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ACGME e-Bulletin

ACGME

Accreditation Council for Graduate Medical Education

The ACGME e-Bulletin is published several times per year by the ACGME and distributed to individuals in residency education. It is also available from the ACGME Web site at http://www.acgme.org/acWebsite/bulletin-e/ebu_index.asp

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OPINION PIECE

The Continuum of General Competency

William W. Robertson, Jr., MD

The Problem

One of my non-ACGME roles includes serving as an instructor for the Physician-Patient Communication Course that was jointly developed by the former Bayer Institute for Health Care Communications and the American Academy of Orthopaedic Surgeons. After participating, orthopaedic surgery residency program directors frequently say, "Much of this course is too rudimentary."

I agree. The program director of any core residency program should not be required to teach residents to take a history from a presenting patient and to present that information, in oral or written form, in an ordered, cohesive, and logical manner. These skills are ones for which the physician-in-training should have demonstrated competence well before the end of medical school.

The development of competence is a continuum. For communication skills, this process begins in the ubiquitous "Introduction to Clinical Medicine" course in medical school. The skill is honed through the various clinical clerkships until the medical student has mastered the general history-taking process for a wide variety of patients and diagnoses.

Specialty training should concentrate on the aspects of history-taking that are unique to that specialty or circumstances prevalent in the patient population. The necessary communication skills vary considerably from specialty to specialty. Pediatricians must be able to obtain histories from children or their parents. Psychiatrists must be able to take histories that are much more involved and go into areas that are not required for the cardiac surgeon. The communication skills required of pathologists and radiologists are most important in the areas of transferring information, both oral and written, to consulting physicians and/or for legal purposes. Two other communication skills are appropriate for mastering during the residency program because residents have a greater level of patient care responsibility than medical students: sharing "bad news" and obtaining informed consent (particularly for the procedural specialties).

While all residents should be able effectively to communicate cases in their specialty as well as teach medical students and other learners, program directors of subspecialty fellowships should not be required to teach their fellows the skills of taking a basic history. It is important that the fellows learn highly specialized areas that would yield information in complex cases and be able to communicate effectively in the role of a consultant in dealing with referring physicians. Fellows must also demonstrate competence in disseminating information in a scholarly manner in presentations and the scientific literature.

Just as specific communication skills are appropriately taught at specific points along the continuum of medical education, so too are skills for each of the general competency areas. *Table 1* suggests a beginning for this stratification. In the realm of continuing medical education the appropriate skills are those of keeping up with advances in medical knowledge, techniques, and technologies that were not available during the physician's medical school, residency, and fellowship training.

Implementing the Solution

While the ACGME has no control over the teaching and evaluation of competency areas in medical school or continuing medical education, a dialogue should be opened between the LCME, the AAMC, the ABMS, the ACCME, and the ACGME to identify competency areas that are appropriate for the various levels of medical education.

In the meantime, an appropriate first step could be for the RRCs to identify tools that programs might use to determine the competency of residents upon entry into graduate medical education. Another task appropriate for the RRCs would be the identification of competency areas that should be mastered during residency and fellowship, to ensure that residents and fellows are educated and evaluated at the appropriate level for their knowledge and experience. ■

Table 1

Matrix for Teaching Competency-based Skills

Competency	Medical School	Core Residency	Fellowship
Medical Knowledge	Basic science and clinical science underlying common diseases	Basic science and clinical science underlying diseases common to the specialty	Basic science and clinical science underlying less common diseases in subspecialty
	Use of basic diagnostic modalities (laboratory, imaging)	Use and interpretation of diagnostic tests relevant to specialty area	Advanced technical skills for subspecialty
Clinical Skills	Basic physical examination	Physical exam directed to specialty area	Advanced technical skills for subspecialty
	Use of basic tools (otoscope, ophthalmoscope, stethoscope, etc.)	Safe use of specialty tools and instruments	
	Basic procedural skills (e.g., phlebotomy, intubation)	Technical skills for specialty	
	Basic Life Support Certification	ACLS certification	
Professionalism	Punctuality	Responsibility	Mentoring skills
	Appropriateness of dress	Advanced directives	Role modeling
	Reliability	Risk management	Ethical decision-making
	Veracity	Ethical behavior	
	Need to admit mistakes		
	Appropriate record keeping	Relevant cultural issues	
	Awareness of cultural issues	Physician impairment (especially in higher risk specialties)	
	Physician impairment		

