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**ACGME** BULLETIN November 2002

Accreditation Council for Graduate Medical Education  
515 North State Street, Suite 2000  
Chicago, IL 60610-4322



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### ***Editor's Introduction:*** **The Return of the "Regular" Format of the ACGME Bulletin**

*Ingrid Philibert*

Following two "special" issues of the ACGME Bulletin, devoted respectively to the Outcome Project and resident duty hours, this issue represents a return to the more general format. It offers summaries from the ACGME meetings held in 2002 and other information of interest to program directors, designated institutional officials and others involved in resident education. In keeping with the ongoing interest in the general competencies and the duty hour initiative, this issue features articles on both topics. Also included is an article about the VA's patient safety curriculum for residents, and the lead article by Dr. Leach describes efforts to streamline the ACGME process of collecting data for accreditation. The intent of the Bulletin continues to be an information exchange between the ACGME and the resident education community, and we welcome your comments on the topics presented in each issue.

**Correction:** The article in the August 2002 issue entitled *New York's Experience With Resident Duty Hour Limitations* by Tim Johnson did not identify Mr. Johnson's organization, which is the Greater New York Hospital Association. We regret this oversight.

### ***Executive Director's Column:*** **Less Process, More Outcome**

*David C. Leach, MD*

The ACGME Outcome Project has two major components: the use of educational outcome measures as an accreditation tool; and the removal of needless process and structure measures. While more needs to be done to use educational outcome measures to inform accreditation decisions we are off to a good start; now it is time to begin the second component of the initiative.

The purpose of this second component is to take a close look at what data the ACGME collects about programs and how it is used. The goal is to make optimal use of emerging information technologies and database design to achieve two primary outcomes: to provide Residency Review Committee (RRC) members with the information they need to make the best judgments possible; and to make the process more useful and efficient for program directors and institutional officials. The initiative should increase the focus on the results of resident education and decrease the waste associated with moving information around.

The work of the ACGME can be framed as: what do we notice; how do we make sense of what we notice; and how do we take action?<sup>(1)</sup> We notice what is submitted in the program information forms (PIFs), what is observed at the time of site visit, and other supplemental data such as resident surveys and surgical logs. Importantly, these elements are noticed in the context of the dynamic history of the program and the institution. We are seeking opportunities to reduce needless process and structure measures that currently consume much energy and often provide little yield, and to pay more attention to the results of educational programs. Not everything in the PIF is equally useful in making judgments about programs. The plastic surgery RRC has developed a radically shortened version of its program information form and is currently studying the usefulness of a more focused approach. Information about the



*David C. Leach, MD*

**“We are seeking opportunities to reduce needless process and structure measures that currently consume much energy and often provide little yield, and to pay more attention to the results of educational programs.”**

methods used in teaching, assessing, and improving the approaches to teaching and assessing the six competencies is being collected over the Internet in a PIF addendum. Resident questionnaires, including questions about duty hours, have been developed and will soon be deployed to supplement the resident interviews that occur at the time of the site visit. Adding information about outcomes and duty hours without subtracting less useful data elements will overwhelm an already burdensome system. We are very grateful that Bill Williams, MD, immediate past chair of the Institutional Review Committee and co-chair of the Work Group on Duty Hours, will work with individual RRCs toward the goals of providing the RRCs with information that they need while at the same time making the process more efficient for program directors and institutional officials. This is a big job; he will begin with a few volunteer RRCs, identify lessons learned and eventually improve the entire system.

The RRCs use group discussions to make sense of all the data gathered. Information technology can assist this process by providing normative data from the universe of programs, trended data for a particular program, and triangulation of data from different sources. For the past two years the ACGME has developed a relational database that should make "making sense" easier. The Accreditation Data System (ADS) is now supplemented by a database for the Common Program Requirements, resident surveys and case/operative logs. At present, this information is displayed in ways that are both traditional and inefficient. Lots of words and numbers have to be examined to get at the nuggets that reveal the true character of the program. It is likely that visual display of key data elements using graphs, charts, and trends can make it easier to convert raw data into useful information. This is challenging when the data is in the form of paper PIFs, but very possible when it is in a relational database.

RRC members take two fundamental actions: make accreditation decisions and develop program requirements. Both of these actions can be enhanced by more useful displays of data. Accreditation decisions are based on a substantial compliance model in which a given program's data is reviewed against the program requirements. Substantial compliance is a judgment made by the RRC as a whole, based on their experience and on the data presented to them. Data displays that enhance understanding of how a particular program is evolving and how it compares to the universe of programs in a given specialty can

enhance these judgments. Further trends within a specialty can be identified and displayed to enhance the process of developing program requirements.

