

Accreditation Council for Graduate Medical Education

The ACGME e-Bulletin is published four times per year by the ACGME and distributed electronically to approximately 12,000 individuals in residency education. It is also available from the ACGME Web site.

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FROM THE EDITOR

Introducing the ACGME e-Bulletin

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In 2003, a survey of the readers of the *ACGME Bulletin* showed that many desired more frequent contact with the ACGME, focused around practical information related to resident education. The **ACGME e-Bulletin** was developed in response to this. It will appear four times annually, approximately at the mid-point between editions of the regular printed *ACGME Bulletin*, and will be disseminated electronically to the same audience as the *Bulletin*. It will also be available from the ACGME Web site. Major focal areas will be clarification of the standards, practical advice related to accreditation, and short descriptions of “best practices.” The *e-Bulletin* will also feature interviews with individuals in resident education, beginning with an interview with David C. Leach, MD, Executive Director of the ACGME, about protection of individuals who report alleged non-compliance with the accreditation standards to the ACGME.

Behind this somewhat prosaic introduction is the ACGME's wish to communicate in a more timely and effective manner with the resident education community. A first lesson in history, science or any discipline, is that there is always more to know, for the relative novice and the experienced practitioner. Residency programs and sponsoring institutions live in a world of rapid, fluid change, both in the educational programs and in the institutions in which they are located. We hope the *e-Bulletin* will facilitate information sharing to keep our community informed. ■

Getting Beyond Whistle-blowing: Protecting Individual Who Report Non-compliance with the Accreditation Standards

An interview with David C. Leach, MD

Question: *What are the similarities and differences between residents' “confidential reporting” of alleged non-compliance with the accreditation standards and the “whistleblower” model in the employment setting?*

Dr. Leach: There are differences between “whistle-blowing” in employment settings and situations where residents confront non-compliance with the accreditation standards. Whistle-blowing frequently is a public forum to address employment grievances that affect one individual. In contrast, non-compliance

with the accreditation standards may endanger patient care or resident formation. It thus has greater implications for society, because it disrupts the education and formation of physicians. In that sense, reporting of non-compliance by residents and others is similar to some whistle blowing to expose organizational malfeasance that may harm individuals beyond the whistleblower – the employees of the given organization, perhaps society as a whole. Another difference is the fact that in most whistleblower situations, the primary objective is to protect the individual's job. In resident education, if someone reports a non-compliance issue, the only way to move forward is through open conversations that maintain the reporting individual's relationships with faculty and peers. The process is focused to a much greater degree on those relationships, which are critical to the resident's education and formation. The very delivery of important aspects of the residency curriculum depends to a considerable extent on these relationships.

Question: *What internal and external resources exist for residents who are faced with an instance of potential non-compliance with the standards and seek to have it addressed?*

Dr. Leach: The initial resources for residents are internal, through conversations with their program director and, if necessary, the sponsoring institution's designated institutional official and graduate medical education committee, or an ombudsperson or similar resource, if available. The ACGME is appropriate as a resource only if these internal processes have failed. Its more meaningful roles are in contributing, through the institutional standards, to an environment in which residents can raise concerns about the educational program without fear of retaliation or retribution, and in ensuring that any actions a program takes that affect residents allow for a fair hearing.

Question: *What are the goals of reporting alleged non-compliance to an external body?*

Dr. Leach: The first goal is to protect residents from an imbalance of power in cases where the institutional system has failed to address their concerns. A second goal involves representing society's interests in the education and formation of the next generation of physicians and in the quality of care provided in settings where residents train.

Question: *What systems serve residents best who make confidential reports about alleged non-compliance with the accreditation standards?*

Dr. Leach: Addressing their concerns in the internal system is always preferable to involvement of external entities – this includes accrediting organizations. The primary role of the external system – accreditors, regulators and the courts – is to ensure that the internal systems operate effectively and fairly. This suggests that these entities should step in only when evidence suggests that the internal system has failed. Generally, internal systems have a greater understanding of the issues and context, and allow for more nuanced responses than those that occur once external bodies are involved.

Question: *What systems exist to protect residents who make confidential reports? How could these systems be enhanced?*

Dr. Leach: We continue to see evidence that even with a confidential reporting system, there are risks to the resident or residents reporting a concern to the ACGME. The issue is not confidentiality, or even anonymity. Often, the size of programs and knowledge of the particulars of a concern, when it has been raised previously in the internal system, make it relatively easy to identify the individual who made the report. Clearly, what occurs next is a test of professionalism in the program and sponsoring institution.