Table 1 (continued)
Matrix for Teaching Competency-based Skills

Competency	Medical School	Core Residency	Fellowship
Systems-based Practice	Functioning within patient care team	Cost-effectiveness	Administrative skills for subspecialty practice
		Leading patient care team	
	Basics of health care policy and law	Coding	
		Maintenance of Procedure Log	
		Health care policy related to specialty area	
		Administrative skills for specialty practice	
Practice-based Learning and Improvement	Basics of research design, hypothesis testing, statistics, epidemiology	Analysis of published material	Setting standards of practice through publications and presentations
		Application of new material to practice specialty	
	Medical informatics and decision making skills	Analysis of changes in practice	
Interpersonal and Communication Skills	General history-taking for a wide variety of diseases	Relating "bad news"	Teaching all level residents in and outside specialty
		Obtaining informed consent	
	Orderly presentation of History & Physical to supervising residents and attending physicians	Teaching medical students and junior residents	Disseminating information in a scholarly manner in nations presentations and in the scientific literature
		Presentation of information to consultants, referring physicians, and colleagues	

William W. Robertson, Jr., MD is an Accreditation Field Representative for the ACGME, and a Pediatric Orthopaedic surgeon with extensive academic practice experience.

Number of Subspecialties Requiring Information on the Teaching and Evaluation of the Competencies Grows

As the implementation of the six general competencies nears Phase 3, which will begin in July 2006, a growing number of accredited subspecialties require information on the application of the competencies in the education and evaluation of residents. *Exhibit 1* below shows the subspecialties that currently require completion of the data collection form for the competencies (the Competencies and Assessment Form or CAF), and those that plan to require it in the coming months. Programs in specialties that require completion of the CAF can obtain this document from the Accreditation Data System (ADS).

As part of a larger effort to advance the use of the competencies in the accreditation of residency programs, the ACGME is working to update and refine the data collection form for the competencies. The new data collection tool is expected to be released in the next 12 months. ■

Exhibit 1

Specialties and Subspecialties Requiring Completion of the CAF

Specialty/Subspecialty	Specialty Codes	Completion of CAF Required	Date CAF will be required
Allergy & Immunology	# 020	Yes	
Anesthesiology	# 040	Yes	
Anesthesiology Subspecialties	# 041-48	No	
Colon and Rectal Surgery	# 060	Yes	
Dermatology	# 080	Yes	
Procedural Dermatology	# 081	No	
Dermatopathology	# 100	No	
Emergency Medicine	# 110	Yes	
EM Subspecialties	# 114-119	No	
Family Practice	# 120	Yes	
FP Subspecialties	# 125-127	**Pending**	**7/1/2006**
Internal Medicine	# 140	Yes	
IM Subspecialties	# 141-157	Yes	
Medical Genetics	# 130	Yes	
Molecular Genetic Pathology	# 190	No	
Neurological Surgery	# 160	Yes	
Neurology	# 180	Yes	
Neurology Subspecialties	# 181-88	Yes	**1/1/2006**
Neurodevelopment Disabilities	# 186	Yes	
Nuclear Medicine	# 200	Yes	
Obstetrics–Gynecology	# 220	Yes	
Ophthalmology	# 240	Yes	
Orthopedic Surgery	# 260	Yes	
Orthopaedic Surgery Subspecialties	# 261-270	No	
Otolaryngology	# 280	Yes	
Neurotology	# 286	Yes	
Pediatric Otolaryngology	# 288	No	
Pathology–Anatomic and Clinical	# 300	Yes	
Pathology Subspecialties	# 301-316	No	
Pediatrics	# 320	Yes	
Pediatrics Subspecialties	# 321-336	**Planned**	**1/1/2007**
PM&R	# 340	Yes	
PM&R Subspecialties	# 341-345	No	

Exhibit 1 (continued)

Specialties and Subspecialties Requiring Completion of the CAF

Specialty/Subspecialty	Specialty Codes	Completion of CAF Required	Date CAF will be required
Plastic Surgery	# 360	Yes	
Plastic Subspecialties	# 361-363	No	
Preventive Medicine	# 380	Yes	
Preventive Subspecialties	# 398-399	Yes	
Psychiatry	# 400	Yes	
Child & Adolescent Psychiatry	# 405	Yes	
Psychiatry Subspecialties	# 401–407	No	
Radiation Oncology	# 430	Yes	
Radiology–Diagnostic	# 420	Yes	
Diagnostic Radiology Subspecialties	# 421-427	No	
Surgery	# 440	Yes	
Surgery Subspecialties	#442-446	No	
Vascular Surgery (Integrated Programs)	#450	**Pending**	**7/1/2006**
Vascular Surgery (Non-Integrated Programs)	#450	No	
Thoracic Surgery	# 460	Yes	
Thoracic Surgery Subspecialty	#466	No	
Urology	# 480	Yes	
Urology Subspecialties	# 485	No	
Transitional Year	# 999	Yes	
Sleep Medicine (Internal Med., Neurology, Otolaryngology, Pediatrics, Psychiatry)	# 520	No	