In brief, we hope that this initiative will make use of emerging information technologies and database design to both enhance the work of the RRCs and to reduce the waste associated with gathering and moving information from programs to the RRCs and back again. However, it should also preserve and even enhance the dynamism and vitality of the current system. The system should be complex but not complicated. Glouberman and Zimmerman<sup>(2)</sup> recently wrote a remarkable paper distinguishing complicated and complex systems, which applies to resident education and the accreditation process. Residency programs adapt to dynamic environments; solutions to problems tend to come within rather than being imposed from outside the system; educational outcomes are emergent and uncertain, rather than completely predictable: they are complex rather, not complicated in nature. Much of the data that we now collect assumes that residency education is complicated rather than complex. It may be more accurate to state that each residency program must adapt intelligently to its particular environment while being faithful to established standards. The vitality and creative energy of both programs and RRCs may be enhanced by information that reflects successful adaptation: less process, more outcome.

1) Weick KE. The Reduction of Medical Errors Through Mindful Interdependence. In Medical Error: What do we know? What do we do? Rosenthal, et al., Eds.; JosseyBass, 2002.

2) Glouberman S, Zimmerman B. Complicated and Complex Systems: What Would Successful Reform of Medicare Look Like? Discussion Paper No. 8 Commission on the Future of Health Care in Canada. July 2002.

## **A Patient Safety Curriculum for Residents and Students: The VA Healthcare System's Pilot Project**

*John Gosbee, MD, MS*

"It helps you attack the problem [of patient safety], instead of avoid it"; "I think I was very influenced by your course"; "I remember thinking the course was very helpful...stuff that was thought to be common sense does need study" ... – Quote from a resident during telephone interview several months after being taught about patient safety and human factors engineering.

### **An Overview**

At the National Center for Patient Safety in the Department of Veterans Affairs (VA), we are developing and pilot testing a patient safety curriculum for medical residents and students. A number of physicians and patient safety personnel from VA hospitals (VAMCs) and affiliated universities have volunteered to

assist with this long-term endeavor. They will use many formats and educational venues to evaluate five curriculum modules for training residents and, in some cases, medical students: Patient Safety Overview; Human Factors Engineering and Patient Safety; Patient Safety Interventions; Usability Testing Exercise; and Root Cause Analysis Exercise. The pilot project started in the summer of 2002 at 12 VA facilities. Qualitative research will be used to explore many of the pragmatic issues, and to assess the effectiveness of the approach. In the spring of 2003, we plan on using our pilot experience to further deploy these concepts in several dozen VA facilities that teach medical residents.

### Background

The National Center for Patient Safety (NCPS) provides tools, policies, and implementation support for patient safety activities within the more than 160 Veterans Affairs federal healthcare facilities. NCPS has worked for the past three years to provide extensive training and help implement tools for Root Cause Analysis (RCA) and Healthcare Failure Mode and Effect Analysis (HFMEA™). Most often NCPS works with the patient safety manager and quality improvement personnel at each hospital. Anecdotally, there have been comments about difficulty in getting physicians and residents involved in patient safety activities. A quantitative analysis of participation on VA RCAs in the past two years showed that residents are represented on less than 1 percent of RCA teams.

NCPS is also aware of the requirements of VA facilities to help provide a broad education experience for residents in partnership with residency programs and their sponsoring institutions. As many readers know, one of the ACGME General Competencies is Systems-Based Practice, which includes many items that relate directly to patient safety activities. Some of these specific requirements are for residents to: (1) practice cost-effective health care and resource allocation that does not compromise quality of care; 2) advocate for quality patient care and assist patients in dealing with system complexities; and 3) know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance. NCPS is working with professional societies (the American College of Surgeons, the American Academy of Family Physicians) to help residents learn to apply patient safety principles while working in the VA and in their future endeavors. Finally, NCPS supports the Institute of Medicine (IOM) recommendation to train residents and students about patient safety, which can be found in the IOM

**"...one of the ACGME General Competencies is Systems-Based Practice, which includes many items that relate directly to patient safety activities."**

reports "To Err is Human" and "Crossing the Quality Chasm". The VA is also responding to similar patient safety recommendations in the "Report of the Quality Interagency Coordination Task Force to the President ([www.quic.gov](http://www.quic.gov)).

### The Pilot Initiative

In late summer of 2002, several physicians and patient safety personnel from VA medical centers (VAMCs) and affiliated universities volunteered to assist with the patient safety curriculum pilot (see **Table 1**). With a few exceptions, all were self-selected and contacted my office without solicitation. All physicians were encouraged to contact their local VAMC patient safety manager for involvement. The pilot is a true volunteer effort with no remuneration to participants or obligation by facilities or universities. The general expectation is for each site to try at least two modules at least twice, and participate in monthly teleconferences. Some volunteers had previous experience in quality or safety training for medical students or residents; others did not. All VA patient safety managers who volunteered were interested in training and gaining more effective involvement of teaching physicians and residents in patient safety activities.

The volunteers agreed that there were many ways to "experiment" with patient safety learning experiences – from a more systems-thinking oriented approach for morbidity and mortality (M&M) conferences to new interactive lecture sessions. They were excited about sharing lessons learned, given the diversity of university settings and VAMC administrative structures.

