elements will be known as Part I of the PIF.

Part II of the PIF will be specialty-specific and, for the time being, will continue to be completed using the traditional PIF format and be confirmed via the site visit. An emerging part of the data set used in GME accreditation will be Part III of the PIF, which will comprise key educational outcome measures the RRCs have determined to be important for accreditation actions. Identifying these

measures will be facilitated by an ongoing dialogue of key stakeholder in GME and GME accreditation, in which we all will explore how to improve measurement of educational outcomes and build knowledge about good GME. We are beginning the dialogue with retreats in May and September of this year. These retreats, jointly sponsored by the American Board of Medical Specialties (ABMS) and the ACGME, will include RRC chairs, directors of the Boards, program directors, site visitors, and residents. This enhanced accreditation effort will ultimately require additional data systems that inform and support the community, as we all take advantage of the tremendous opportunity to learn about the best way to teach residents.


In addition to supporting the ACGME's new initiatives to implement outcomes-based accreditation, the new fee structure is also designed to stabilize costs to programs. The ACGME's intent is to freeze accreditation fees for three years, and to stop what has been an annual fee increase of 8 percent over the past several years. An added advantage is that institutions can now budget predictable accreditation costs and will no longer endure the wide swings in costs associated with the variable numbers of site visits that were occurring each year. Many burdensome aspects of the old accreditation fee model have been reduced or eliminated under the new system. It must be noted, though, that some institutions are paying more under a model based on annual accreditation fees. Institutions with large residency programs, few small programs and short cycle lengths are paying less under the new model. In contrast, institutions with a large number of small programs and long cycle lengths will pay more than they did under the old approach. This may seem perverse, because it appears to financially reward institutions with short cycle lengths. However, financing accreditation by charging for the site visit also had perverse incentives — the more frequently the ACGME visited programs, the more revenue was generated. The new data-driven accreditation model described in this article will ultimately result in all GME programs receiving some form of annual review. This makes a comparison with the historical model, where costs were determined by the length of the accreditation cycle less relevant. Finally, the new model will permit a lengthening of the cycle of site visits, which at the program and institution level reduces the time and financial costs associated with preparing for the site visit. You could call it a form of "managed accreditation." 

## Data for Accreditation

Marvin R. Dunn, MD

There are increasing numbers of entrepreneurial web-based GME data collection systems available. Some of these are tailored for a single discipline and others are quite broad. In the article entitled "What's Up with the New ACGME Fee Structure" in this issue of the *ACGME Bulletin*, Dr. Leach describes the plan of the ACGME to begin to make available an Internet-based version of the common elements in the first part of the program information form (PIF) by this July. It is the ACGME's plan that, in time, the entire PIF will be web-based.

It is important to recognize that the data required for the GME accreditation process must be collected through the ACGME's PIF. This is necessary because the RRCs determine what data are needed, in what form, and how these should be defined and configured. Surveys done by other organizations tend to go far beyond the data needed for accreditation. More importantly, data used for accreditation must be collected, maintained and verified by the ACGME to sustain legal challenges in accreditation actions. Additionally, some survey data sets in GME either do or potentially may have data available for commercial purposes. ACGME does not provide accreditation data for any commercial purpose. This is important to note, because accreditation data must be kept confidential. Some RRCs have data needs, which create special added confidentiality requirements. An example is the use of operative log data in the accreditation of some surgical specialties. In instances where operative logs and other patient information are used, the need for confidentiality is of the highest order.

These are the principal reasons that the data required for accreditation will be collected directly by the ACGME. The data will continue to be collected in the PIF as in the past, but beginning this year the ACGME will employ a more user-friendly, web-based version. 

## Programs and Institutions Cited for Work Hours and Related Requirements during 1999

Marvin R. Dunn, MD

As has been stated frequently, a residency is fundamentally an educational program. It involves the performance of clinical service as an integral part of that educational experience. The twenty-seven Residency Review Committees (RRCs) have descriptions in their respective Program Requirements of the limitations and boundaries

of service requirements to ensure a primacy of education over clinical service. The reasons for these limits are self-evident, but the emphasis is on establishing an environment that is optimal for both resident education and patient care.


The enforcement of these requirements begins with the Sponsoring Institution. The ACGME Institutional Requirements state in II.D.2:

"The sponsoring institution must ensure that each residency program established formal policies governing resident duty hours that foster resident education and facilitate the care of patients. Duty hours must be consistent with the Institutional and the relevant Program Requirements of the specialties and subspecialties that apply to each program. These formal policies must apply to all institutions to which a resident rotates.

The educational goals of the program and learning objectives of residents must not be compromised by excessive reliance on residents to fulfill institutional service obligations. Duty hours, however, must reflect the fact that responsibilities for continuing patient care are not automatically discharged at specific times. Programs must ensure that residents are provided appropriate backup support when patient care responsibilities are especially difficult or prolonged."

These Institutional Requirements apply to all accredited GME programs. In addition, each of the RRCs have in their program requirements additional limitations. For all, this includes that residents not be assigned on-call in-house duty more often than every third night, and that residents have at least one day in seven free of patient care duties. Six of the RRCs have set a maximum number of hours that residents may spend in patient care duties per week, usually averaged over a four-week rotation or assignment.

For the reasons given above, the Residency Review Committees take this issue of duty hours, the balance between education and service, and the need for an optimal environment for both education and patient care, very seriously. Of the 86 sponsoring institutions reviewed in 1999, seventeen or approximately 20 percent, were cited for failure to fully comply with these provisions in the Institutional Requirements.