Core Specialties and Subspecialties requiring completion of information on the competencies.

ACGME Celebrates 2006 Parker Palmer Award Winners, Picker Institute Provides Inaugural Challenge Grants

At its February meeting, the ACGME held a reception and dinner for the ten recipients of the 2006 Parker J. Palmer "Courage to Teach" Award, the two recipients of the "Courage of Lead" Award and the recipient of the John C. Gienapp Award for 2005. The ACGME selected D. David Glass, MD, who chaired the subcommittee that oversaw the initial implementation of the ACGME's duty hour standards for residents in all accredited programs, to receive the Accreditation Council for Graduate Medical Education's John C. Gienapp Award. The award recognizes individuals for their outstanding contribution to graduate medical education. It is named after the ACGME's first executive director, John C. Gienapp, PhD.

The Courage to Teach Award recognizes program directors that have made a profound contribution to the education of residents. This the fifth time the Parker Palmer Award has been presented. The recipients are shown below:

- **Steven Cohen, MD,** Mount Sinai, New York, Dermatology
- **Deborah Cowley, MD,** University of Washington, Psychiatry
- **Karen Deveney, MD,** Oregon Health and Sciences University, General Surgery
- **Jehan El-Bayoumi, MD,** Program Director for Internal Medicine, George Washington University
- **Ralph Greco, MD,** Stanford Hospitals and Clinics, General Surgery
- **Kirk Keegan, MD,** University of California, Irvine, Obstetrics-Gynecology
- **Dorothy Lane, MD,** Stony Brook University, Preventive Medicine
- **Shahla Masood, MD,** University of Florida, Jacksonville, Pathology
- **Kemuel Philbrick, MD,** Mayo, Psychiatry
- **Volker Sonntag, MD,** Barrow Institute for Neurological Surgery, Neurosurgery

The Courage to Lead Award, which was presented for the first time, honors designated institutional officials (DIOs) who have demonstrated excellence in overseeing residency programs at their sponsoring institutions. DIOs have authority and responsibility for all graduate medical education programs in a teaching hospital, community hospital or other type of institution that sponsors residency programs. The first recipients of the Courage to Lead Award were **Pamela Boyers, PhD,** Riverside Methodist Hospital, Columbus, Ohio, and **Rosemarie Fisher,** MD, Yale-New Haven Medical Center, New Haven, Connecticut.

Five current and past recipients of Courage to Teach and Lead Awards received inaugural Challenge Grants from the Picker Institute for a research project in medical education and/or patient centered care. The Picker Institute conducts measurement with the goal of improving the health care experience for patients, and sponsors research and education in the field of patient-centered care. The following awardees received inaugural Challenge Grants:

- **Pamela J. Boyers, PhD,** Designated Institutional Official, Riverside Methodist Hospital
- **William H. Hester, MD,** Program Director in Family Medicine, McLeod Health
- **Kirk A. Keegan, Jr, MD,** Program Director in Obstetrics and Gynecology, University of California at Irvine Medical Center
- **Anthony A. Meyer, MD,** Program Director in Surgery, University of North Carolina at Chapel Hill
- **John L. Tarpley, MD,** Program Director in Surgery, Vanderbilt University ■

Dependent and Independent Subspecialties: Know the Difference

Most program directors and staff know that a residency program can be: 1) a core program (leading to initial board certification); 2) a Transitional Year Program (a one-year experience in multiple clinical disciplines to prepare residents for entry into clinical specialties at the second post-graduate year); 3) an independent subspecialty (for which entry requires completion of a core residency, but which can be a stand-alone program); or 4) a dependent subspecialty (which requires completion of a core program prior to entry, and must be operated in conjunction with a core residency program in that specialty).