The initial plan was to use multiple formats and educational venues to evaluate five curriculum modules to educate residents and, in some sites, medical students. The five curriculum modules (three interactive lecture modules and two small group exercises) are more fully described below. Computer presentations and accompanying teaching guides were sent for the lecture modules, and teaching guides were provided for the group exercises. Each volunteer site also received supplementary material in the form of an interactive CD-ROM, RCA checklists, and videotapes that were created earlier to teach these concepts to VAMC patient safety personnel. Some sites are planning to use the modules during the already scheduled lecture sessions in the ambulatory care rotation. Others will try teaching during morning or noontime teaching sessions for all residents on a particular rotation. Some volunteers will informally gather all residents on a rotation for an impromptu session. In some of these formats, the learners will be both residents and medical students. Finally, all physician teachers are encouraged to have the VAMC patient safety manager attend some sessions to address questions and provide a bridge to future activities like Root Cause Analysis.

In addition to trading ideas during the monthly teleconferences, we plan to qualitatively assess many of the pragmatic issues, such as scheduling, allocation of time, and evaluation issues. Surveys and open-ended questions for interviews were made available to each site for resident and student assessment. We will do a qualitative and quantitative evaluation of resident participation in Root Cause Analysis and Failure Mode and Effects Analysis teams in the VA facilities. In the spring, the volunteers who tried out the modules will meet to share their

**Table 1.**  
**Volunteers for Patient Safety Curriculum Pilot**

Physician and Patient Safety Manager Volunteers	Specialties	VA Medical Center (VAMC) and University Affiliate
Kaveh Shojanian, MD	Internal Medicine	San Francisco VAMC and Univ. of California at San Francisco
Aileen Sedman, MD, Allen Kachalia, MD, and Raj Mangrulkar, MD	Pediatrics; Internal Medicine	Ann Arbor VAMC and University of Michigan
John Bonner, MD	Anesthesiology	Atlanta VAMC and Emory University
Matthew Weinger, MD	Anesthesiology	San Diego VAMC and University of California at San Diego
Craig Renner, MD, Brian Bevacqua, MD, and Chris Hildebrand, MD	Patient Safety Manager; Anesthesiology; Internal Medicine	Madison VAMC and University of Wisconsin
Mark Graber, MD	Internal Medicine	Northport VAMC and SUNY at Stony Creek
Pamela Bennett, MD and Byron Bair, MD	Patient Safety Manager; Internal Medicine	Salt Lake City VAMC and University of Utah
Greg Ogrinc, MD	Internal Medicine	White River Junction VAMC and Dartmouth University
Kimberly Krohn, MD	Family Practice	Family practice residency and University of North Dakota
Timothy Anderson, MD and Luke Chelluri, MD	Patient Safety Manager; Internal Medicine	Columbia (MO) VA and University of Missouri at Columbia
Jerome Van Ruiswyk, MD	Internal Medicine	Milwaukee VAMC and Medical College of Wisconsin
Richard Bjerke, MD	Anesthesiology	Pittsburgh VAMC and University of Pittsburgh
Gerry Hayes, MD	Surgery	Washington DC VA

experience. The expected outcomes are improvements in module content; development of train the trainer tools; and workable ideas for integrating these modules into resident education.

**“The expected outcomes are improvements in module content; train the trainer tools; and workable ideas for integrating these modules into resident education.”**

**Draft Goals and Objectives**

The goals and objectives for the Pilot Patient Safety Curriculum have been developed from several sources. Most arise from the well-documented need for everyone in the healthcare system to become a part of a change toward a more safety- and system-oriented culture. An example is the ACGME's Systems-Based Practice competencies. Some are derived from the fact that

residents need to be a key part of patient safety activities in the VA healthcare system (e.g., member of RCA teams). The human factors engineering goals and objectives emerged from my involvement in patient safety education activities for several hundred nurses and physicians in training at Michigan State and Western Michigan Universities between 1994 and 2000.

**Goals**

1. The learner will become an agent of change by moving toward a systems and quality approach, and away from a blame and train model (i.e., safety culture transformation);
2. The learner will incorporate an understanding of human performance and high-reliability organizations into patient care and patient safety activities within the healthcare system (e.g., RCA, FMEA); and
3. The learner will become a better consumer, selector, and implementer of computer and medical device technology.

**Objectives**

1. Understand the scope and gravity of patient safety;
2. Know theoretical and practical reasons why "blame and train" and "bad apples" approaches fail;
3. Become familiar with basic theories and terms in safety and human factors engineering;
4. Understand importance of discovering root causes as a basis for developing interventions;

5. Become familiar with human factors engineering techniques that determine root causes and how those techniques are crucial to the design of effective interventions;
6. Understand major categories of patient safety interventions;
7. Understand limitations and pitfalls of automation as an intervention;
8. Understand that some adverse events and systemic problems are "guaranteed" by poor design;
9. Understand and know how to participate in patient safety activities (e.g., RCA); and
10. Develop basic skills for team communication techniques that address major root causes in healthcare settings (e.g., Medical Team Management).