If there is retaliation, even in subtle ways, it violates an institutional requirement. It also speaks to deficiencies in the professional climate in which resident formation occurs and thus has broader implications for society.

Question: *What is the program director's role when residents report a concern about an alleged non-compliance? What is the role of the sponsoring institution? The ACGME? Are there others who should have a role?*

Dr. Leach: Program directors have an obligation to promote an appropriate environment for the education and professional formation of residents. This includes addressing the residents' concerns. Institutions need to foster an institutional climate that allows for education and continuous improvement, and ensures that the program director maintains an open system of communication. Only when these systems are determined to have failed, does the ACGME step in. There are other resources that may be beneficial, including institutional ombudspersons that can provide a confidential means for a concern or complaint to be addressed. Finally, ACGME does not adjudicate individual disputes, and in situations where it is not possible to resolve these at the institutional level, the resource for residents who feel their case requires external adjudication is the legal system.

Question: *What are the roles and obligations of residents who have knowledge about an alleged non-compliance and want to report it to get it addressed?*

Dr. Leach: Residents, like all others in the educational system, have an obligation to strive to improve the quality of graduate medical education. If residents are aware of non-compliance, they should seek to have it addressed, for their benefit, and toward meeting the greater societal expectations I alluded to earlier.

Question: *How would you advise a resident with a concern that is not getting resolved at the local level?*

Dr. Leach: First, I would recommend that he or she should explore if there is an internal resource within the larger institution, such as an ombudsperson within the hospital or the university in which their program is situated. If such a resource does not exist, or is not able to help, I would advise the resident to review the ACGME complaint procedures, and follow them, citing the concern and the ACGME standard the resident feels is violated. The latter is important because the Residency Review Committee and ACGME need to determine which accreditation standard was breached.

Question: *What should residents do to deal with retaliation/retribution after making a complaint? What is the role of the ACGME when retaliation or retribution occurs?*

Dr. Leach: Residents who are facing retaliation or retribution should immediately contact the ACGME through its complaint management staff and report that this has occurred. ACGME will assess the situation with the sponsoring institution and its designated institutional official, who is responsible for adherence to the standards prohibiting retaliation. Should retaliation be confirmed, it could result in harsh accreditation consequences, including in the most serious cases, withdrawal of the institution's ability to sponsor residency programs. ■

Redesigning the Ambulatory Care Curriculum at Lenox Hill Hospital

Julie Jacob

A decision to redesign the ambulatory care curriculum in the internal medicine residency program at Lenox Hill Hospital in New York City provided a perfect opportunity for the program's faculty to incorporate the ACGME's general competencies into the ambulatory care curriculum and receive feedback from residents regarding their ambulatory care training. "We educated the residents on what the core competencies were and how to integrate them into the curriculum," said Julia D. Andrieni, MD, Lenox Hill's associate chair of clinical services. "We asked for their feedback on what we were implementing, and also asked for their recommendations."

The goal of the "resident-driven graduate medical education" project, begun in July 2001, was to develop an ambulatory care curriculum in which residents provided feedback and information regarding their training, focusing on what they had wanted to achieve during the rotation and what was lacking. Following the rotation, residents complete evaluation forms on the lectures, workshops, subspecialty clinics and overall rotation. Examples of changes made based on the feedback from the residents include the addition of workshops in areas in which the residents had requested more training, such as EKG and blood smear interpretation.

The internal medicine program also changed the ambulatory care curriculum to provide residents in that rotation with opportunities for scholarly activity. These include initiating research and writing articles for *Resident Revue*, the department of medicine's resident journal.

In July of 2003, the internal medicine residency program decided to incorporate resident feedback into its inpatient program as well. "Now we have an inpatient residency autonomy initiative," said Dr. Andrieni. "The resident is more of a decision-maker, with the attending serving as the facilitator. Resident forums on the inpatient service conducted by the chief residents and the resident program director are an opportunity to capture valuable feedback."

The shift to a curriculum incorporating resident feedback has been positive for both residents and faculty, said Dr. Andrieni. "The great thing is that the ideas come from the residents. Innovations that you may think are working well aren't always working so well. No one knows that as well as the learner." ■

ACGME Web Site Redesign

The ACGME is redesigning its Web site to be more functional and easier to navigate, as well as to give it a fresh look that matches the ACGME's new logo and graphic identity. The new Web site will likely feature a "splash" page, which will allow program directors, designated institutional officials, residents and members of the public to go directly to pages and links of interest to them. A streamlined menu of links on the main page will also mean less scrolling and sorting through the long lists of options for users.