For programs in an independent subspecialty, it is not required that the sponsor operates a program in the associated core specialty, and the program may be the only ACGME accredited program under the given sponsor. In contrast, a dependent subspecialty program must be under the same sponsoring institution. The only exception is that some pediatric subspecialties of adult core specialties (such as anesthesiology and radiology) may be sponsored by a children's hospital that operates under common ownership or in a close relationship with the institution sponsoring the core program. The accreditation of all dependent subspecialty programs is dependent on the continued accreditation of its core program.

Specialties with Dependent Subspecialties

Anesthesiology
Emergency Medicine
Family Medicine
Internal Medicine
Neurology (except child Neurology)
Otolaryngology
Radiology–Diagnostic
Pediatrics
Physical Medicine and Rehabilitation
Plastic Surgery
Psychiatry (except Child and Adolescent Psychiatry)
Preventive Medicine
Thoracic Surgery (beginning July 2006)
Urology

Specialties with Independent Subspecialties

Dermatology
Neurology (Child Neurology)
Orthopaedic Surgery
Pathology
Psychiatry (Child and Adolescent Psychiatry)
Surgery–General

Specialties without Subspecialties
Allergy and Immunology
Colon and Rectal Surgery
Medical Genetics
Neurological Surgery
Nuclear Medicine
Obstetrics/Gynecology (subspecialties are accredited by ABOG, not ACGME)
Ophthalmology
Radiation Oncology
Transitional Year ■

ACGME Publishes Responses to Frequently Asked Questions (FAQs) about the Accreditation of New Programs and Related Matters

The ACGME has just released a set of succinct responses to frequently asked questions regarding the process of new program accreditation, program merger, and transfers of sponsorship. The document offers general information and practical advice, including detailed information about how the accreditation of new programs affects the sponsoring institution. Topics covered include: 1) practical pointers for the application process; 2) information about the steps and timeline for new program accreditation; 3) accreditation status codes for new programs; 4) institutional considerations arising from the accreditation of new programs under a given sponsoring institution; and 5) practical advice for program mergers and transfers of sponsorship among different sponsoring institutions. The document can be found on the ACGME's web site at http://www.acgme.org/acWebsite/fieldStaff/fs_faq.pdf ■

New FAQ Clarifies Expectations for Institutional Affiliation Agreements and Program Level Letters of Agreement

In February, the ACGME released on its web site answers to frequently asked questions (FAQ) about letters of agreement (http://www.acgme.org/acWebsite/about/ab_FAQAgreement02_07_06.pdf). The document highlights the differences between the master institutional affiliation agreements that govern the relationship between a sponsoring institution and all major participating institutions and the letters of agreement individual residency programs are expected to have with all sites used in the education of residents. Program-level agreements define expectations in four areas: 1) the teaching faculty; 2) the faculty's responsibilities for teaching and supervision; 3) the duration and content of the educational experience; and 4) the policies and procedures for the rotation.

The FAQ also includes topics that were the subject of prior questions from programs and sponsoring institutions. One such question was whether national education courses taken by some residents, such as the Armed Forces Institute of Pathology course or the Bellevue Hospital Toxicology Course, require affiliation agreements (they do not). Another inquiry was whether master affiliation agreements program level letters are required when institutions operate under joint governance (they are required unless the institutions operate under true joint governance). An exhibit included with the FAQ shows RRC-specific requirements for program-level letters of agreement. ■

Highlights from the ACGME 2006 Educational Conference

From March 2 to 5, 2006, the ACGME held its 2006 Annual Educational Conference at the Gaylord Palms Resort and Conference Center in Kissimmee, FL. The conference included a dedicated day-long patient safety workshop, and nearly 60 sessions of interest to program directors, program coordinators, and DIOs. Among the sessions were "Opening Good Conversations about Bad Outcomes" and "Team Training (Crew Resource Management) for Patient Safety in Resident Education," which are summarized below.

Opening Good Conversations about Bad Outcomes

Sometimes, despite the best efforts of everyone involved, things go wrong in medicine or mistakes are made. Talking to patients about bad outcomes, whether from a medical error or not, is difficult for many physicians because "We don't always know how to have these conversations," noted David C. Leach, MD, Executive Director of the ACGME, who moderated the conference session on discussing bad outcomes with patients.

Dr. Leach introduced Allison Clay, MD, an assistant professor in critical care medicine at Duke University Medical Center in Durham, NC. Dr. Clay described how a series of medical errors stretched a trip to the emergency room to treat an allergic reaction after a bee sting into a week-long hospital stay.

