

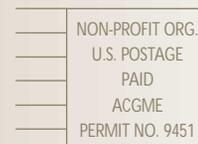


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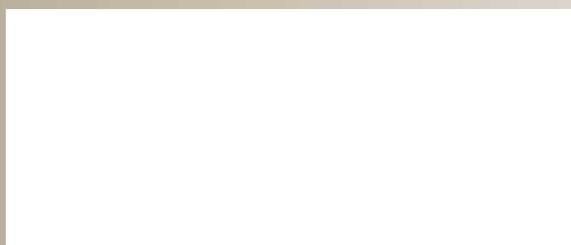
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Executive Director's Column:



David C. Leach, M.D.

We See What We Look For

When we examine a patient, our exam is enhanced significantly by the things we look for, as well as what we look at. The same is true for a residency program. When the ACGME site visitor and the Residency Review Committee (RRC) examine a residency program, what they see depends on some extent on the 'lens' they are using, and what it permits them to see. I would like to suggest that the shift to educational outcome measures as an accreditation tool offers two additional lenses and the potential to enhance what is seen.

The classic accreditation model provides a "minimal threshold lens." Standards are established by the RRC and programs are judged against the standards. The operant question becomes, "is the program in substantial compliance with the standards?" What is "seen" is only that which relates to the minimal standards, and the answer is yes or no. There is no system to allow one fully accredited programs to be distinguished from another, and the minimum standard approach does not permit any type of ranking of programs. This "one size fits all" lens can be a source of frustration for residency programs. Program directors frequently have made improvements in the program that may substantially enhance the program and the education it provides, but that are invisible to the review process if the improvement is not directly related to one of the standards.

A second lens, the competency lens, will become available in the foreseeable future, when educational outcomes will be assessed as part of the accreditation process. In a sense, the minimal threshold lens identifies if a program has the potential to educate residents, a competency lens examines whether the program is actually educating them. Reviews using this lens might conclude that a program is fully accredited and is especially strong in some area, such as communicating with patients, and weak in another, such as systems-based practice. Using the competency lens, programs can be profiled, their strengths and weaknesses identified, and differentiation between fully accredited programs can be demonstrated.

"In a sense, the minimal threshold lens identifies if a program has the potential to educate residents, a competency lens examines whether the program is actually educating them."

The power of this lens is already evident to some degree by the public release of five-year average board certification pass rates by some member boards of the American Board of Medical Specialties (ABMS). Fully accredited programs in these disciplines can be ranked by the board pass rates their graduates achieve, an effort that has in itself led to improvement in the pass rates. The competency lens promotes improvement work.

The third lens is not an accreditation lens, rather it is a performance excellence lens. Designed to look primarily at institutions rather than individual programs, it detects

“The performance excellence lens sees things that can be shared with the larger medical education community and can provide useful templates for adoption by others.”

systematic institutional improvement work and identifies how benchmark institutions use data and process improvements to enhance educational outcomes. This lens “sees” things that can be shared with the larger medical education community and can provide useful templates for adoption by others. At the June ACGME meeting the Strategic Initiatives Committee considered opportunities presented by this lens. As the ACGME Outcomes Initiative moves forward, the RRCs, the Institutional Review Committee and the ACGME will gain experience using each of these lenses. Analysis of these experiences will serve the goal of building knowledge about good GME. 

ACGME Bulletin Editor's Occasional Column:
A Performance Excellence Model for GME Programs - New Metric or a Different Approach

Ingrid Philibert

In grief and managed care, people really like stages. Elisabeth Kubler-Ross’ stages of grief and the managed care market model developed in the mid-1990s by the University Healthsystem Consortium both highlight that explicit sequencing of phenomena clarifies the evolutionary nature of the stages. In essence, it tells us how to get there from here. The performance excellence approach to the evaluation of educational programs and the institutions housing those programs shares this concept and relates it to the evolution of an organization’s stewardship. The evolution begins with ‘random acts of improvement,’ advances to a more organized and disseminated approach, and culminates in an organization-wide commitment to performance excellence.

In the preceding piece, Dr. Leach suggests that three ‘lenses’ can be used to assess the quality of graduate medical education (GME) programs. In addition to the

“minimal threshold” and “competency” models, he proposes “performance excellence” as a third lens. At the same time, he emphasizes that this lens is not accreditation in the traditional sense. Rather, it assesses and provides feedback on the degree to which a given organization has incorporated the principles of performance excellence - the degree to which they are ‘embedded’ in all aspects of its business.

A well-known performance excellence model is the Malcolm Baldrige National Quality Award (MBNQA). The Award was signed into law by Congress in 1987. It is operated by the National Institute of Standards and Technology via a unique public-private partnership. Principal support comes from the Foundation for the Malcolm Baldrige National Quality Award, established in 1988. The Award is named for Malcolm Baldrige, who served as U. S. Secretary of Commerce from 1981 until his death in 1987. Past recipients have included Motorola, Inc., the Ritz-Carlton Hotel Company, AT&T Consumer Communications Services, and the Cadillac Motor Car Company. In addition to the national program, many states operate state-based performance excellence programs based on the Baldrige criteria. In 1999, President Clinton announced the availability of Criteria for Performance Excellence in the fields of education and health care. Prior to that date, awards were given only for manufacturers, service industries and small businesses. In the first year of availability in these new areas, no health care or education institution received a national Baldrige award.