### Summary of the Teaching Modules

I begin with some general comments about the five teaching modules described below. Most of them can expand and contract to fit 60- to 120-minute blocks. Module number one should be presented before any of the other four modules. Parts of the first module could also be incorporated into introductions to the others. All five of the modules have been tried on numerous occasions with several audience types. All work well enough to keep people's attention and prompt unsolicited positive comments. Two common comments are: "why didn't our program teach us this stuff earlier?," and "what are you going to do to fix the problems and hazards we just examined in such detail?"

**Module number one** is the "Patient Safety Overview." It includes working definitions of patient safety, adverse events, and "close calls" or "near misses." There is also discussion of the scope of the patient safety problem and issues determining the scope. The concepts of the "culture of safety" and "high reliability organizations" are introduced with special focus on near-misses.

**Module number two** is "Human Factors Engineering (HFE) and Patient Safety." It includes a presentation of the definition and conceptual model of HFE. Brief case studies with medical devices and software systems highlight the main points of HFE. Group demonstrations and "games" (e.g., Stroop Effect demonstrations) are used to illustrate the concepts and make concrete ties to patient safety incidents.

**Module number three** is "Patient Safety Interventions." It includes discussion and demonstration of how development of good root cause analyses is crucial to developing and implementing effective interventions. Learners are provided a general overview of safety intervention types (e.g., labeling, policy, training, interlocks). The unintended consequences of some "obvious" remedies are highlighted.

**Module number four** is a "Usability Testing Exercise." Everyday objects are used as an analogy to medical devices and systems (e.g., baby wipes in travel packs, hard to use mint dispensers). Groups of three to five learners evaluate these devices around a common table or work surface. One learner is assigned as "participant" to use the system and to walk through the tasks. Others act as observers of such things as participant actions, words, and facial expressions. Once the person has completed the task(s), the team explores the problems related to usage (e.g., errors, inefficient system, and dissatisfaction) and for each, recommends redesign.

**Module number five** is the Root Cause Analysis (RCA) Exercise.

It can be done in many ways with various audience sizes and time constraints. For example, one standard case is provided to teams of four to six participants who generate lists of root causes, safety interventions, and how they would measure effectiveness. Tools from the VA's RCA training course and program are used (e.g., CD-ROM, checklist booklets).

Additional ideas and activities are also being explored on a trial basis. One is the "Patient Safety Journal Club," which can use articles and case studies from, among other sources, Quality and Safety in Healthcare, Annals of Internal Medicine, Morbidity & Mortality (M&M) rounds, and Journal of Academic Emergency Medicine's "Profiles in Patient Safety." Another idea is to have residents keep a Personal Safety Journal, which is discussed with their mentor on a periodic basis. Finally, many facilities inside and outside the VA are looking into medical team management and training techniques. These activities vary widely by size

and content, and data on their effectiveness is just becoming available.

### Cautions and Conclusions

Before readers try any of these modules or ideas, they should take heed of many cautions and lessons that we have learned the hard way. The outcome of this type of effort can be worse than a waste of time if the instructor does not have a "systems" thinking or human factors engineering mind-set. Additionally, the teacher must be able to deal with ethical and legal issues during frank discussions. It has been our early experience that it is difficult to integrate the theory into the class activities for novice teachers.

My major caution to readers: the current effort is a pilot and still is a WORK IN PROGRESS! Updates are expected and encouraged from all participants in this initiative. We expect changes, as we determine the optimal format, trade-off in content, and the best "home" for all these ideas in busy and diverse residencies. Finally, conventional wisdom for curriculum change has not always been observed during our early efforts. A good example of this is the comment we keep hearing from residents: "you should have taught us this material earlier."

All of us at NCPS and the participants in the voluntary effort are excited about the possibility of helping residents to be leaders in moving our hospitals towards a culture of safety. Leadership at our VAMCs and university affiliates has been supportive of these efforts. We will continue to share our small and large successes with the ACGME and other applicable audiences. It is also gratifying to share the constructive attitude and spirit we experienced in our teaching sessions with the residents.