Following Dr. Clay's talk, the participants broke into small groups where they shared stories about times when they had to break news of medical errors or bad outcomes to patients and discussed how they felt about those conversations.

Dr. Leach then played a videotape produced by Thomas Gallagher, MD, an assistant professor of medicine at the University of Washington. The videotape shows a conversation between a physician and patient following an error in a dosage of insulin that illustrates how such a conversation can quickly go awry. The video, noted Dr. Leach, highlights the importance of having "structured internal conversations" among health care professionals to figure out how a mistake occurred before having a conversation with the patient. The conversation with the patient, he said, should include a "clean, simple, truthful explanation, an apology, and a statement that this error will be prevented in the future."

In closing the session, Dr. Leach noted that "good conversations create a space where obedience to truth is practiced."

Team Training (Crew Resource Management) for Patient Safety in Resident Education

Benjamin P. Sachs, MD, chief of Obstetrics and Gynecology at Beth Israel Deaconess Medical Center, Boston, opened the session on team training for patient safety with a video produced by the Harvard Risk Management Foundation, the malpractice insurer for teaching hospitals affiliated with Harvard

Medical School. The video was a composite dramatic reenactment of two separate incidents in Obstetrics and Gynecology that resulted in malpractice lawsuits. In the video, a couple that speaks poor English struggles to communicate with busy, distracted physicians and nurses, while the physicians and nurses bicker among themselves and blame one another for mistakes. Both the mother and baby are placed at grave risk as a result of a series of medical errors and miscommunications.

Following the video, Dr. Sachs led the group in a discussion of the case. Participants commented that a lack of communication and teamwork among staff, conflict among health care team members, work overload, and a failure among staff to challenge questionable decisions by others contributed to the errors.

Dr. Sachs then discussed a team training program that was introduced in the Obstetrics/Gynecology Department at Beth Israel Deaconess in 2002. Elements of the team training include: 1) identification of core teams of obstetricians, anesthesiologists, and nurses who work closely together on cases; 2) frequent team meetings; 3) a work environment in which team members are encouraged to question and check decisions made by other team members. The program also includes contingency teams trained to respond rapidly to emergencies, as well as a coordinating team that manages scheduling.

The program appears to be reducing the number of lawsuits. Between 1999 and 2002, the Beth Israel Deaconess Obstetrics/Gynecology Department had seven malpractice claims and lawsuits, compared with two between 2002 and 2005, said Dr. Sachs. The number of high severity claims dropped from five to one during that same period. Dr. Sachs indicated that while there was some initial resistance from some doctors to the team training approach, it is now viewed quite positively. Dr. Sachs noted that it is better if physicians are taught the principles of team training while they are still in the process of becoming doctors. "It has to start with medical students and it has to be multidisciplinary," said Dr. Sachs. ■

ACGME Releases DVD on How to Share News about Medical Errors, Bad Outcomes

Julie Jacob

Breaking the news of bad outcomes or medical errors to patients and their families is one of the hardest situations that physicians must face. What makes these scenarios even harder is that medical students and residents are in many cases not taught how to tackle conversations that may be uncomfortable, yet are necessary.

The ACGME has created a DVD that may help program directors and residents begin a discussion of how to approach these dialogues with patients and their families. The DVD, called "Disclosure of Medical Errors to Patients," is an interview between ACGME Executive Director David C. Leach, MD, and the Dean and CEO of John Hopkins Medicine, Edward Miller, MD. The two physicians talk about the times when physicians must discuss bad outcomes or medical errors to patients; why these conversations are difficult for physicians; why they are important for physicians, patients, and their families; and how residents can learn to heal from situations in which they make a medical error or have a bad patient outcome. Dr. Miller also discusses how John Hopkins developed its medical error disclosures policy following the death of a two-year-old at the hospital that resulted from a medical error.

To request a copy of "Disclosure of Medical Errors to Patients," contact Julie Jacob, Manager of Communications, at juliej@acgme.org. ■

Winning Posters from the 2006 Marvin Dunn Poster Session at the ACGME Educational Conference

The 2006 Marvin R. Dunn Poster Session at the ACGME Educational Conference, named in honor of Dr. Dunn, the late Director of RRC Activities, included more than 50 posters on a wide range of topics in graduate medical education and the application of the competencies. This issue of the ACGM e-Bulletin includes the abstracts for the winning posters and the three judges' awards. The abstracts highlight the quality and variety of the posters shown at the session.