The ACGME's Web master, Beverly Bowers, PhD, asks that users of the ACGME Web site remain patient during the conversion to a new Web design. It usually takes several months for a Web site to be redesigned, she said, especially a site that is as large and complex as the ACGME's Web site, which has more than 2,000 pages of documents. All of these must be manually recoded and transferred to the

new Web site. The main page of the ACGME's current Web site, for instance, contains more than 200 lines of code alone – multiply that by 2,000 and that comes to more than 400,000 lines of code that must be written for the new Web site. ■

Duty Hour FAQs: Four Recent Questions

Question: *The ACGME common duty hour standards state that residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, with one day defined as one continuous 24-hour period. How should programs interpret this standard if the “day off” occurs after the resident’s on-call day?*

Answer: This question is complex because it requires the simultaneous interpretation of several ACGME standards, and because there are differences in the interpretation of this standard by the individual RRCs. Where the common duty hour standards call for a 24-hour day off, many RRCs have recommended that this day off should ideally be a “calendar day,” e.g., the resident wakes up in his or her home and has a whole day available. Others have noted that it is not permissible to have the day off routinely scheduled on a resident’s post-call day.

Having the day off always be a non post-call day can create scheduling problems in smaller programs, but the argument for keeping the post-call day and the day off separate comes from Doris Stoll, PhD, Executive Director of several surgical RRCs. Dr. Stoll notes that time left in the day after an in-house call is not a day off. This is because the requirement for a rest period after in-house call to rest and sleep, suggesting that this rest period is not a part of the 24-hour day off. Because call from home (pager call) does not require a rest period, the day after a pager call may be considered 24 hours off. Other RRCs have not been as explicit, but would likely not consider it appropriate to have the residents’ day regularly scheduled on their post-call day.

Question: *The requirement 10-hour rest period continues to be problematic for many programs. How does the ACGME interpret this common duty hour standard?*

Answer: The language of this requirement states, “Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.” Adequate rest is a “**must**” requirement, while the requirement for a 10-hour period is a “**should**.” “**Should**” is interpreted as “a term used to designate requirements that are so important that their absence must be justified.” This allows programs to provide somewhat shorter rest periods, when an appropriate educational justification is offered. Interpretation of what constitutes “appropriate justification” cannot truly be made a priori, but allowing added time for didactic lectures of high importance or for surgical experience, especially rare cases or cases with particular educational value of the given resident, are examples most RRCs would consider appropriate. It is important to remember that any abbreviated rest period must be justified from an educational perspective, and the program director and faculty must monitor the resident for the signs of sleep deprivation.

Question: *Some programs have interpreted the standard for averaging the 80-hour weekly limit, call frequency and days off as allowing a constantly rolling 4-week average. Does the use of a “rolling average” comply with the common duty hour standards?*

Answer: No. Averaging must be done by individual clinical rotation or by four-week block. Nowhere do the standards call for a “rolling” average. A rolling average would not be acceptable, because it may make it possible to average across high and low duty hour rotations to hide a compliance problem. In addition, call frequency should be averaged for periods with call, e.g., it is not appropriate to include call rotations and ambulatory rotations that do not include call together in the numerator or the denominator to calculate on-call frequency. Essentially, because they are minimum standards, the rotations with the greatest hours and frequency of call must comply with the common duty hour standards.

Question: *I have heard about interest in the surgical community to have duty hours for chief residents extended to 88 hours per week. If I am interested in extending hours for my chief residents, what are my options?*

Answer: The ACGME and the chairs of the surgical Residency Review Committees (RRCs) are discussing a proposal for extending duty hours for residents in the surgical chief resident year (the final accredited year in a surgical core residency) to 88 hours, but the proposal has not been acted on to date. In the interim, surgical residency programs interested in extending the duty hours for their chief resident year may apply to their RRC for the “88-hour exception” currently available with (1) endorsement from the sponsoring institution’s designated institutional official (DIO), and (2) approval by the RRC. Such an exception must have a sound educational rationale. Once approved, it allows programs to extend weekly duty hours to 88 hours. Like the 80-hour limit, this is averaged over four weeks. ACGME and the surgical RRCs are expecting that a number of surgical programs will take advantage of this option, and DIOs should be aware that they may see requests for extending weekly duty hours to 88 hours to be applied just to the chief resident year. ■

A “Best Practices” Model for General Surgery Education

The general surgery residency program of the McGaw Medical Center at Northwestern University has developed four practical resident rotation schemes program directors could evaluate for adopting in their local environment to facilitate residency education under the constraints of the 80-hour work week, while at the same time maintaining or enhancing resident education. Four models emerged from a think tank at Northwestern University Hospital: the Stretch Model, the Night Float Model, the Apprentice Model and the Mastery or Case-Based Model. Current practice is assumed to be hospital-based teams of residents who work with multiple attending physicians on a service and who take night call on a regular schedule, typically every third night.