**"We expect changes, as we determine the optimal format, trade-off in content, and the best "home" for all of these ideas in busy and diverse residencies."**

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- John Gosbee, MD, MS, is active in the Department of Veterans Affairs' National Center for Patient Safety ([www.patientsafety.gov](http://www.patientsafety.gov)) ([www.patientsafety.gov](http://www.patientsafety.gov)). Previously, Dr. Gosbee has worked for contractors to NASA Johnson Space Center on the design and development of medical devices and information systems for the future NASA Space Station, and was co-investigator for several design-related experiments on the Space Shuttle. He practices at the Veterans Health Administration Hospital in Ann Arbor, MI.*

## Assessing the General Competencies: ACGME Work in Progress

Susan Swing PhD

### **The ACGME's "Model" Assessment System**

In July 2002, the ACGME began to review information about how programs are using outcome measurement in the development of curricula and the evaluation of residents. One measure of the success of the Outcome Project will be the extent to which residency programs put into place effective techniques for assessing residents' attainment of the competencies. A litmus test for effectiveness is the usefulness of assessment results, that is, the degree to which results provide insights into resident capabilities, performance, and educational needs. Effective measures will provide specific, accurate evidence of what residents do well and reveal deficits in essential skills and knowledge. They will point to additional educational experiences needed by residents and to ways programs' educational curricula should be changed. In addition, effective assessment will enable program directors to attest with a high degree of confidence to their residents' competence.

What does effective assessment of the competencies look like? What assessment instruments and processes will produce results

useful for the above purposes? Despite an abundance of scholarly work on assessment (in general) and techniques for assessing clinical performance (in particular), there is no previously identified and agreed-upon set of measures for in-training assessment that can be offered as a gold standard.

Thus, from the beginning of our outcome initiative, the ACGME has been working to develop a model system for assessing the competencies. When complete, the model system will consist of a set of assessment approaches matched to competencies, example tools, and general features supportive of dependable, useful results. The system is being shaped from two perspectives: (1) assessment principles and research on evaluation tools

**“When complete, the model system will consist of a set of assessment approaches matched to competencies, example tools, and general features supportive of dependable, useful results.”**

reported in the published literature; and (2) the perspectives of physicians knowledgeable about assessment and/or experienced in evaluating residents. These individuals have contributed to model system development through their participation in the ACGME's Outcome Project Advisory Group, the ABMS/ACGME quadrads (composed of an RRC, Board, program director association, and resident representative), the RRC Outcome Project Think Tank, and work groups for assessing Practice-Based Learning and Improvement and Professionalism.

The development process began with the Outcome Project Advisory Group who identified a set of general features for the model assessment system:

- (1) assessment whether residents demonstrate the specific competencies identified in the programs' educational objectives;
- (2) assessment of performance for a representative sample of the most essential/consequential competencies and clinical tasks;
- (3) use of multiple assessment methods;
- (4) use of clearly described standards and criteria for judging performance; and
- (5) assessment of resident behaviors by evaluators in a variety of roles (e.g. supervisors, patients, nurses, peers).

The Advisory Group also identified assessment approaches for each component of each competency. The ABMS/ACGME quadrads reviewed methods from the ACGME/ABMS Toolbox of Assessment Methods and identified those most appropriate for the assessment of the competencies in their specialty.

Their products are being used to inform and reality test assessment tool selection for the model system.

Whereas, initial development work identified a broad set of appropriate assessment methods, the Think Tank's efforts have focused on identifying a minimum set of techniques to illustrate a start-up approach to assessing the competencies. In constructing their approach to assessment, feasibility of instrument use has been a major consideration. The emerging example start-up system includes the following approaches:

- (1) global ratings of all the general competencies;
- (2) focused assessment (observation + concurrent evaluation) of multiple single encounters that pose communication challenges to the resident (e.g. patient, uncooperative colleagues);
- (3) modified 360-degree assessments, i.e. ratings by at least one professional associate (e.g. peers or nurses) and patients, of residents' interpersonal and communication skills and professionalism;
- (4) written vignettes to assess residents' thinking about professional and ethical dilemmas; and
- (5) an evidence file/portfolio of work products and narratives that document residents' on-going practice-based learning and improvement behaviors or supervisor evaluations based on discussions with individual residents structured to reveal their practice-based learning and improvement behaviors.

The Think Tank has not yet considered assessment for the Patient Care, Medical Knowledge, and Systems-based Practice competencies.

Based on our work thus far, it is evident that: (a) acceptable approaches are currently available for assessment, but need to be tailored to better fit the competencies; (b) progress toward effective assessment is possible; (c) feasibility may be influenced by availability of resources, which will limit what can be done; and (d) model assessment per se will be a goal for the future. The first ACGME assessment model will be a start-up system for assessing the competencies. Nonetheless, the litmus test for effective assessment remains the same. It must produce credible, dependable, useful results that provide insights into residents' capabilities, performance, and educational needs.

**“...the litmus test for effective assessment remains the same. It must produce credible, dependable, useful results that provide insights into residents' capabilities, performance, and educational needs.”**

## **A Report on the Activities of the RRC Outcome Project Think Tank**

*Susan Swing, PhD*

The RRC Outcome Project Think Tank met in August 2002 and discussed assessment of Practice-Based Learning and Improvement and Professionalism. Think Tank member Barry Smith M.D. presented the resulting suggestions to the RRC Chair Council at the September ACGME meeting. For Practice-Based Learning and Improvement, the group emphasized that residents must internalize the value of on-going, self-directed learning and improvement of practice and that this would be demonstrated when residents: (a) reflect on and analyze practice experience; (b) locate and apply scientific evidence; (c) take steps to improve practice; and (d) demonstrate improvements. The group discussed and provisionally suggested use of either of the following two assessment methods: supervisor recording of observed incidences of the above during their encounters with residents or an evidence file/portfolio which contains documentation for each of the above behaviors.