FIRST PLACE

Implementation of a Multi-Rater Competency-Based Videotape Evaluation Process

Karla Hemesath, PhD, Mark Gennis, MD, Anthony Otters, MD, Department of Internal Medicine, University of Wisconsin Medical School and the Aurora Internal Medicine Residency Program, Milwaukee, WI.

Purpose: The purpose of this project was to implement a multi-rater evaluation of resident communication and interview skills in a videotaped clinic encounter. As we move toward complete competency assessment, evaluation methods must be based on observational data.

Method: Videotaped resident clinic encounters were reviewed in a group consisting of 2–3 members of Internal Medicine Residency Competency committee and the resident. The tool used for the faculty and resident assessment of the clinic visits is a 30-item checklist of behaviors essential for an ambulatory visit and is referenced to specific competencies in patient care, medical knowledge, professionalism, and communication skills.[1]

Results: Fourteen tape reviews were conducted and we are analyzing the data from these reviews to assess: 1) level of agreement between faculty raters; 2) congruence between resident self-assessment and faculty assessment of performance; and 3) relationships between this data to and other evaluation data.

Conclusions: The tape reviews provided excellent formative performance feedback. As we continue to modify the assessment tool we will be able to use this process as a summative assessment of resident skills and to investigate relationships between this data and to patient outcomes and other evaluation data. We plan to develop a process similar to that of Dyche and Swiderski[2] to link assessment data to patient feedback.

[1] *Hemesath, K., Gennis, M., Otters, A. Development of a Competency-Based Video Review Checklist. Accreditation Council for Graduate Medical Education Annual Conference. Kissimmee, FL. March 2005.*

[2] *Dyche, L., Swiderski, D. (2005). The effect of physician solicitation approaches on ability to identify patient concerns. JGIM, 20, 267-270.*

SECOND PLACE

A Graduate Medical Education Initiative to Promote Professional Excellence among Residency Program Coordinators

Ann Norwood, Elizabeth Hicks, Carol Thrush, Majka Woods, Jim Clardy, University of Arkansas for Medical Sciences College of Medicine and Office of Educational Development, Little Rock, AR

Purpose: As the administrative, managerial, clerical, and educational roles of residency program coordinators (PCs) become more complex,[1] it is imperative that graduate medical education programs begin to assess and understand this change. To support its PCs, the College of Medicine at the University of Arkansas for Medical Sciences sponsors a PC-run Program Coordinators' Organization (PCO) for all residency and fellowship program coordinators. The PCO is designed to facilitate networking among PCs, promote excellence in the administration of residency and fellowship programs, and provide educational opportunities in graduate medical education program administration. The PCO provides a forum for positive collaboration among PCs who often are unsure of their actual job descriptions and of where to turn for guidance.[2] This exploratory study was conducted as a quality assurance activity to learn more about PCs' perceptions of the PCO.

Methods: A literature review of attendance barriers and residency program coordinators was conducted to inform construction of survey items. The research team developed a 23-item survey to assess PCs' perceptions of the PCO, barriers that prevent PCs from attending PCO meetings, and the perceived impact of the PCO on graduate medical education and on the PCs' professional development. IRB approval has been obtained and the survey will be administered in a paper-and-pencil format at the January 2006 PCO meeting, with the survey sent by email to PCs who are unable to attend.

Results: A summary of the survey results and implications will be presented in detail, including descriptive statistics. Qualitative data will be used to supplement the descriptive results.

Conclusions: This study will share lessons learned about implementing and sustaining a Residency Program Coordinators organization at our institution. Since there is national interest in PCs' professional development,[3] we anticipate these results will be of interest to academic medical centers.

[1] *Collins, J. (2005). Importance of the radiology program coordinator. Academic Radiology, 12(8), 1033-1038.*

[2] *Cook, J., Ebnet, C., Enger, T., Merten, M., and Rink, G. Residency Coordinators' Network. Presented at the Mastering the Accreditation Process workshop. March 2–3, 2000, Chicago, IL.*

[3] *Training Administrators of Graduate Medical Education (TAGME) website. Retrieved 12/14/05 from http://www.tagme.org/*

THIRD PLACE

General Surgery Morning Report: A Competency-Based Conference that Enhances Patient Care and Resident Education

Brendon M. Stiles, T. Brett Reece, Traci L. Hedrick, Robert A. Garwood, Michael G. Hughes, Joseph J. Dubose, Hilary A. Sanfey, Reid B. Adams, Bruce D. Schirmer, Robert G. Sawyer, University of Virginia, Charlottesville, VA

Purpose: Our residency program initiated a daily morning report (MR) to discuss new consults and admissions. This is attended by all residents and students on the general surgery, transplant, and trauma services. While initially developed to facilitate transfer of patient information, we hypothesize that MR now also serves as a core competency-based resident education tool.