In the **Stretch Model**, residents take call every fourth night (or less frequently) and leave early the next morning after call (although up to six hours are allowed for transition of care). This reduces the number of work hours in the week. The stretch model is probably the easiest way to get to an 80-hour week, but it has no real educational advantages other than shortening the work week and presumably giving residents more time to read.

The **Night Float Model** consists of a traditional resident team system, except that a percentage of the program’s total residents are designated to work a permanent night shift, usually for a month at a time (in most programs, residents will be on night float two to three months per year). Several teams would work the day shift, that includes a one hour overlap with the night team allowing for a robust “sign-

out.” Teams working during the day would leave in the evening and take no in-house night call. There is again an overlap hour in the evening for “sign-out.” The “night float” team would work a night shift six days per week, although larger programs may be able to have a five nights per week schedule.

The **Apprentice Model** involves one resident working exclusively with one or two faculty members over one to three months. Residents work side-by-side with their assigned mentors in the operating room and outpatient office, and take home call when their mentor is on call. Residents are involved only in the care of their mentors’ patients. Faculty members would need to be selected carefully based on dedication to education and an appropriate practice profile. This model lends itself particularly well to certain subspecialty areas like colorectal surgery or breast surgery but can be used for general surgery rotations as well. Because apprentices take no regular in-house night call, it is usually possible to construct a work week that is less than 80 hours long, even if the resident has to come in at night once or twice a week.

In the **Mastery (Case-Based) Model**, patient cases are assigned to residents based on the residents’ learning needs irrespective of attending or team assignments. Proficiency, knowledge and skills associated with diseases and operations are measured by personal progress, not by time. Proficiency is verified through formal assessment, and then residents are allowed to move on to other areas, and are not required to scrub on operations they have mastered unless they feel the need to refresh their knowledge. Participating residents would meet each week to receive their final patient/attending assignments for the coming week. Residents are responsible for making arrangements to review the cases with the appropriate attending. Residents round on their own patients in the morning and go to the clinic or operating room depending on their assignments for that week. They do not necessarily take regular night call, but could take call from home. Either in-house or home call can work with the model. Residents would follow all of their assigned/operated patients, irrespective of attending or service. There would be an outpatient clinic block, which would probably have to be attending-based, since it would be difficult for residents to follow-up on their patients in multiple ambulatory offices. Learning expectations are made clear at the start and are mastery-based, but broken down by years for planning purposes.

The models can be mixed in constructing an overall residency program. Northwestern has added a night float pool. It also retained some traditional inpatient teams during the day but changed several daytime rotations to the apprenticeship model. ■

This model for surgical education is also described in Darosa DA, Bell RH Jr, Dunnington GL. Residency program models, implications, and evaluation: results of a think tank consortium on resident work hours. Surgery. 2003 Jan; 133(1):13-23. It is reprinted here with the permission from Elsevier and the authors.

More detailed information on the four models for surgical education can be found on the American College of Surgeons Residency Assist Page (<http://www.facs.org/education/residencyassistbell.html>).

ABMS and ACGME Co-sponsor Conference on Systems-based Practice

The American Board of Medical Specialties (ABMS) and the ACGME will co-sponsor a conference on Systems-based Practice, to be held in Rosemont, Illinois, near Chicago, on September 23 and 24, 2004. The conference will begin on Thursday, September 23, at 5:30 pm with a reception and will end

Friday, September 24, at 4:30 pm. It will feature plenary sessions and small group discussions on a range of topics relating to systems based practices in residency education and in the maintenance of certification for practicing physicians. Topics to be covered include real-world examples of systems-based practice in areas such as patient safety, access to care, and improving the reliability of health care systems.

The conference will also feature a poster session, and ABMS and ACGME are inviting individuals and groups to submit abstracts for posters to be included in this session. Topics include:

- What Residents/Physicians in Practice Should Know about Systems-based Practice
- Real World Examples of Systems-based Practice
- Tools to Assess Systems-based Practice

Abstracts accepted for the conference will be presented on September 23, 2004 from 5:30–8:00 p.m. during a poster session allowing for extended discussion with attendees, and will also be reproduced in the conference syllabus. ■

More detailed information about the conference and for submission requirements for the abstracts, please visit the ACGME Web site at <http://www.acgme.org> for the conference brochure and the call for poster session abstracts.