The number of programs cited for not fully complying with these provisions in the Program Requirements are shown in *Exhibit 1* on the next page. *Exhibit 1* also shows the total number reviewed in 1999 for each RRC, and the percentage of programs that were cited. 

**Exhibit 1**  
**Number of Programs and Institutions Cited During 1999 for  
 Work Hours and Related Requirements**

Specialty	No. of Programs Cited/Total No. of Programs Reviewed	Percent Cited
INSTITUTIONAL REVIEW	17/86	20.0%
Allergy and Immunology	4/18	22.0%
Anesthesiology	2/135	2.0%
Colon and Rectal Surgery	3/9	33.0%
Dermatology	2/29	7.0%
Emergency Medicine	3/30	10.0%
Family Practice	17/122	13.0%
Internal Medicine	28/92	30.0%
Internal Medicine Subspecialties	17/388	4.0%
Medical Genetics	1/17	6.0%
Neurological Surgery	2/21	10.0%
Neurology	4/29	14.0%
Nuclear Medicine	0/37	0.0%
Obstetrics and Gynecology	17/89	19.0%
Ophthalmology	3/22	13.0%
Orthopaedic Surgery	20/69	29.0%
Orthopaedic Surgery Subspecialties	8/81	10.0%
Otolaryngology	4/40	10.0%
Anatomic and Clinical Pathology	15/74	20.0%
Pathology subspecialties	6/107	6.0%
Pediatrics (excludes subspecialties)	7/33	21.0%
Physical Medicine and Rehabilitation	3/25	12.0%
Plastic Surgery	3/29	10.0%
Preventive Medicine	0/20	0.0%
Psychiatry	0/36	0.0%
Radiology-Diagnostic	0/169	0.0%
Radiation Oncology	0/38	0.0%
Surgery-General	25/69	36.0%
Vascular	4/23	17.0%
Pediatric	7/13	53.0%
Thoracic Surgery	4/25	16.0%
Urology	4/49	8.0%
Transitional Year	13/54	24.0%

## ACGME Invites Comments on the Topic of Resident Work Hours

The companion to the article on work hour citations, shown below, offers some information, both from the United States and from other countries, on the complex topic of resident work hours. The ACGME is exploring this subject as part of a broad Council effort to address the issues raised in the Institute of Medicine report "To Err is Human" (also see *Medical Errors and Patient Safety* on page 8 of this issue of the *Bulletin*). To facilitate the ACGME receiving and considering all views on this matter, we would like to invite comment on the article, and on the general topic of resident work hours and their relationship to the attainment of educational objectives and the safety and effectiveness of patient care. Please send your comments to: Ingrid Philibert, Editor, *ACGME Bulletin*, 515 North State Street, Suite 2000, Chicago, IL 60610, or via FACSIMILE to 312/464-4098. Comments will be aggregated for review and discussion by the ACGME and a summary and selected ones will be published in the July 2000 issue of the *ACGME Bulletin*.

### Limiting Resident Work Hours:

#### **Some Data from Two Learning Laboratories - New York State and the European Community**

*Ingrid Philibert*

In the preceding piece on citations for failures to comply with the ACGME's resident work hour requirements, Dr. Dunn underscores that participation in patient care activities is vital to preparing residents for independent practice, but that the ACGME's limits on work hours exist to allow time for study, rest and relaxation. Another way of stating it is that an exhausted, sleep-deprived resident is likely not able to achieve the program's educational objectives nor the goal of providing safe and effective patient care.

Over the past decades, researchers have sought to analyze the relationship between resident work load and work hours, resident educational achievement, and patient care quality. Each of these studies has explored a slightly different facet of this complex subject. For

example, an exhaustive review of studies on the impact of sleep deprivation on residents published between 1970 and 1991 found that acuity on tests requiring prolonged concentration and effort tended to deteriorate with loss of sleep (1). Manual dexterity, reaction times, and short-term recall were not impacted. The authors of the review noted this suggests that residents can compensate for loss of sleep during special circumstances and crisis situations, but may be more prone to errors in routine work and work that requires sustained effort. In the policy research arena, New York State's 405 Regulation, which limits resident work hours to 80 per week (with some highly specific, complex exemptions for surgical training programs), has been assessed for its impact on resident learning, quality of patient care, and costs resulting from the additional providers needed to 'fill in' for services formerly provided by residents. Ongoing efforts in the European community to reduce work hours for physicians in training and those in practice are providing another learning laboratory of the impact of limiting work hours for individuals in residency and the medical profession as a whole.

Preliminary data from Great Britain, where regulation implemented in 1995 reduced work hours for physicians in training programs ("junior doctors") to 72 hours per week (of which only 56 hours can be spent as actual work time) and from Germany, where similar regulations became effective in 1996, have shown that residents are less exhausted. However, there is concern over the seeming inability to avoid shift work patterns for physicians in training to bring their hours within the limits and on the impact of this on education. A study in Great Britain found that implementing a shift system reduced house officers' work hours (mean hours: shift work 59.8; traditional on-call system 72.7), but was accompanied by residents' perception that it negatively impacted their training(2). A study of several European nations showed that countries that implemented 'resident-friendly' working conditions, including reducing hours, working shorter shifts and giving days off after call, gained these advantages by reducing all work, including work with an educational value, rather than merely repetitive, routine tasks(3). Based on this finding, the authors of the study suggested that reducing 'non-medical' tasks and the resulting decrease in work intensity is more important than further reductions in work hours.