Evidence file documentation might consist, for example, of descriptions of near misses, critical incidences, poor patient outcomes for "a" above. For "b," it may consist of copies of literature search print-outs and articles read with definitive information highlighted. For category "c," there may be residents' descriptions of changes needed or made; and for rubric "d," a medical chart or other documentation source could provide evidence of improved performance.

For Professionalism, the Think Tank's assessment suggestions focused on knowledge and reasoning pertaining to ethical and professional dilemmas, residents' professional behaviors, and the learning environment. The Think Tank suggested use of written case vignettes for assessing residents' professional/ethical knowledge and beliefs and reasoning about professional dilemmas. This technique when used with open-ended response or discussion enables insight into how residents are thinking in situations of value conflict (when the choice is between values of equal worth and there is no single right answer). For assessment of professional behaviors, the Think Tank suggested modified 360-degree ratings, that is, ratings should at minimum involve patients and one type of professional associate (e.g. nurses, peers, or allied health professionals). As a departure from its usual practice of suggesting only resident performance measures, for Professionalism, the Think Tank also suggested that residents assess the professional climate of the residency program (as created by the demonstration of professional/unprofessional behavior across all faculty, attendings, and other health professionals with whom they interact). This suggestion followed from the belief that the professional behaviors exhibited in the learning environment are instrumental in determining residents' own conceptions and performance of professional behavior.

The above suggestions are being provided as guidance to the field and not as prescriptions. The Think Tank will continue its work by considering how to assess Systems-Based Practice and Patient Care. The Think Tank is composed of members or former members from eight Residency Review Committees and a representative from the ABMS. 

## Progress on the Competencies

### in Two Specialties

Pat Surdyk, PhD

The ACGME Bulletin regularly highlights the efforts of various specialties to address the competencies. This issue features the Council of Emergency Medicine Residency Directors (CORD) and the Council on Resident Education in Obstetrics-Gynecology (CREOG)

#### **Council of Emergency Medicine Residency Directors (CORD)**

"The ACGME Core Competencies: Getting Ahead of the Curve" was the title of a recent conference sponsored by the Council of Emergency Medicine Residency Directors (CORD) in collaboration with the specialty journal Academic Emergency

members, emerging trends and best practices identified through these CORD meetings will help drive the development of the RRC's expectations for teaching and assessing the competencies in emergency medicine.

#### **Council on Resident Education in Obstetrics-Gynecology (CREOG)**

A task force appointed by the Council on Resident Education in Obstetrics-Gynecology (CREOG) is vested with the responsibility for determining which assessment methods are appropriate and feasible for use by all Obstetrics-Gynecology residency programs. A grant from the American College of Obstetrics-Gynecology Foundation supports its work. The task force organized itself into small work groups for each competency, dividing the Patient Care general competency into two sections, which focus respectively on general activities and on specific surgical competence.

As the work progressed and task force members reviewed the available literature, they recognized the need to identify appropriate instructional methods so an appropriate link can be made between learning and assessment. Such learning activities account for the fact that the preponderance of resident learning occurs outside a structured classroom. Recommendations will most likely include more computer-based instruction that utilizes real clinical cases. The task force already developed and disseminated a global assessment tool for the competencies that can be used by all residencies.

Diane M. Hartmann, MD, associate dean for graduate medical education at the University of Rochester, chairs the task force. Haywood L. Brown, MD, a member of the task force, is also an appointee of the American Board of Obstetrics-Gynecology (ACOG) to the RRC for Obstetrics-Gynecology. Thus, as the RRC develops its expectations for implementing the competencies, it will draw upon the work of the task force through the relationship established by Dr. Brown's membership on both groups. According to Dr. Hartmann, the ultimate goal of the task force is to develop baseline measures from data collected through standardized assessments in Obstetrics-Gynecology. These measures will eventually provide more valid and reliable information regarding the quality of training in the specialty. 

**"The goal of the conference was to develop consensus around specialty-specific definitions, instructional methods, and appropriate assessment models for each of the competencies within emergency medicine."**

Medicine. The goal of the conference was to develop consensus around specialty-specific definitions, instructional methods, and appropriate assessment models for each of the competencies within emergency medicine. Participants from the academic emergency medicine community, the ACGME, and other academic medical organizations met in a combination of informational, plenary, and working group sessions.

Proceedings of the conference will be published in a special November 2002 issue of Academic Emergency Medicine as a result of the journal's partnership in conference planning. [Note: The Table of Contents for this issue is available online at <http://www.aemj.org/future/9.11.shtml#SPECIALCONSENSUSISSUE>.]