Method: An anonymous survey was distributed to residents (n=25). Questions were asked on a 5-point Likert scale regarding the value of the current MR, how it addresses the core competencies, and how it could be improved with regard to patient care and resident education. Respondents also ranked conferences (MR, morbidity and mortality, grand rounds, and specialty conferences) in terms of educational benefit derived.

Results: The majority of residents agreed that MR is an efficient method to sign out patient care (84%), that it provides an excellent educational experience (88%), and that it is presented in an evidence-based format (88%). Regarding the core competencies, residents all asserted that MR addresses “Patient care” (100%) and “Medical knowledge” (100%). Most agreed that it addresses “Professionalism” (60%), “Interpersonal skills and communication” (76%), and “Practice-based learning and improvement” (92%). The four most important components identified with respect to both patient care and resident education were the presence of the on-call attending, a review of relevant radiology, provision of follow-up on select cases, and critical review of the literature. MR was regarded as our most educational conference, with 52% of residents ranking it first.

Conclusions: While MR is ubiquitous in primary care residency programs, such a conference has not typically been held on surgical services. Our MR conference has become an excellent tool for resident education, in addition to enhancing patient care. Importantly, we are also using MR to provide evidence of learning and assessment of the core competencies. This conference provides an example of how to tailor existing resident work sessions or conferences to meet ACGME competency requirements.

JUDGES AWARDS

A Systems-Based Practice Workshop for Interns

Arnold R. Eiser, MD, Joanne Connaugton, MD, Department of Medical Education, Mercy Catholic Medical Center and Drexel University College of Medicine, Philadelphia, PA

Purpose: Improve resident understanding of Systems-Based Practice and the non-physician perspectives on health care delivery

Methodology and Results: We developed, implemented, and analyzed a two-week Systems-Based Practice Workshop wherein medical interns experience care delivery from the perspective of non-physician health care perspectives including pharmacy, hospice, home health, utilization management, and the clinical laboratory. Each rotation has a preceptor in the designated area that mentors and certifies that the intern has successfully completed that portion of the rotation. Pre- and post-testing of the interns reveal that specific knowledge in each area increased.

Pharmacy: The proper techniques of drug level monitoring are better understood as well as renal dosing of medications and the role of the clinical pharmacist. Pharmacy-based patient safety initiatives are reviewed. Interns make home visits during both hospice and homecare rotations. From the hospice experience, the rules, policies, philosophy, goals, and objectives of hospice are learned along with its interdisciplinary nature. The intern attends the hospice interdisciplinary conference led by the hospice director. From the visiting nurse, interns become aware of home wound care, ostomy care, catheter management, home physical therapy, home antibiotics and LMW heparins, awareness of support groups, and the role of social work in homecare. The trainees learn insurance policies regarding home care and hospice care. Laboratory knowledge includes aspects of quality control, specimen integrity, culturing, and staining techniques. The utilization management experience reviews utilization criteria, length of stay standards for common DRGs as well as discharge planning. Survey results reflect a greater understanding of the policy and procedures of these other non-physician medical disciplines.

Conclusions: An interdisciplinary workshop as described above fills a void in understanding the non-physician disciplines and helps orient international and American medical school graduates to the American health care system.

Systems-Based Practice Projects in Anesthesia Education

Melissa Davidson, MD, Ellise Delphin, MD, MPH, Department of Anesthesiology, UMDNJ-New Jersey Medical School, Newark, NJ

Purpose: Systems-Based Practice (SBP) remains the most challenging competency to teach and learn. It is even more challenging in hospital based specialties with limited longitudinal patient care. We implemented an innovative method of teaching and learning SBP in our Department.

Method: Residents are required annually to complete one SBP project. All residents work in groups to enhance the concept of teamwork in the health care system. Teams begin by choosing an appropriate project topic from a group of categories that include access to anesthesia services, safety issues, medical economics, and administration. Projects start with background research, with emphasis on governmental

guidelines, local and regional standards, and institutional practice/policy. Residents then follow the process linearly, identifying enhancers and hindrances of the system, analyzing economic implications, and formulating next steps in system improvement. Projects are presented in a poster discussion session that is attended by faculty and residents. Posters detail a flow chart of the process followed and suggested improvements. An award is given by judges for the best project.