It should be noted that comparison of U.S. graduate medical education with the European systems of physician education may not be fair to both sides of the Atlantic. In many specialties, the period of physician training in European countries is longer than the residency education period in the United States. But the educational systems are not comparable. U.S. graduate medical education programs may offer more 'formal education', while in the European systems a significant portion of training time

is spent on routine medical work. Formal education may comprise less than 10 percent of physicians' time (4) in European programs, and supervision and tutoring of the trainee in patient care activities are far less prevalent than they are in this country.

In the United States, studies of the impact of New York State's regulation limiting work hours have produced mixed results. A survey in obstetrics-gynecology showed that resident life style improved and time for reading and learning increased. Surgical case load remained the same, and Council on Resident Education in Obstetrics and Gynecology (CREOG) exam scores did

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not change. At the same time, quality of patient care was not felt to improve under the new system, and continuity of care was thought to be adversely affected(5). Another study, which assessed internal medicine residents and faculty, found that residents felt the regulations diminished their fatigue, did not affect their ability to observe the full impact of interventions on patients, and resulted in better patient care. Their attending physicians were uncertain or disagreed on these parameters. In contrast, the attendees felt that the regulations caused a shift-work mentality among residents, but the residents did not corroborate this finding(6). Other studies have produced varying findings, ranging from considerable improvement to a detrimental impact of the regulation. This distribution of the findings can be explained in part by differences in the disciplines studied; the majority of research to date having assessed individuals' perceptions rather than the actual implications of the regulation; and the differing hypotheses of the researchers regarding the impact of regulation on education and patient care.

Data from another study of New York State's regulations demonstrates that the regulations themselves may create

moral and ethical dilemmas for residents(7). The study collected information on residents' perceptions of their responsibility for patients and the impact of the 405 Regulation. It showed that concern for their patients' welfare made it difficult for residents to maintain the boundaries between their work and their personal lives. Even with work hours limited by regulation, the study found "an open-ended workday and competing considerations confronting residents when deciding to leave the hospital – including concerns about leaving patients at critical junctures in their care, confidence in the colleague to whom they were signing out, regard for the workload of this colleague, and uneasiness about the educational consequences." The study also found "barriers to acknowledging and acting on an individual's limits in performing work, and a recurrent conflict between delegating responsibility and retaining control over patient care."

One seemingly logical conclusion to this dilemma would be a team-based approach to care, which could reduce both the individual's work hours and solitary responsibility. However, the authors of the New York study summarized in the preceding paragraph found that the values of autonomy and individual accountability learned in medical education may not be suited to a team approach, and "may conflict with the shared decision making and collective responsibility among peers necessitated by work-hour limitations and associated changes in program structure." Admittedly, these values are inculcated in the U.S. medical education system, they may be changing or could be re-evaluated, and they are not universal to medical practice around the world. In Scandinavian countries, for example, an entire surgical team may hand over a patient to a second team in the middle of a lengthy operation.

Yet there are data that suggest that a team-based approach itself may contribute to medical errors. Or rather, that use of medical teams may result in trading one type of error, errors caused by fatigue, for another – errors resulting from inadequate exchange of information about patients during more frequent hand-offs among the individuals involved in their care. A study of medical care in settings where a team approach is used, found that 'interdependence' among the team members may lead to coordination problems. In the study, these

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expressed themselves as variations in the use of clinical resources (8). It is not difficult to make the leap that extends these 'difficulties in exchanging information' to situations where team and shift approaches require hand-offs of patients among team members or among physicians working in a shift pattern. Though the contribution of 'gaps' to errors in health care has been identified, traditional (non-team) models of care have many gaps and not all gaps result in errors. At present, data from comparison studies is unavailable, making it possible to imagine that the use of shift and team models could increase these hand-off errors.

As stated at the beginning of the article, the dual goals of safe patient care and the education of the residents are the primary reasons for attention to the number of hours residents work. As the GME community looks at work hours, it is important that alternatives for organizing training to reduce resident work hours and resident workload be explored in-depth for their impact on patient care and education. To date, this information is either lacking or has not been explored adequately to allow generalizing on studies, especially studies from other countries where physician graduate education is organized differently. Most sketchy is the information on how education is impacted. Present data are limited to assessments of individuals' perceptions, with little information on how moving to team- and shift-based approaches impacts resident learning or competencies at various stages or training or at completion of the residency.

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## Highlights from the February 2000 ACGME Meeting

### 1999 ACGME Annual Report Activity

Review of ACGME data for the last year revealed there were 7,731 accredited residency programs in 1999, a slight increase over 1998. The number of programs in core specialty area increased 3 percent, and subspecialty programs increased 2.2 percent. For the first time in the ACGME's history, the number of residents in accredited programs declined slightly, to 98,220.

### December 1999 ACGME Executive Committee Retreat

Dr. Leach reported on the December 1999 Executive Committee Retreat, at which the committee explored the development of a quality improvement model for accreditation. The Committee discussed three models: (1) the threshold of performance model, on which the current ACGME system of accreditation is based; (2) the competency model, which would assess programs' performance on the six general competencies for GME accreditation, and allow stratification of programs on these competency areas; and (3) the performance excellence model, which charts the progress of a program or institution along an evolution from isolated quality measurement and improvement activities occurring in selected areas to a broad-based commitment to performance improvement permeating all aspects of operations.