The leaders of the conference, Debra G. Perina, MD, President of CORD, Michelle Biros, MD, Editor-in-Chief of the journal and Joseph LaMantia, MD, Planning Committee Chair, view the conference as a seminal event for the emergency medicine community in its effort to improve quality of training and practice. A second conference entitled "Best Practices in Residency Training—Reaching for Excellence" will be held in February 2003. This follow-up meeting will continue the move toward consensus by focusing on current best practices in assessment methodologies and on various curriculum challenges faced by program directors.

As a member of the RRC, Dr. Perina fills a valuable liaison role, representing the needs and interests of program directors to the committee. Through her involvement and that of other RRC

**"...as the RRC develops its expectations for implementing the competencies, it will draw upon the work of the task force through the relationship established by Dr. Brown's membership on both groups."**

## **A Report from the Field:**

### **The Print Is Too Small and We Don't Have Time To Read It – Perceptions of the ACGME Field Staff**

Marianne D. Gideon, PhD

*Editor's note: Marianne Gideon, PhD, presented this report from the field to the ACGME Executive Committee and the Council of RRC Chairs on September 9, 2002. It features several topics important to the graduate medical education community, described from the perspective of the ACGME field staff.*

#### **The General Competencies**

This year's report provides information on issues of interest in the field, including the general competencies, duty hours, and the call for less paper work. On the general competencies, there is good news. We are happy to report that the attitude of program directors toward the general competencies is mostly favorable, and programs can demonstrate that they are beginning to use the competencies in the education and assessment of residents. One program director mentioned that the need to comply with the competencies has placed education at the top on the priorities for his institution. Programs with innovative ideas want to know if what they are doing will meet the RRC's approval, and less imaginative program directors would like the RRCs to prescribe what programs need to do. Many would like to see the ACGME web toolbox filled with more examples endorsed by the RRCs.

On the other hand, one program director expressed concern that there might be so many approaches to the general competencies that the RRCs and ACGME may not be able determine if one is better than another. Some programs just match their old methods of teaching and evaluation to the words of the competencies. They may benefit from information provided by the ACGME to help their program directors know what a competency-based curriculum and measurement system looks like. Members of the field staff believe the variation in the quality of the approach to the general competencies has a lot to do with the institution's leadership. The most comprehensive and innovative ideas are found in places where the graduate medical education committee or the director of education has taken an active, helpful role. Institutions with limited resources are finding some ideas costly. Simulated patients, faculty training, and even collation of 360-degree evaluations require resources they do not easily find.

#### **The Work Environment**

Outside of New York (and also inside New York City) program directors are busily figuring out how to keep resident duty hours at 80 per week and not have to hire additional non-resident personnel. We are hearing mixed messages on the new duty hour standards. Some residents, especially those in surgical disciplines, are concerned that fewer hours may ultimately mean

longer training programs. Residents and faculty are concerned about the burden of work that will be placed on the remaining residents when the post-call residents go home, because only a few teaching hospitals can afford to hire replacement providers for this task. One New York City hospital has hired sufficient physician assistants to allow neurological surgery residents to go home post-call and chief residents in the program average just over 80 hours per week.

Program directors in surgical specialties report that 88 hours a week is something they could "live with," but that 80 hours will be difficult. More than one resident has expressed concern about their personal finances if in-house moonlighting is counted in the weekly duty hour limit. One attending told me "residents need to learn that they can still function when they are tired," and that the public expects them to do this after graduation, and that the majority of physicians will ultimately practice in non-teaching hospitals. Private physicians are called "24/7," and are expected to give orders on the phone or come in and provide care – even when tired. At the same time, there are many residents who are thankful that their hours will be monitored.

#### **Programs' Perspective**

Program directors do not seem to be any more or less familiar with the program requirements than in the past. When asked if he had read the requirements prior to the site visit, one program director told the ACGME field representative he had looked at them on the Web, but "the print was too small and I don't have time to read it." More than one program director said he/she is spending more time on their program either because their RRC requires a commitment of a certain number of hours, or because it takes longer to keep up with the details of monitoring logs, implementing competencies, and making sure faculty and residents turn in evaluations. Program directors would like more help – program coordinators or assistant program directors – and more pay for this role.

Programs are struggling with increased documentation needs and no added, or occasionally, less support from administration. Program information forms are getting longer and have more addenda. One program director told me, "The ACGME has too many regulations and fluff. It keeps adding requirements and does not remove any. None of the new requirements have been tested to show whether they really will produce a better physician." A physician member of the field staff is worried that if the ACGME does

not stop demanding added documentation, more program directors will eventually give up the job.

Program directors are also struggling to balance financial, research and educational demands on the faculty – one example of the problem is faculty not getting to educational conferences.

*continues on page 11*

**The most comprehensive and innovative ideas are found in places where the graduate medical education committee or the director of education has taken an active, helpful role.**

## ***ACGME Approves New and Revised Program Requirements***

At its February 2002 meeting, the ACGME approved the minor revision to the Program Requirements for Transitional Year, Dermatology and Neurology, effective April 12, 2002.