Results: The program has been in effect for two years. Learning is evidenced in the completion of the projects themselves, as well as in the impact they have had in the program. 5 of 15 projects have or will result in significant changes in departmental and/or hospital policy; 9 led to recommendations for improving existing systems; 5 included economic analysis leading to changes in standard department practice; 5 were used as teaching tools (examples–*Table 1*). Success is also measured in enthusiasm for the projects: 6 of 8 groups in year one chose topics from a provided list; by second year, 8 of 8 projects were independently chosen and developed or were continuations of previous year's projects.

Conclusion: Independent team projects provide a useful method for demonstrating competence in SBP in Anesthesiology.

Table 1

SBP Projects 2004–05

Project Name	Teaching Tool	Policy Change	Recommended Improvement in Existing Systems	Economic Analysis
"I am a Bag of Trash" – Guidelines for Medical Waste Management	x		x	x
The Approval Process of a University Hospital Standing Order Form			x	
Anesthesiology Coding and Billing System at UMDNJ	x			
Process Analysis of MRI Under Anesthesia		x	x	
OR Case Cancellation Charges and Billing	x		x	
Etomidate Usage and Utilization				x
Cost Effectiveness of Routine Daily Preparation of Atropine, Ephedrine, and Phenylephrine				x
Physician Credentialing at University Hospital, UMDNJ	x		x	

Incorporating Practice-Based Learning, Face-to-Face Feedback, and Objective Assessment of Interpersonal and Communication Skills in a Busy Ambulatory Teaching Clinic

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Purpose: We developed a teaching model in our "Bone Clinic" for Endocrinology fellows to stimulate self-directed learning, provide face-to-face feedback, and assess interpersonal and communications skills via direct observation.

Method: The teaching model was developed by a group of faculty educators. Educational aspects of the model include: 1) an initial session reviewing learning goals and expectations for the rotation; 2) structured teaching sessions based on fellows' self-directed learning; 3) face-to face feedback and review of goals for future learning and; 4) documentation of goals, learning resources used, and key learning points acquired during the rotation are kept in the fellows' portfolios for review quarterly with the program director. An objective checklist was also developed for faculty to directly observe and assess fellows' interpersonal and communication skills when counseling patients. Currently, observation is unstructured and use of the checklist will be implemented in February 2006. Fellows and faculty were surveyed on the teaching model's strengths and weaknesses.

Summary of Results: Trainees reported improved impetus for learning, were appreciative of the dedicated teaching time, valued the feedback provided after observation by staff, and requested that this pilot get rolled out in each of the teaching clinics. Faculty found it easier to provide face-to-face feedback when objectives and expectations had been discussed up-front and assessment was more objective based on direct observation. Barriers to implementation included cancellation of some of the planned sessions due to busy schedules, and fellows trying to accomplish more than was practically feasible during the rotation.

Conclusions: Incorporating structured education time into a busy ambulatory clinic may increase self-directed learning and quality of feedback provided to learners. Future studies will include evaluation of fellows' interpersonal and communication skills using an objective checklist.

In addition, the following posters received Honorable Mention by the Judges.

Redesigning the Morbidity and Mortality Conference — Integrating Clinical Practice, Quality Improvement, and the ACGME Competencies
Julie M. Stausmire MSN, CNS, APRN-BC, Mercy Family Medicine Residency and Transitional Year Programs, Toledo, OH

Cleveland Clinic Neurosurgery Resident Competency Assessment
Edward C. Benzel, MD, Connie Murphy, Deborah Benzil, MD, Cleveland Clinic, Cleveland, OH

Evaluating the Competencies: A Comprehensive, Longitudinal Approach
Timothy S. Meneely, DO, Director, Family Medicine Residency Program, Carle Foundation Hospital, Bharat Gopal MD, Associate Director, Family Medicine Residency Program Carle Foundation Hospital, Nancy F. Barrett, EdD, Education Specialist Family Medicine Residency Program, Carle Foundation Hospital, Urbana, IL

Extending the Boundaries of Procedural Competence: Getting Beyond Medical Knowledge and Patient Care in E-Learning
I. Rubinfeld, J.H. Paxton, H.M. Horst, P. Watson, S. Drake, D. Kwon, J. Butler, G. Gnamm, J. Jordan, A. Shepard, Henry Ford Hospital, Detroit, MI ■