### Revision of ACGME Bylaws

The Council accepted for first reading a revision of the Bylaws that would achieve separate incorporation of the ACGME. Two additional Bylaws revisions also received a first reading. The first of these addressed the fiduciary responsibilities of sponsoring organizations' representatives serving on the ACGME. New language was developed to clarify and emphasize that ACGME representatives have fiduciary responsibilities first and foremost to the ACGME, independent of their appointing organization. The second change extends the terms for selected members of the Council who serve as officers from six to eight years, to allow incumbents the opportunity to succeed to the position of Chair. This change was necessitated by a revision in the Bylaws made in 1999, which extended the term of the Chair to two years. The three revisions will receive a second reading at the June 2000 meeting.

### ACGME Position Statement on Resident Unionization

On November 26, 1999, the National Labor Relations Board decided that resident physicians are "employees" under the National Labor Act, giving residents in private institutions the right to collectively bargain. Since the ACGME is uncertain about the impact this decision will have on graduate medical education and teaching

institutions, the Council prepared a draft statement for wide dissemination, including publication on the ACGME Web page, and invited comments from the GME community and other interested parties. These comments will be reviewed and possible recommendations may come forth from the Council.

#### ***Medical Errors and Patient Safety***

Prior to the meeting, all ACGME representatives had received a copy of the Institute of Medicine (IOM) Report entitled "To Err Is Human," which discusses the issue of medical errors and suggests approaches for reducing them. The Committee for Strategic Initiatives discussed the report, and explored how the ACGME should respond to the issues covered in it. The Committee suggested that the ACGME develop recommendations, potentially to include a mechanism to incorporate error prevention within the "systems-based practice" component of the six general competencies that will be used in the ACGME's planned outcomes-based accreditation system.

#### ***Principles for Authorizing a Residency Program as "Inactive"***

The ACGME discussed the formulation of an "inactive" status category in lieu of voluntary withdrawal of accreditation for residency programs that do not have any residents training in them at a given time. The major advantage of the new "inactive" status option is that it creates an alternative to having a program administratively withdrawn, and to the practice of preventing that action by appointing a resident of less than optimal qualifications.

#### ***Monitoring Committee Activities***


The ACGME adopted the final report from the Monitoring Committee on the work of the Residency Review Committee for Preventive Medicine. In addition, the Monitoring Committee is currently analyzing similarities and differences in the way the accreditation standards are developed among the various RRCs. The results of the analysis will be reviewed by the Committee for Review of Program Requirements at its June meeting. The Committee is also trying to develop a systematic way of sharing best practices for the development and revision of accreditation standards among the RRCs.

#### ***Manual of Policies and Procedures***

The ACGME approved amendments and editorial revisions to the Manual of Policies and Procedures for Graduate Medical Education Review Committees, except for a policy on resident moonlighting. This policy will be reviewed and discussed by the RRC Council of Chairs at its upcoming meeting, and recommendations will be returned to the ACGME. 

## **ACGME Symposium: Good Learning for Good Healthcare: Pursuing Excellence in Physician Education**

On March 4 and 5, 2000 the ACGME hosted approximately 75 individuals in a two-day conference that combined speaker presentations and work by small groups of graduate medical education stakeholders to discuss the destabilizing impact of the current health care environment on physician education and to identify ways to counteract destabilization, including use of an ACGME-sponsored Request for Proposals (RFP) process to foster excellence and innovation in GME.

The speakers, which included Dee Hock, Founder and CEO Emeritus of the Visa Corporation, and Catherine DeAngelis, MD, Editor of the Journal of the American Medical Association, discussed complexity science, 'chaordic' principles — a blending of the principles of chaos and order, and how to deal with the fragmentation of medical knowledge. A panel of ACGME Executive Committee members discussed potential roles for the ACGME in assisting programs and institutions in dealing with, and succeeding in, the current environment. During the work group sessions, attendees participated in the development of objectives and evaluation criteria for the RFP process. A number of potential areas for RFPs were discussed, including efforts to explore the relationship between excellence in patient care and excellence in GME, and initiatives to empower an institution's GME Committee to assume responsibility for the quality of the residency programs. The intent of the RFP process is to remove potential restrictions to excellence and innovations in GME created by the accreditation process. The final draft concept for an ACGME-sponsored RFP process will be reviewed by the Council at its June 2000 meeting. 

## **Winning Posters from the 2000 ACGME Poster Competition "Best Practices in Graduate Medical Education"**

In conjunction with the annual Mastering the Accreditation Process Workshop, held March 2-3, 2000, the ACGME sponsored a poster presentation on the theme "Best Practices in Graduate Medical Education."



Over 30 posters were received in a wide range of areas that included outcomes-based measurement, continuous quality improvement, and the impact of mergers on residency education programs. A panel of judges awarded three prizes, and a 'special judges award.' The abstracts for these four winning posters are shown below.

**1st Place: Clinical Profiling in Surgical Education, Michigan State University**

*C. I. Anderson, RN, MSA, and R. E. Dean, MD*

Clinical profiling of surgery faculty regarding patient outcomes can serve as a model for residents in training, better preparing them for entry into practice. Comprehensive profiling (hospital, ambulatory surgery, and office clinical activities) can provide more accurate data than that reported by individual hospitals or insurance carriers. Individual and group information is collected in three categories (see chart below): (1) common surgical procedures; (2) significant complications or deaths; and (3) principal causes for complications. Data are reported at predetermined periods (current quarter, 12 months, etc.). Complication rates are determined by comparing the number of operative cases done to the number of adverse outcomes reported.