----- Exhibit 1 -----

Education Criteria

Criteria Organization and Category Point Values

Strategy and Deployment

1 Leadership	125
2 Strategic Planning	85
3 Student and Stakeholder Focus	85
4 Information and Analysis	85
5 Faculty and Staff Focus	85
6 Educational and Support Process Management	85

Results

7 Organizational Performance Results . . .	450
(200 of these are focused on student results)	

Source: Malcolm Baldrige National Quality Award (MBNQA), 2000

The Baldrige approach uses information on applicant organizations’ strategic planning and ongoing operations (termed approach and deployment) and their outcomes (termed results). The organization of the

“On a conceptual level, the Baldrige approach maps an organization’s evolution toward a performance excellence model.”

criteria in *Exhibit 1* shows that 450 of the 1,000 total possible points in the Baldrige scoring system are in the “results” category. Even more important is that in the education criteria, 200 points, or one-fifth of the total possible score is based on student outcomes.

The process requires an organization to complete a compre-

hensive Baldrige Application. This application is reviewed and scored independently by a group of Baldrige Examiners, who have received special training in the criteria and the evaluation process. Scores are averaged and a panel of Baldrige Judges decides on a cutoff score above which all applications make it to the next round of evaluation. In the second round - the consensus conference - a group of examiners collectively discusses and re-evaluates the application, which produces a second score that is independent of the first. Using the documents from the consensus review, the judges then decide which organizations will proceed to the site visit stage. Following the site visits, the judges select the organizations that receive the award.

On a conceptual level, the Baldrige approach maps an organization’s evolution toward a performance excellence model. Perhaps most important from the perspective of performance improvement is that the MBNQA program, as well as the state award programs based on the Baldrige model, provide clear, applicant-focused, ‘actionable’ feedback, irrespective of whether

Of value to the greater community is that the examples of ‘educational excellence’ identified through this approach could be adopted and adapted by other institutions, and could also be used to refine the accreditation standards and processes.

an applicant is eliminated in the ‘first round’ or reaches the consensus review or site visit stage. This feedback tells the organization where it must focus its effort to come closer to performance excellence. It does so without specifying a single predetermined approach the organization must follow to address the ‘opportunities for improvement.’ In essence, it shows the organization how, at the present point in its evolution, it compares to the ‘ideal.’

----- *Exhibit 2* -----

The Baldrige Core Values for Education

1. Visionary Leadership
2. Learning-Centered Education
3. Organizational and Personal Learning
4. Valuing Faculty, Staff and Partners
5. Agility
6. Focus on the Future
7. Managing for Innovation
8. Management by Fact
9. Public Responsibility and Citizenship
10. Focus on Results and Creating Value
11. Systems Perspective

Source: *Malcolm Baldrige National Quality Award (MBNQA), 2000*

Underlying the Baldrige criteria is a set of core values. The core values for education are shown in *Exhibit 2*. The Baldrige approach has a clear definition for each of these values. The definitions for visionary leadership and learning-centered education are as follows:

“Senior leaders need to create a student-focused, learning-oriented climate, clear directions, and high expectations; they should inspire and motivate faculty and staff. The organization’s values and strategies should help guide all activities and decisions. Senior leaders should serve as role models and may work to build community support.”

“Learning-centered education focuses on learning and the real needs of students; such needs derive from marketplace requirements and citizenship responsibilities. Education organizations must keep pace with rapid changes in the marketplace. Key characteristics of learning-centered education are high expectations and standards, teaching that accommodates different ways and rates of learning, emphasis on active learning, use of assessments, and focus on transitions such as school-to-school and school-to-work.”

Finally, the Baldrige approach uses a systems perspective. The seven categories (shown in *Exhibit 1*) and the core

values (shown in **Exhibit 2**) together provide a system for managing the organization and achieving performance excellence. Synthesis (focusing on what is important to an individual organization) and alignment (concentrating on linkages among categories) are important factors that are evaluated in the review of an applicant.

In his article, Dr. Leach noted that at its June 2000 meeting, the ACGME Committee on Strategic Initiatives discussed and explored the potential uses of a performance excellence model like the MBNOA. The Committee decided, and Dr. Leach emphasized this in his article, that this approach clearly is not intended for every program or institution. Ultimately, a subset of GME institutions and potentially a few programs could participate in an assessment of performance excellence on a voluntary and self-selected basis. The benefit to these programs would be an opportunity to demonstrate excellence, the advantage of receiving the specific, 'actionable' feedback that is part of this approach, and the cachet of being recognized as an 'excellent teaching institution.' Of value to the greater community would be that the examples of 'educational excellence' identified through this approach could be adopted and adapted by other institutions, and could also be used to refine the accreditation standards and processes.

Clearly, even exploration of a performance excellence "option" by the ACGME will raise a host of questions that need be answered. The most fundamental of these is whether an optional Baldrige approach is a new metric or whether it represents a new species of GME accreditation. As a new metric, the Baldrige model would measure the same parameters as traditional GME accreditation, but would offer potential desirable advantages - such as the opportunity to chart the evolution of quality improvement for a given institution, to identify and reward the highest quality programs, or the capacity to provide usable feedback. As a new form of GME accreditation, it would need to be extensively tested and validated. Beyond this, there are legitimate concerns with touting an accreditation model for an excellent few. What is to be avoided is that, in the purest sense of these words, "excellence becomes the enemy of participation." Finally, one should not be naive about the significant effort on the part of both applicant institutions and the ACGME that would go into a performance excellence model in GME, even if just a few applications would be received.