Sample Complication Rates (Based on percent of cases)	Current Quarter	Past 12 Months	Past 18 Months
1) Laparoscopic Cholecystectomy:	3.85	5.20	4.55
Hernia Repair:	2.74	4.00	4.44
2) Wound Problems:	0.79	1.38	1.26
Post operative bleed:	0.17	0.27	0.26
3) Missed Diagnosis:	0.30	0.17	0.22
Decision Errors:	0.40	0.48	0.52

Quarterly reports show variations in department and individual complication rates and allow for comparative analysis. Significant variations may require in-service training, educational conferences, research projects, administrative review, focused audits, or system changes. All profiling efforts are directed at improving patient care and enhancing resident training, not punitive actions. Clinical profiling could benefit any residency training program.

**2nd Place: Initial Outcomes of Academic Program Revisions, Rush University**

*Linnea S. Hauge, PhD, and Constantine V. Godellas, MD*

Recent review by the ACGME and our GME Review Committee identified educational and curricular issues that needed attention in our surgical residency program. Furthermore, over a recent period of five years, our department observed a downward trend in resident

ABSITE scores. In 1998, the department made significant changes to the academic program. These changes included reorganization of the residents' curriculum, clarification of resident promotion criteria, institution of a Reading Club, hiring of an Educational Specialist, and improvements to conferences and faculty teaching evaluations.

Educational outcomes associated with these changes were, and continue to be, measured in several ways. Residents completed questionnaires about their preparation for the ABSITE, and evaluations of program components and changes. Department records were used to determine resident probationary status and conference attendance. A statistical analysis of ABSITE scores indicated a significant improvement between 1998 and 1999 percentile scores (paired  $t = -225$ ,  $p = .03$ ;  $m = 11.9$ ,  $sd = 30.5$ , median = 41). Pearson's correlations indicated that probationary status (+.58,  $p = .001$ ), anxiety (+.53,  $p = .001$ ), amount of study (+.61,  $p = .001$ ), past ABSITE performance (-.60,  $p = .001$ ), and conference attendance (+.56,  $p = .001$ ) were correlated with ABSITE improvement. The institution of a topic-based curriculum was rated very positively by residents. The newly formed Reading Club, and restructured Basic Science conferences were deemed to have the most educational value of all conferences.

In conclusion, the identification and ongoing evaluation of program components and resident study practices are important to ensuring resident's academic, and ultimately, clinical success.

**3rd Place: Admission Diagnosis vs. Hospital Discharge Diagnosis as a Means of ED Patient Follow-up, New York Medical College**

*Mona Singh, MD, and Peter Dahlheimer, MD*

Emergency Medicine residency programs require residents to follow up their patients who are admitted to the hospital to determine the final diagnosis and whether the admitting diagnosis was correct. The episodic nature of the practice of Emergency Medicine often makes this follow up difficult. A database was developed to track and compare patient care information including admitting and final diagnoses.

We utilized two computerized databases, one based on the ED visit, and the second based on data from the hospital admission. The first database included triage time and acuity, time of MD evaluation, MD name, MD training level, disposition diagnosis and time, and medical record number. The second database contained


dates and length of stay, discharge diagnoses, and medical record number. An automated process used medical record numbers to match information in each database so that physician-specific reports could be generated comparing admission with discharge diagnoses. Using the data, the residency director will be able to assess and track the diagnostic acumen of the residents and modify and individualize teaching as needed. The faculty will gain an understanding which disease processes are misdiagnosed in the ED.

**Special Judges Award: Establishing a Residency Coordinators' Network, Mayo Clinic Graduate School of Medicine**

*Judith Cook, Cyndee Ebnet, Teresa Enger, Michele Merten, and Georgina Rink*

"Alone," is how Residency Coordinators (RCs) feel if they do not have support or communication with other colleagues in the vast ocean of ACGME, RRC, Boards, and Program Requirements. RCs at Mayo recognized

the need for interactive communication, continued training, and support for new and experienced RCs. The RCs formed a Steering Committee (SC) to address these needs at monthly meetings of all RCs and Mayo Clinic Graduate School of Medicine (MGSM) representatives. The SC sets the agenda, which always includes an open forum discussion about how dissimilar programs accomplish GME tasks. Topics have included: ACGME requirements, MGSM policies/procedures, licensure, curriculum development, recruitment, RC mentorship, orientation, evaluations, computer enrichment, and helpful hints necessary for a residency to be successful.

Better communication and an increased understanding of the RC role were immediate benefits of the monthly meetings. Unexpected positive outcomes were increased morale, camaraderie, the confidence to seek assistance when needed, and the development of a network of experts. The source of GME knowledge does not come from one individual but from a sharing of many RCs' knowledge. 

## RRC/IRC COLUMN

### RRC for Pediatrics Approves Minor Changes in Program Requirements

The ACGME approved minor changes in the wording of two components in the Program Requirements for Residency Education in Pediatrics, effective May 1, 2000. The changes pertain to the designation of affiliated institutions as *integrated* and the criteria for affiliation agreements. The document, with changes highlighted, is available on the Pediatrics page of the ACGME Web site.

### So you MUST Make Last-Minute Changes to Your Program Information Form (PIF) – Please Observe the Proper Form and Etiquette

The ACGME scheduling letter that informs you of your site visit date clearly states that the program information form (PIF) sent to the site visitor and the three copies provided on the day of the visit must be identical and must be in final form. Draft copies are not acceptable to the site visitor or the ACGME. However, on occasion program directors or staff do discover that their PIF was not 'ready for prime time.' Errors and discrepancies may also be found on the day of the visit. While the operant term in the headline above is MUST, and a flawless PIF sent to the site visitor well in advance of the 10-business day deadline is vastly preferred, the suggestions below will guide you to the proper form and etiquette if you need to make changes to the PIF.

◆ **Case 1: Changes after the PIF has been sent to the field representative but before the site visit:**

Changing the PIF after the site visitor has been sent his or her copy and before the day of the visit should be avoided at all cost. Minor discrepancies discovered after the PIF has left your mail room can be cleared up on the day of the visit. The rare exception that necessitates sending a correction before the visit is a major error or omissions in the PIF that profoundly impacts the review. In this case, send the site visitor only the pages that were changed, with the changes clearly highlighted. Do not send an entire new PIF,

as the site visitor may have already reviewed and annotated his or her copy. The three copies provided on the day of the visit must be in the new 'improved' form.

◆ **Case 2: Changes on the day of the site visit**

The day of the site visit is when little errors are often discovered. It is acceptable to make changes to the PIF, providing this can be done easily on the day of the visit before the site visitor departs. Please do not ask your field representative to wait while you make extensive changes (for major corrections, see below). Once changes have been made, one copy of any changed pages is given to the site visitor, with the changes clearly highlighted. The revised pages also need to be replaced in the three copies to be sent to the ACGME before they are packaged for mailing.

◆ **Case 3: Changes that cannot be made on the day of the visit**

Major changes after the day of the visit are generally discouraged, and this approach should be used as an approach of last resort for the very rare situations when a PIF has major flaws and requires significant changes. If this occurs, provide the needed changes as a succinct addendum to the PIF, addressed to the RRC team and clearly marked with your program number and name, and send this directly to the ACGME's Chicago address (you do not need to send a copy to the field representative). On the day of the visit, the three copies of the PIF, however 'flawed,' must be turned over to the site visitor for mailing to the ACGME. The addendum must be sent within two weeks (10 business days) of the site visit date. Addenda are accepted at the discretion of the RRC, and not all RRCs accept them. If you need to send one, you should contact your RRC team in advance of preparing and sending it.

While changing the PIF is clearly not the preferred approach, if it must be done, observing these basic suggestions will make the process easier for you, the ACGME site visitor and the RRC. However, please be aware it creates added work for everyone involved, including most of all the program. This should be a powerful incentive to get the PIF 'right' the first time.

## ACGME Discontinues Viewing of Internal Review Documents during Program Site visits

In the July 1999 issue of the *ACGME Bulletin*, we included information on how programs should document their internal reviews in the context of a program site visit. Although we hoped this would clarify the issue, the ACGME is sensitive to continuing concerns that information from written documentation of the internal review, shown during the program site visit, might find its way to the RRCs.

At its April 2000 meeting, the ACGME Institutional Review Committee (IRC) decided that it would discontinue requesting that site visitors be shown documentation of the internal review *during program site visits*. Written document will continue to be requested for institutional reviews. For program site visits, the site visitor will ask the program director to share verbally the essential information about the internal review process: (1) the date of the review, (2) the individuals involved, and (3) the process for sharing the results with the program and the Institutional Graduate Medical Education Committee. This verbally shared information will be included in the site visit report.

Despite discontinuing this review of printed documentation during the program site visit, the matter of internal reviews continues to remain an important issue, and the IRC is committed to ensuring that sponsoring institutions have a functional internal review process in place. Documentation on institutions' internal reviews *will continue to be collected in the institutional review document (IRD) and used in the institutional site visit*.



## Abraham Flexner Comments on the Six General Competencies - A Medical Education Fantasy

Ingrid Philibert

"Knowledge is the distilled essence of our intuitions,  
corroborated by experience" - Elbert Hubbard

Abraham Flexner does not work for the ACGME. He is not even alive at the present time. However, in this more lighthearted column by the editor of the *Bulletin*, which will appear occasionally, and address issues in some manner related to residency education and/or accreditation, it is possible to speculate a bit about his thoughts on the use of the six general competencies in the accreditation of residency education programs.

Flexner is best known as the author of the "Flexner Report" (the little-used official name of the document is "Medical Education in the United States and Canada"), which was commissioned by the Carnegie Foundation for the Advancement of Teaching as a comprehensive report on the quality of undergraduate medical education. It was released in 1910. Its author was a non-physician and the former director of a secondary school. To collect the information for the report, Flexner site visited all medical schools in operation at the time, which included a great many more than would ultimately remain in operation following the report's publication.

The six general competencies of the ACGME, which were endorsed by the Council at its February 1999 meeting, are: patient care, medical knowledge, interpersonal skills and communication, professionalism, practice-based learning and improvement, and systems-based practice. It may appear incongruous to compare Flexner's treatise on undergraduate medical education with concepts used in the accreditation of residency education. My justification is based on one argument: the six competencies as a means of measuring whether education is occurring/has occurred have implications for the continuum of medical education, not just graduate medical education. In addition, it could be stated that in 1910, the medical education community was just beginning to explore the processes for physician education following graduation from medical school, and a number of concepts articulated in Flexner's report can be applied to graduate medical education.

Before we begin to try and connect Flexner's work and the six general competencies, it probably pays to focus on the two principal recommendations have been identified with the report and have given rise to the adjective 'flexnerian.' They are (1) placing emphasis on the basic sciences in medical education, and (2) requiring that medical schools function as or within "full-service" university institutions, staffed by full-time clinical faculty, who devote themselves to research, teaching and patient care. Critics of the report have argued that it was evidence of collusion among the scientific community, allopathic medicine, and organized philanthropy, and an effort to force a minority view of the superiority of university-based medical education on the discipline. More likely, a major intent, and the virtually immediate result of the report's publication, was to bring about the closing of a large number of proprietary medical schools operating with marginal faculties and solely intent on profit-making. Some 'university-based' schools were also found to be educationally deficient, but the report painted such a convincing picture of the benefits of change, that another arm of the Rockefeller philanthropic enterprise (the General Education Board) supported the adoption of Flexner's concepts by investing more than \$100 million. This may not appear much, but in today's dollars it would amount to a sum of approximately \$1.5 billion.