It might not be inappropriate to compare the application of the Baldrige criteria and process in GME accreditation to the use of novel therapies in the treatment of patients. These new therapies may offer some exciting promise over the traditional way of doing things. However, they may possess aspects that have not yet been completely explored and to be used more widely, there needs to be

evidence that they are a more effective approach. Another aspect both have in common is that for their broader applicability to be assessed, there need to be some 'early adopters' who are willing to explore the usefulness of the model as well as check it for the existence of significant drawbacks. Finally, in another parallel with some forms of therapy, while we have great faith in the validity of the standards and the work of the RRCs and ACGME, the linkages between meeting the standards and the presence of high quality education are not completely understood.

Recognition by one's peers as excellent may bring "joy" into the accreditation process. It has the potential of being a deeply satisfying experience and to strengthen expression of our noblest aspirations. While we have come a long way, the present-day model of accreditation can still give rise to thinking along a series of Kubler-Ross-like stages. They range from denial ("Oh no, not an accreditation site visit.") through anger, bargaining ("I think we can get it postponed.") and depression ("There is sooooo much we have to do to get ready, and no time to do it.") to acceptance ("We will be prepared."). Perhaps a performance excellence model could begin the process of seeing beyond accreditation as a necessary evil, to a new model of volunteering to participate in a process that defines and measures excellence in education. 

Approaches to Teaching Residents about the Improvement of Health Care

Leigh S. Hamby, MD, FACS, VA Quality Scholar

Graduate medical education (GME) is under a deluge of destabilizing forces that include competitive pressures, rapid scientific advances, reduced payment for education and others shown in **Figure 1**. The members of the GME community may believe they are in a unique and particularly disadvantaged position. However, the forces impacting on GME are not dissimilar to those faced by every other stakeholder in health care. In fact a listing of the critical destabilizing elements affecting GME would look familiar to any hospital executive, senior managing partner of a multi-specialty group or health services researcher.

There are many challenges for medical educators in responding to this environment. One of the most important is to assist in addressing some of the causes of destabilization by producing a generation of care givers that can actually lead the overall improvement of health care. To do this, we need to educate physicians who can

Forces Impacting Graduate Medical Education



Figure 1

both use existing knowledge and test new ideas about the improvement of health care. The magnitude of the potential impact that GME could have on health care suggests our strategy should be to use education as a tool for change. However, we quickly face the paradox that we must begin to teach others what we ourselves have been unable to do.

Fortunately, through the general competencies, the ACGME has stimulated us to begin our journey of improving health care by describing for us our destination. It is up to each of us to choose the path. This article is a summary of some of the ideas we have tried at Dartmouth University and the White River Junction

Opportunities to Teach the ACGME Competencies

	OR	Rounds	Clinic	Conf.
Patient Care	X	X	X	X
Medical Knowledge	X	X	X	X
Practice-Based Learning and Improvement				
Interpersonal & Communication Skills				
Professionalism				
Systems-Based Practice				

Figure 2

Veterans Affairs Medical Center to use education to improve health care and to teach residents the principles and tools of health care improvement.

Failed Attempt # 1

As the new kid on the block, I was eager to transmit my knowledge of Deming, Batalden, Berwick, Senge and others to the surgical residents assigned to me. My strategy was to have a one-hour conference about health care improvement each week. The vision was that the residents would take this information and go forth and make health care better. However, to my dismay, 15 minutes into my discourse about systems and processes, the intern had to leave and tend to a patient in the ICU. The chief resident was post-call and proceeded to fall asleep and the third-year resident had a frightful stare.

Lesson Number 1

The ideas about improvement cannot be introduced using a conference-only format. Additional feedback from the residents told me the ideas were too abstract. They could not see how the ideas about systems fit into their daily work.

Attempt # 2

At this point, I decided to incorporate the concepts of health care improvement into my everyday interaction with the residents. To figure out how to “plug” the ACGME competencies related to health care improvement into the beginnings of a curriculum, I developed a matrix (Figure 2). The columns of the matrix represent the ACGME competencies and the rows are the various opportunities I had to teach the residents. The goal was to produce a GME environment where improvement was a regular part of daily practice, rather than a set of abstract ideas in a conference. The matrix would assist in this process. I would place an “X” in the appropriate box when I felt I had achieved that goal for that competency.

Looking at the matrix, I felt pretty comfortable placing “X”s in the patient care and medical knowledge boxes across all the rows (Figure 2). This was “business as usual” for the day-to-day interaction I had with the

“....these exercises are being delivered into the context of an ongoing program in which the interpersonal dynamics add an important, yet often unexplored perspective.”

residents. However, I was drawn to the big blank row labeled “systems-based practice.”

I looked into ways that others industries taught “systems-thinking” and tried to match that with my own reading of Senge and others. Paul Batalden, MD, Professor and Director, Center for the Evaluative Clinical Sciences at Dartmouth Medical School, had been using a board game called “Friday Night at the ER” developed by Breakthrough Learning, Inc. (www.blearning.com) in his graduate course in quality improvement. We thought we would give it a try, using a one-hour time slot for conference involving 12 medicine and surgery residents together.

Briefly, the game is a vinyl board simulating a hospital divided into four departments: the Emergency Room, a step-down unit, Surgery and a critical care unit. Residents are the “managers” of those departments for 24 hours (each hour is 1 minute). Their job is to match patients (blue tokens) with staff (white tokens). They draw from a stack of random cards that tell them how many patients move into their area and how many can be discharged to other areas. Several random realistic “events,” including staff shortages, patient acuity problems and unforeseen circumstances challenge them during the game. To be successful, they

“These once abstract ideas can now be grounded within the game. More importantly, the residents are able to relate them back to recent “real-life” experiences they have had working within the hospital.”

them into the department next to his. The interesting part was that the person doing the dropping was the chief resident of the person receiving the tokens. The receiver took the tokens without comment. This reminded me that these exercises are being delivered into the context of an ongoing program in which the interpersonal dynamics add an important, yet often unexplored perspective. Aspects of this type of thinking were then made explicit during a debriefing immediately following the game. The job of the game facilitator was to create an environment to allow these ideas to be safely discussed.