Of the six general competencies, two are explicitly discussed in Flexner's report: medical and scientific knowledge and patient care. Flexner clearly believed in education in the basic and clinical sciences. His report lauded schools that taught pathology and physiology. Interestingly, he did not place a high value on the teaching of pharmacology. The reason may have been that the medical profession as a whole, and the proprietary medical schools his report considered inferior, in particular, were involved in advertising and prescribing a large variety of "patent medicines" of unknown value and occasionally considerable dangerousness. These were marketed and used for a wide range of complaints. The explosion of pharmaceutical compounds with a true therapeutic value was still some years in the future, and following the purging of the patent remedies, the formulary available to practitioners in the early 20th century was quite limited.

Two additional general competencies – interpersonal skills and communication, and professionalism – received more than passing interest from Flexner. To wit, an excerpt from the 1910 report:

The practitioner deals with facts of two categories. Chemistry, physics, biology, enable him to apprehend one set; he needs a different apperceptive and appreciative apparatus to deal with the other, more subtle elements. Specific preparation in this direction is more difficult; one must rely for the requisite insight and sympathy on a varied and enlarging cultural experience. Such enlargement of the physician's horizon is otherwise important, for scientific progress has greatly modified his ethical responsibility. It goes without saying, that this type of doctor is first of all an educated man.

*(Medical Education in the United States and Canada. A Report to the Carnegie Foundation for the Advancement of Teaching, 1910)*

While one may quibble with the dated language, and the perception of the physician as exclusively male (at a time when there were female physicians and medical students), the concepts of professionalism, ethics, communication and compassion are present in this passage, albeit vaguely stated. Some 90 years after the publication of the report, the recommendation for 'medical humanism,' which incorporates these concepts, is still difficult to articulate and implementation is by no means complete. Despite being bound by the scientific understanding of his day, Flexner also could foresee some glimpse of the extraordinary growth in science, technology and medical knowledge that would occur in the remainder of the century. In his later writings, he alluded to the moral complexities that would eventually result from these advances in science:

.....the more vigorously science is prosecuted, the more acute the need that society be held accountable for the purposes to which larger knowledge and experience are turned. Philosophers and critics, therefore, gain in importance as science makes life more complex – more rational in some ways, more irrational in others. *(Medical Education: A Comparative Study, 1925)*

A related statement by Flexner on the need to include humanism was cited by Edmund Pellegrino, MD, when he, on the occasion of the 75th anniversary of the publication of the report, reflected on the yet uncompleted task of how reconcile technology and humanism in medical education: "But scientific medicine in America – young, vigorous, and positivistic – is today sadly deficient in cultural and philosophic background." In the same article, Pellegrino commented that Flexner's belief that the humanities must be in a dialogue with the sciences was another reason for his recommendation of locating undergraduate medical education within the university.

What would Flexner have thought of practice-based learning and improvement, and systems-based practice? Well, it may help to go from what is known about his famous report to what we know about Abraham Flexner himself. His background was in psychology, and his educational philosophy placed a high value on learning by observing and doing. While he advocated a broad-based humanistic education, he also thought that education should be "utilitarian and should prepare the individual for the responsibilities of citizenship and for an occupation or a profession." The concept of physicians learning from reflecting on their practice could have appealed to him. In considering his potential views on systems-based practice, we need to note that he clearly alluded to the role of the medical faculty in studying problems in a comparison report on Universities in three nations, published in 1930. In a passage from this report, cited below, one also gets the sense that Flexner would have enjoyed participating in the current debate about the conflicting demands placed on clinical faculty in teaching institutions. Given his much mentioned outspokenness and verbal skills, he would have been interesting to have as a participant. Perhaps unfortunately, save for the quotes from his work, this short piece is merely a medical education fantasy. Here is the excerpt that deals with the role of the faculty in maintaining both a systems and an academic focus:

The professor of medicine ought to be thoroughly humane, realizing fully that he is dealing with, and in that sense responsible for, human life. But the professor of medicine is primarily a student of problems and a trainer of men. He has not the slightest obligation to look after as many people as he can; on the contrary the moment he regards his task as that of caring for more and more of the sick, he will cease to discharge his duty to the university – his duty to study problems, to keep abreast of literature, to make his own contributions to sciences, to train men who can 'carry on.' *(Universities: American, English, German, 1930)*

#### Sources:

Ebert RH. Flexner's model and the future of medical education. *Academic Medicine* Nov; 67(11):737-742, 1992.

King DJ. The psychological training of Abraham Flexner, the reformer of medical education. *Journal of Psychology* Sep;100:131-137, 1978.

Pellegrino ED. The reconciliation of technology and humanism: A flexnerian task 75 years later; in *Flexner: 75 years later. A current commentary on Medical Education*, 1985, University Press of America.



## ACGME Field Staff News


*New Field Representative - Mhairi Graham MacDonald, MbChB., FRCP(E), DCH*

Dr. Mhairi MacDonald joined the ACGME field staff in April of this year and is currently being oriented to her site surveyor role. Mr. MacDonald completed pre-medical and undergraduate medical education at Edinburgh University, where she graduated with a M.B.Ch.B. She trained in pediatrics at Western General Hospital, the Royal Infirmary, and the Hospital for Sick Children, all in Edinburgh, Scotland, followed by training as a registrar in General Pediatrics and Neonatology at the Hospital for Sick Children and at Victoria Hospital in Kirkcaldy, Scotland.

Dr. MacDonald completed additional training in pediatrics and neonatology in the United States, both at Johns Hopkins University and at Capital Regional Perinatal Center in Albany, New York. She was an Associate Professor and Professor in Pediatrics at George Washington University School of Medicine and

Health Sciences, and served as attending neonatologist at Children's National Medical. She most recently was the Director of Neonatology at Loudoun Hospital Center, Leesburg, Virginia, and has also held a number of research appointments. Dr. MacDonald will survey programs on a part-time basis. She lives in a suburb of Washington, DC.

### Other Changes

In March, E. Lee Taylor, MD, resigned from the ACGME field staff. Dr. Taylor, a family practitioner, had joined the field staff in January 1999. In addition, at the end of January, Dr. L. Newton Turk, III, MD, officially announced his retirement. Dr. Turk surveyed programs for the ACGME for more than eleven years. We will miss him on the field staff, but are delighted to announce that he has joined Dr. Charles Fagan and Dr. William Staples on the roster of the "ACGME Field Staff Reserves." Field staff reservists, who are experienced site surveyors, are available to occasionally review programs, and also replace site surveyors who are ill or for another reason unable to do assigned surveys. 



**The ACGME Field Staff, 2000.**

From left to right, seated: James Shanley, DMD, Joan Manganello, EdD, Marianne Gideon, PhD, Deborah Jones, PhD, Barbara Bush, PhD, Ingrid Philibert, Susan Trimble, MD, David Leach, MD. Standing: Nathan Blank, MD, Charles Fagan, MD, Charles Joslyn, PhD, Joseph Campisano, PhD, David Schramm, PhD, Darnell Jones, MD, Donald Lackey, MD, Jimmy Simon, MD, L. Newton Turk, MD, Terry Myers, MD, PhD, Christopher Pack, PhD, John Beernink, MD, John Caughron, MD. Not shown: Mhairi MacDonald, MbChB, William Staples, MD.

## RRC Meeting Dates for the Remainder of 2000 and 2001

*Please note that for most RRCs, the deadline for programs to be assigned for review is approximately 90 days prior to the RRC meeting date.*

### **Meeting Dates for 2000**

4/28 Nuclear Medicine  
4/28-29 Psychiatry  
5/4-5 Plastic Surgery  
5/22-24 Family Practice  
6/1-2 Urology  
6/1-3 Obstetrics/Gynecology  
6/2-5 Internal Medicine  
6/16-17 Ophthalmology  
6/16-17 Neurological Surgery  
6/22-23 General Surgery  
6/25-26 Orthopaedic Surgery  
7/14-15 Thoracic Surgery  
7/14-16 Internal Medicine  
8/4-5 Otolaryngology  
8/25-26 Physical Medicine & Rehabilitation  
8/28-29 Radiation Oncology  
9/8-11 Internal Medicine  
9/11-13 Family Practice  
9/12-13 Radiation Oncology  
9/18 Medical Genetics  
9/22 Colon & Rectal Surgery  
9/22-23 Allergy & Immunology  
9/22-24 Emergency Medicine  
9/28-29 Transitional Year  
10/3-6 Diagnostic Radiology  
10/5-6 Preventive Medicine  
10/5-7 Obstetrics/Gynecology  
10/6-7 Pathology  
10/12-13 General Surgery  
10/15-18 Pediatrics  
10/18-19 Institutional Review  
10/20-21 Psychiatry  
10/29 Dermatology  
11/2 Nuclear Medicine  
11/2-3 Plastic Surgery  
11/8-10 Anesthesiology  
11/16-17 Neurology  
11/30-12/1 Urology  
12/8-9 Ophthalmology

### **Meeting Dates for 2001**

1/11-13 Obstetrics/Gynecology  
1/11-13 Orthopaedic Surgery  
1/12-13 Neurological Surgery  
1/12-13 Thoracic Surgery  
1/26-29 Internal Medicine  
1/29-31 Family Practice  
2/2-4 Emergency Medicine  
2/16-17 Physical Medicine & Rehabilitation  
2/22-23 General Surgery  
3/7-10 Diagnostic Radiology  
3/13-14 Radiation Oncology  
3/23-24 Preventive Medicine  
4/1-4 Pediatrics  
4/5-6 Neurology  
4/12-14 Anesthesiology  
4/18-10 Institutional Review  
4/20-21 Psychiatry  
4/20-21 Transitional Year  
4/27 Nuclear Medicine  
5/21-23 Family Practice  
5/31-6/2 Obstetrics/Gynecology  
6/1-4 Internal Medicine  
6/21-22 General Surgery  
6/29-30 Neurological Surgery  
7/13-15 Internal Medicine  
9/23-25 Family Practice  
10/3-6 Diagnostic Radiology  
10/4-5 Preventive Medicine  
10/11-14 Pediatrics  
10/17-18 Institutional Review  
10/19-20 Psychiatry  
10/25-26 General Surgery  
11/2 Nuclear Medicine  
11/8-10 Anesthesiology  
11/9-10 Transitional Year  
11/15-16 Neurology



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### **Change of Address:**

Requests for a change of address should be sent to the editor at the address given above. Please include a copy of the mailing label from the most recent copy of the ACGME Bulletin along with your new address.