**Opportunities to Teach
The ACGME Competencies** *(continued)*

	OR	Rounds	Clinic	Conf.
Patient Care	X	X	X	X
Medical Knowledge	X	X	X	X
Practice-Based Learning and Improvement				
Interpersonal & Communication Skills				X
Professionalism				X
Systems-Based Practice				X

Figure 3

have to be able to communicate with the other department “managers” and realize that they are all part of a complex interdependent system. Following the 24 minute exercise, a structured debriefing is held that allows the residents to explore and share ideas about systems-thinking.

Interestingly, during the exercise, one of the participants decided that “his department” was overwhelmed and he simply picked up his patient tokens and “dropped”

Lesson Number 2

Issues explored in these debriefing conversations included the fact that there are complex interdependencies between departments, that structure drives behavior, that actions can produce unintended consequences, and that cause and effect are separated by time and space. These once abstract ideas can now be grounded within the game. More importantly, the residents are able to relate them back to recent “real-life” experiences they have had working within the hospital (**Figure 3**).

Attempt # 3

The next blank row was “how do you teach about communication and professionalism in the operating room.” To test an idea, we videotaped residents performing a minor procedure in the operating room. The next day, we met with the OR staff to watch it together (30 minutes). Residents and staff were then encouraged to discuss ideas about what were the specific behaviors that led to “good communication” styles or “bad communication styles.” The surprise came when the group consensus was quickly reached about “good” and “bad” communication styles, even though the behavior may not have been seen on that specific videotape. Everyone could relate to elements of both styles they had seen in themselves and others outside of the OR on rounds, in the ICU and outpatient clinic from past experiences (**Figure 3**).

Final Lesson Learned

I was also interested in filling in the last blank row, "Practice-based Learning and Improvement." On further reflection, it became apparent to me that the most effective way residents would incorporate the value of improving their practice was if they saw me doing that in my own "practice." Toward that end, we began to monitor and improve several aspects of our daily practice together.

The residents wanted to work on the team "goal" of completing the day's work so that residents not on call could leave by 6 p.m. As we went through several Plan-Do-Study-Act cycles of improvement, we discovered many ways in which we could rearrange our work flow together to accomplish the team goal. An example was that, if the chief resident was running late in the OR, the available residents and attending would proceed with afternoon rounds without the chief. This required improvement in communication between the team and attendings. Next, the team determined that one barrier to leaving on time was "re-working" the pre-op patients the night prior to their surgery. That is to say, things that could have been done at the time of admission were being done at the last minute. This was inefficient and led to cancellation of cases because of "balls having been dropped." To address this issue, the team set about improving the scheduling process for patients in the surgery clinic. After two weeks of the team interacting with the same-day surgery staff and information systems staff, the entire scheduling process was automated. This improvement has been working satisfactorily now for several months and has spread to other departments as well.

Conclusion

What I learned from the interactions described in this article is that it is up to us to teach our residents how to improve health care. This has to start by improvement of our own practices and demonstrating to the residents the value added by this. I also learned that the ACGME core competencies are a useful framework for thinking about incorporating health care improvement into daily surgical practice. 

Court-Ordered Retention of Resident Physicians - Issues for Residency Program and Sponsoring Institutions

Douglas Carlson, JD, and Ingrid Philibert

In two recent decisions, state courts in different states ordered institutions to retain residents the institution sought to dismiss. Both cases involved surgical residency programs. In each case, the resident physician had transferred from another residency program. The remaining circumstances are quite complex and idiosyncratic. At the same time, the basis for each court's decision was a failure on the part of the program and its sponsoring institution to abide by its own contractual or due process rules.

Court-ordered retention of residents in graduate medical education (GME) program is a new phenomenon and contrasts with earlier precedent in which courts have been reluctant to usurp faculty prerogatives to determine the competence of residents. Courts lack the knowledge and expertise needed to determine individual competency, the appropriate level of function and the ability of a resident to continue in an education program. A review of these particular cases exposes institutional weaknesses in the review of previous GME experiences, and the failure to exercise existing due process mechanisms or to have adequate due process mechanisms available to residents. It also raises serious questions about patient safety, availability of educational resources, residency program administrative practices in general, and the role of graded supervision once difficulties are identified.

The Cases

In the most recent case, an appellate court affirmed a trial court's entry of a preliminary injunction maintaining a resident in a surgical residency program. The trial court had found that the program and its sponsoring institution had acted in an arbitrary and capricious manner in placing the resident on 'permanent academic suspension' after what the trial court characterized as an inadequate hearing.

In the other case, a trial court ordered specific performance of a resident contract, requiring a hospital to place the resident in a categorical residency position. The court premised this order on a prior finding that the program had breached its contract with the resident by 'demoting' the individual one postgraduate year several months after the resident, who had transferred from another institution, started training.

Patient Safety Issues

In both cases, the program argued that patient safety was an issue mitigating against the court's ordering the retention of the resident. In each case, the court recognized that patient safety was a relevant factor for it to consider, in determining whether to order retention, but that patient safety was a non-issue as a factual matter. One court stated that, under the facts presented, the injunction in question would not endanger patients. The other court determined that, in considering specific performance of a resident's contract, patient welfare was a non-issue.

Availability of Teaching Material and Other Educational Resources

In surgical training programs, and in most other specialties, the ACGME places limits on the numbers of resident physicians training in each year of the program. The rationale is that programs have a finite amount of teaching material and other educational resources available, and a certain amount per resident is needed for appropriate education. In one of the cases, this was not an issue, as the order placed the resident in the same class, and before the expiration of the residency year. In the other case, the court ordered retention of the resident after the slot vacated temporarily by the individual had been filled. The court recognized that a court-ordered retention of this resident might impact other residents negatively by diluting their access to teaching material and other educational resources. However, the court did not have to address this issue as an impediment to the retention, because, in an unrelated action, the ACGME had previously voted to increase the available slots for the following year.

Residency Program Administrative Issues

Neither court fully addressed the administrative issues inherent in court-ordered retention of resident physicians. They are discussed below, with the intent of alerting programs and their sponsoring institutions to these issues and of offering advice in this relatively new area.

By definition, training in a residency program is clinical. Each rotation is carefully planned and usually requires a set of resident physicians, including resident physicians at each of several levels of clinical training. Removing a resident from a rotation or inserting a resident into a rotation or a given clinical year is difficult, and can be disruptive to the clinical experiences of the other residents. Removal/reinsertion could be impossible if other residents were not available and/or if the rotation or year of experience was cumulative, i.e., later participation was highly dependent on learning from earlier experience in the rotation or year.

There are a number of other administrative issues for residency programs inherent in these instances of court-ordered retention of residents. They include, but may not be limited to:

- The degree to which a program/institution accepting a transferring resident needs to assess the resident's records and information on his or her prior GME performance prior to accepting the individual into the program.
- The importance of performance evaluation, academic remediation and counseling of residents who do not perform at the appropriate level.
- The need for institutions to use and abide by their policies and procedures for 'due process' and the obligations resulting from their contracts with residents.

For institutions experiencing a court-ordered retention of a resident, there are additional issues to be considered:

- The extent to which an institution will be able to address patient safety concerns relating to a resident retained by court order, while affording the resident his or her court-ordered GME experience.
- The dilemma institutions and their program directors may ultimately be placed in when a resident reinstated by court order 'completes' the program or transfers, and the program director must make a decision on certifying the resident's ability to enter independent practice, eligibility to sit for the board examination, or preparedness to enter a GME program at a certain postgraduate year level. 

RRC/IRC COLUMN

Approval of New and Revised Program Requirements

At the June meeting, the ACGME approved new program requirements for residency education in Pain Management as a subspecialty of Neurology, Physical Medicine and Rehabilitation, or Psychiatry. New program requirements for Residency Education in Endovascular Surgical Neuroradiology as a subspecialty of Radiology were also approved. Both became effective June 27, 2000.

The following revisions of existing program requirements for residency education in the following specialties and subspecialties were approved: Physical Medicine and Rehabilitation (effective July 1, 2001), Emergency Medicine (effective, January 1, 2001), Anesthesiology (effective, January 1, 2001), and Sports Medicine (effective June 27, 2000).

The ACGME also approved revisions to the Program Requirements for Residency Education in Internal Medicine, which included the addition of the six ACGME General Competencies. The new Internal Medicine requirements will be effective July 1, 2001.

ACGME Reviews Institutional Requirements in Follow-up to NLRB Ruling on Resident Unionization

Following the November 1999 ruling of the National Labor Relations Board (NLRB) that allowed residents at private teaching hospitals to form unions and collectively bargain, the ACGME developed and widely disseminated a position statement on resident unionization. The Council invited input on this statement from all interested and affected parties, to determine whether the Institutional Requirements would need to be revised or amended in response to the NLRB ruling.

After reviewing the responses from the GME community and others, the ACGME decided that at the present time, there is no need for substantive changes or additions to the Institutional Requirements to address resident unionization.



Other Highlights from the June 2000 ACGME Meeting

Strategic Initiatives Committee Discusses the Issue of Health Care Errors

The Strategic Initiatives Committee had a second discussion of errors in healthcare, and the role the ACGME should play in educating physicians about health care errors and in assisting residents in understanding the causes and the impact of these errors. It was proposed that a dedicated web page within the ACGME's web site would be used as one source of educating residents and others. A suggested structure for the web page and the initial content information for the page will be presented at the September meeting of the Committee. In addition, a proposal was made that the ACGME sponsor a conference on healthcare errors and their special implications for physician education and for teaching institutions. Attendees would be program directors, faculty, health care professionals from other disciplines, including hospital administration, and experts in systems-thinking, human factor engineering and analysis of the causes of errors.

RRC Council of Chairs Meet and American Board of Medical Specialties Meet to Discuss General Competencies

One of the presentations at the June ACGME Meeting was a report from the joint meeting of the RRC Council of Chairs and the American Board of Medical Specialties (ABMS), held on May 6, 2000 at the University of Chicago's Gleacher Center. The purpose of the meeting was to discuss the six General Competencies and the tools that could be used in assessing them. Participants included RRC Chairs, Specialty Board members, residency program directors, residents and ACGME and ABMS staff.

The meeting consisted of two breakout sessions and two plenary sessions. Participants were assigned to breakout groups and each of the groups was assigned one of the six general competencies. The objective of the first session was to develop a consensus statement about the components of the particular competency, and to create a process for their further development, with a view toward applying the competency in program accreditation and physician certification. The objective of the second breakout involved identifying the elements of a portfolio that would be used to measure a resident's ability to enter independent practice at the completion of training. In follow-up to the May 6 meeting, small groups have been formed in each medical specialty. Each consists of a Board

Member, an RRC Member, a program director and a resident. The groups are meeting throughout the summer to further advance this work. The results of their effort will be presented at another jointly sponsored meeting scheduled for September 2000.

What Is New in the Green Book?

Fred Lenhoff, American Medical Association

The new 2000-2001 edition of the *Graduate Medical Education Directory*, or "Green Book," is now available from the American Medical Association (AMA). It contains 7,691 ACGME-accredited programs in 27 specialties and 76 subspecialties. This is an increase of 117 total programs and 14 specialties/subspecialties with accredited programs compared to the 1997-1998 edition (see Figures 1 and 2).

The GMED also includes:

- 229 combined specialty programs in 15 areas
- 1,676 GME teaching institutions
- ACGME Institutional and Program Requirements for 107 specialties/subspecialties
- ABMS board certification requirements
- a list of US medical schools
- a specialty/subspecialty taxonomy detailing program length and whether prior GME is required.

Figure 1
Number of Specialties and Subspecialties with ACGME Program Requirements 1997-98 through 2000-01

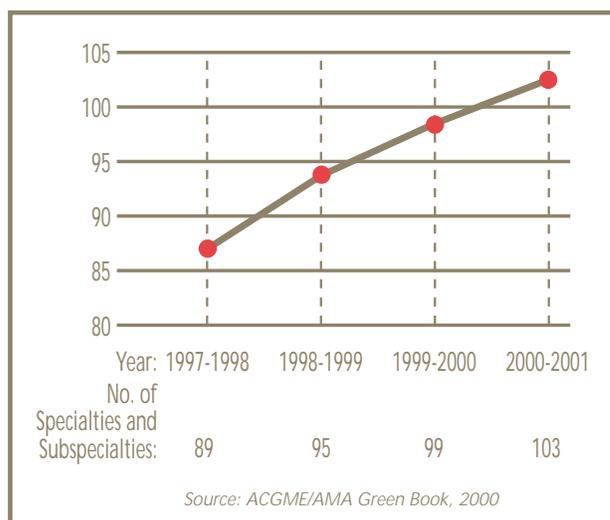
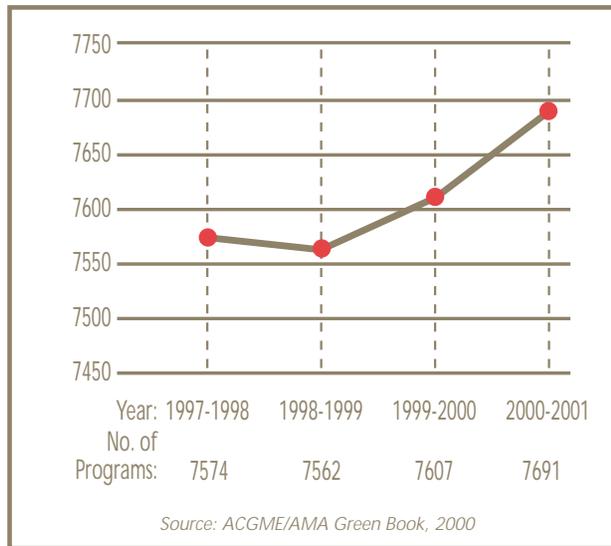


Figure 2
Number of ACGME Accredited Programs
1997-98 through 2000-01



The CD-ROM version of the *Directory* — redesigned for 2000-2001 — offers advanced search functions to help you find the exact program or institution you're looking for. Its new Web browser interface allows for quick, easy access to all program and institution data and clickable links. The CD also includes additional data not shown in the hard copy edition of the *Directory*, including application deadlines, number of applications received, and program start dates. 

To order the Green Book, call the American Medical Association at 800 621-8335.

The Cochrane Collaboration - How Does It Link to Medical Education?

Ingrid Philibert

Many of you know the Cochrane Collaboration as an international effort to collect and share new medical information with physicians, nurses and others in health care. Its intent is to make new knowledge from biomedical, clinical and health sciences research accessible to 'the average practitioner.' The Collaboration is named for Archie Cochrane, a British epidemiologist, who in 1972 observed that individuals who want to make better decisions about health care did not have access to information on the effectiveness of various

treatments. Some 20 years later, 77 individuals from eleven countries founded the Cochrane Collaboration. Today, the Collaboration works internationally through its review groups, centers and databases to prepare and update a register of reviews of the effectiveness of health care interventions. The work is built on nine principles, shown in *Exhibit 1*.

-----Exhibit 1-----

The Nine Principles of the Cochrane Collaboration

1. Collaboration
2. Building on the enthusiasm of individuals
3. Avoiding duplication
4. Minimizing bias
5. Keeping up to date
6. Ensuring relevance
7. Ensuring access
8. Continually improving the quality of the work
9. Ensuring continuity

Source: Cochrane Collaboration, 2000

The major products of the Collaboration are "Cochrane Reviews," published electronically in a "Cochrane Database of Systematic Reviews." Conducting the reviews is the responsibility of more than 40 international collaborative review groups whose work covers most of the important areas of health care. Consumers participate throughout this process is considered essential to fulfilling the Collaboration's goals. For dissemination, Cochrane reviews and information about the review groups are submitted at intervals to the Collaboration's main database and from it to an electronic library. Other databases associated with the Collaboration are the Cochrane Controlled Trials Register, the Database of Abstracts of Reviews of Effectiveness (DARE) and the Cochrane Review Methodology Database, a bibliography of articles on the science of research synthesis.

Is the Medical Community Ready for This?

The Cochrane Collaboration is a large-scale effort to introduce the 'average practitioner' to the use of medical evidence in diagnosis and treatment — using the principles of evidence-based medicine. Presently, that term still causes discomfort in parts of the medical community. This discomfort can extend to traditional approaches for the transfer of medical knowledge, such as review articles, when they are presented in terms of 'medical evidence.' The issue is to some extent one of labeling. An analogy, not intended facetiously, is that evidence-based medicine is to medicine what organic food is to food. The vast majority of medical diagnosis and treatment is based

on evidence, just like virtually all food is organic. Some criticisms of 'evidence-based medicine' focus on the worshipful attitude of its supporters and on their belief that a 'more' evidence-based methodology offers a panacea over traditional ways of approaching diagnosis and treatment. Others critics state that evaluating the merits of various clinical trials simply is not the realm of the 'average physician' and that systems exist to validate new treatments and they subsequently become accepted medical practice. This becomes apparent in the findings of a study of Canadian physicians which found higher use of traditional information (clinical experience, text books, review articles, and colleagues' opinions) than use of evidence-based sources.¹ Cited barriers to the use of evidence-based sources included lack of relevance, newness of the concept, impracticality for use in daily practice, and negative impact on the "traditional skills and art of medicine."

Articles have also commented on the limitations of evidence-based approaches. A 1999 survey of evidence-based educational interventions intended to benefit primary care physicians found that many did not use rigorous methods, and those that did were very heterogeneous in method and target group.² Only two studies assessed resource implications, and only one calculated economic benefit. The authors recommended that future studies target an "identifiable learning need" related to a patient outcome, and that research reports and studies be evaluated on their "intention to educate."

Links to Medical Education

The intent of this short piece is not to end, or even meaningfully contribute to, the debate about the merits of evidence-based medicine. Rather, it seeks to explore whether and how these concepts, which have become business as usual in many settings, could be included to a greater extent into medical education, both the continuum in general, and residency education in particular.

There are direct links between the evidence-based approaches, such as the Collaboration's work, and medical education. Some medical schools, like the University of Michigan, have begun to offer required courses or electives in the use of clinical information from literature reviews, meta-analyses, and practice guidelines.³ The content of what is being taught – critical appraisal of information from a variety of sources and evaluation of its applicability to patient care – is not new. What is new is the use of an evidence-based approach, and the process of linking the learning to a physician's individual practice and patient population. Another effort at the University of California, Irvine, introduced residents and medical

students to evidence-based medicine through the use of a "learning prescription." The prescription is handed to the resident or student by the preceptor after a learning question has been identified in the context of patient care. The prescription uses a format denoted by the acronym PICO (describe the Patient, specify the Intervention, state the Comparison to the intervention, and define the expected Outcome). The prescription is given to the learner with instructions to perform a search of the literature, with a critical appraisal of the findings. After the prescription has been "filled," the preceptor gives feedback on the work. At present, these approaches are still not common. Use of Practice-based Learning and Improvement (one of the six ACGME General Competencies) in the accreditation of residency programs may advance a link between the study and assessment of new medical information and the application of what is learned to day-to-day practice.

We have long assumed that the reason for of life-long learning is to improve physician knowledge in a way that impacts and improves daily practice. Life-long learning encompasses a host of activities, including staying current on the literature, institution-based lectures, conferences and educational rounds, and more formal continuing medical education. This should make the suggestion in the preceding section that (1) educational efforts should target an identifiable learning need, and (2) that research studies should be evaluated on their 'intention to educate' appear redundant. However, stating these assumed objectives explicitly makes them appear quite novel and allows us to assess all of the above-stated activities in a new light.

The value of linking physician education to the learning needs of practicing physicians is beginning to be recognized. The member boards of the American Board of Medical Specialties are moving from recertification to a process of 'maintenance of certification.' Recently, the American Board of Internal Medicine (ABIM) implemented its new program for recertification, termed Continuous Professional Development (CPD). CPD incorporates the principles of continuous quality improvement. Its goal is a continuous evaluation process that is "valuable, tolerable and affordable," according to ABIM President Harry Kimball, MD.⁵

At one level, the Cochrane Collaboration and similar efforts represent a form of life-long learning by the medical community as a whole. One of the things to be learned is whether an evidence-based approach is superior to other methods for disseminating new

medical knowledge. If that is not so, there is no reason to adopt this method. There are historical parallels. Today, pathophysiologic reasoning in diagnosis and treatment are widely accepted. At one time not so many years ago, they represented a novel approach to the operant "miasma theory" in assessing the origin of a disease and recommending treatment. The approach had to prove itself as more than a temporary fad. From a medical education perspective, all efforts to generate, compile and evaluate medical knowledge are potential inputs into the body of knowledge for the education of the next generation of physicians. That perspective may suggest that we put at the core of all reports on current research and new medical literature that 'intent to educate' mentioned earlier. 

Sources:

- 1 McAlister FA, Graham I, Karr GW, Laupacis A. Evidence-based Medicine and the Practicing Clinician. *Journal of General Internal Medicine* 14(4) 1999:236-242.
- 2 Freudenstein U, Howe A. Recommendations for Future Studies: A Systematic Review of Educational Interventions in Primary Care Settings. *British Journal of General Practice* 49(449) 1999:995-1001.
- 3 Wolf FM, Miller JG, Gruppen LD, and WD Ensminger. Teaching Skills for Accessing and Interpreting Information from Systematic Reviews/Meta-analyses, Practice Guidelines, and the Internet. *Procedures, AMIA Annual Fall Symposium* 1997:662-666.
- 4 Rucker, L, Morrison, E. The "EBM Rx" : An Initial Experience with an Evidence-based Learning Prescription. *Academic Medicine* 75(5) 2000:527-528.
- 5 American Board of Internal Medicine, CPD Update, Press Release, July 31, 2000.

ACGME Extends Deadline for Its RFP 2000 Project to September 30, 2000

At the request of some institutions interested in submitting proposals, the deadline for the ACGME's Request for Proposals initiative (the RFP 2000 Project) has been extended to September 30, 2000. The documents announcing the Project were sent out in early July. The Project's intent is to seek out successful approaches that foster excellence that can be adopted by other institutions and to promote sharing of information on them with the graduate medical education community.

Below is additional information to respond to frequently asked questions about the RFP 2000 Project.

Question: What types of proposals is the ACGME seeking in this Project?

Answer: In this first phase of the Project, the ACGME is primarily seeking proposals that require a waiver of certain accreditation requirements that pose a barrier to new approaches. At the same time, the ACGME is accepting proposals that do not require a waiver, but are innovative and/or represent an effective approach to adapt to the environment.

Question: Is the ACGME offering funding through its RFP 2000 project?

Answer: The first round of the RFP 2000 Project does not include any funding support for proposals. Proposals that are accepted will receive either a waiver of certain accreditation requirements and/or recognition. The ACGME plans to use the best of the proposals it receives in this first round to develop an application for grant support from a foundation or a group of foundations. The quality and relevance of the proposals will be important to the success of this effort. Grant support would enable the Council to fund proposals in the second iteration of the Project.

Question: Could be proposals that are granted a release of certain accreditation requirements ultimately change these requirements?

Answer: The waiver of certain accreditation requirements is a powerful incentive to apply. It represents an opportunity to explore release from one or more requirements that a program or institution believes to be burdensome and not contributing to education. An added objective of the RFP 2000 Project is to test whether this approach can contribute to refining the accreditation requirements and the process. It could provide examples of superior methods to educate residents, and for testing these new approaches, which could then inform the process of revising the standards.

Question: What is the time period for the proposals?

Answer: The maximum time for a given proposal that requires a waiver of accreditation requirements is two years, at the end of which the ACGME will assess the impact of the waiver on education quality. All other types of proposals will be accepted for the same initial two-year maximum period, but the ACGME recognizes that the validity and value of some proposals could be assessed in a shorter time frame. 



Note from the Editor:

In responding to Dr. Rhoads' comments, it is important to restate that the ACGME's standards related to work hours require the Sponsoring Institution to "ensure that each residency program established formal policies governing resident duty hours that foster resident education and facilitate the care of patients." Program requirements in all specialties stipulate 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. Beyond that, six RRCs have set a maximum number of hours that residents may spend in patient care duties per week.

Dr. Rhoads states, and the ACGME is aware, that financial burdens may induce some residents to "moonlight." To address the educational and patient safety issues that arise from this, a policy approved by the ACGME in June 2000 explicitly states that "the moonlighting workload must not interfere with the ability of the resident to achieve the goals and objectives of their GME program." Three other points of this policy address Dr. Rhoads' comments. They are: (1) program directors should monitor resident performance to assure that factors such as resident fatigue do not contribute to diminished learning or performance or detract from patient safety; (2) program directors may choose to monitor the number of hours and the nature of the workload of residents who engage in moonlighting experiences; and (3) program directors should acknowledge in writing that they are aware that a resident is moonlighting, and this information should be part of the resident's folder. The last requirement is currently being considered for inclusion in the next revision of the ACGME's Institutional Requirements.

I read with great interest the review of the articles on limiting resident work hours in the last issue of the Bulletin. You may know that the impetus to limit work hours came from the Libby Zion case in New York, and was carried to the ACGME through the action of the Resident Physician Section of the American Medical Association (AMA) where support for limitations on resident working hours was gained from the AMA House of Delegates.

I have two concerns related to the current limitation on resident work hours. First, I believe it teaches residents not to assume responsibility for continuity of care, because they may feel "entitled" to a limited work responsibility. Secondly, I have long had a suspicion that part of the impetus to limit resident working hours was to free them up to do a certain amount of moonlighting. A high percentage of residents have debt and many of them have very substantial amounts of debt, and have a strong incentive to work for additional remuneration. Limiting call to every third night and the total work experience to eighty hours a week, and having one day out of seven free from patient care responsibilities, the program facilitates the possibility for residents to moonlight. This moonlighting is done independently, and is frequently not reported to the program. An opportunity to work outside the program defeats the requirements of limiting call to every third night and for having one day a week free from clinical duties.

I note further that the article in the ACGME Bulletin on limiting resident work hours, citing data from New York State and European Community throws doubt on the validity of the policy of limiting work hours. It was shown that these limits could lead to different types of errors because they can lead to incomplete information transfer during patient hand-offs and they abrogate continuity of care. In my judgement, the jury is still out on the advisability of limiting resident work hours. A paper presented at the recent meeting of the Association of Program Directors in Surgery reviewed the available studies of cognitive and other functions of residents who had been awake for many hours, and reported only minor problems among the sleep-deprived residents.

In some situations, the slack created by limiting resident work hours will be taken up by attending physicians, many of whom are working very hard to start with, and who have less stamina and reserves than the residents do.

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