Also approved were revisions to the Program Requirements for Dermatopathology, Spinal Cord Injury (Orthopaedic Surgery), Pediatric Gastroenterology, Pediatric Infectious Disease, and Pediatric Rheumatology (Pediatrics), effective July 1, 2002.

The Council approved two new subspecialties of Neurology – Neurodevelopmental Disabilities and Vascular Neurology – and the program requirements for these specialties. The ACGME also approved Undersea and Hyperbaric Medicine (Preventive Medicine) as an ACGME subspecialty for accreditation of programs and the program requirements for this subspecialty. The effective date for these new specialties is February 12, 2002.

At its June 2002 meeting, the ACGME approved the revisions to the program requirements in Radiation Oncology, Nuclear Medicine, Adult Reconstructive Orthopaedics, and Orthopaedics-Spine Surgery. These modifications will become effective January 1, 2003.

The Council also approved three new ACGME-accredited subspecialties and the program requirements for these, effective June 11, 2002. The three subspecialties are Pediatric Rehabilitation (Physical Medicine and Rehabilitation), Developmental and Behavioral Pediatrics (Pediatrics), and Cardiothoracic Radiology (Diagnostic Radiology).

The ACGME approved revisions to the Institutional Requirements, as well as several amendments to the proposed Common Program Requirements, to become effective July 1, 2003.

Current standards and standards that have been approved but are not yet in effect can be viewed on the ACGME Web site (<http://www.acgme.org>).

## ***ACGME Defers Action on the Revision of the Requirements for Internal Medicine and Recognition of Procedural Dermatology***

At its September meeting, the ACGME deferred approval of major revision to the Program Requirements for Internal Medicine. The Council also deferred recognition of Procedural Dermatology as an ACGME-accredited subspecialty, as well as approval of the Program Requirements for this subspecialty.

## ***Work Continues on the Standards for Resident Duty Hours***

At its September 2002 meeting, the ACGME approved the draft of common requirements for resident duty hours to be incorporated into the Common Program Requirements, and the draft of the expanded Institutional Requirements relating to duty hours. The Council also continued the process of refining the proposed general requirements for resident duty hours. Revisions made included a minor modification related to the use of the added period of up to six hours following call. The intent is to make the requirement as flexible as possible to preserve continuity of care and educationally valuable activities, while placing an appropriate limit on continuous hours of service to address concerns about patient safety and resident well-being.

The ACGME also further discussed the charge to a new advisory Subcommittee on Duty Hours. Its role will entail review of data on resident hours and the effect of the new standards, collected from resident surveys and other sources, and advising the ACGME during the implementation of the new duty hour standards. The proposed membership will include representatives from the ACGME Board of Directors and other individuals with special knowledge and expertise. Plans for this Subcommittee will be finalized at the November 2002 retreat of the ACGME Executive Committee.

The ACGME discussed the process by which programs may request an exception of up to 10 percent to the 80-hour weekly limit. Plans call for each RRC to develop procedures for handling these requests, and for the IRC to periodically review data from RRCs about the number of requests at a given institution. Regarding a proposed exception to the 80-hour weekly limit for all programs in a given specialty, the ACGME decided that no specialty-wide exceptions would be granted initially to allow programs time to demonstrate their ability to comply with the standards. Additional information is provided in the article on Page 12, "A few more frequently asked questions about resident duty hours."

They are also seeking ways to give residents and fellows progressive responsibility, when faculty members believe they must see and examine patients and write notes in order to comply with reimbursement rules. Faculty would like to be able to make a distinction between first-year residents and fellows. They believe they have to provide the same level of documentation for both. Some faculty physicians are concerned that with procedures being divided up between more and more disciplines, such as renal biopsies performed by nephrology, surgery, and now radiology, attendings will have a difficult time educating fellows, as well as maintaining their own skills. Many program directors and faculty members like that the ACGME has "gotten tough" on institutions, such as insisting on internal reviews, with the result that institutions and programs are now better organized.

Some program directors tell us that the ACGME and RRCs need more practicing physicians –those who do not have residents to cover for them– to tell them what it is like in the real world. Similarly, the ACGME needs representation from community hospitals.

### **The World of the ACGME Field Representative**

The members of the field staff are experiencing more difficulty traveling. There are fewer flights; fewer choices; more e-tickets and automated check in with fewer staff at the ticket counters; random searches at security. Worst of all is the person with the rubber gloves who slowly examines every single item in your carry on bags and can lose your contact lens case in the process. All of this makes it unpredictable how long it will take to get from the front door of the airport to the plane. And when you finally get to your seat and pick the airline's magazine out of the seat pocket, you find that the print is too small and you don't have time to read it. 🩺

## **Other Highlights from the 2002 ACGME Meetings**

### **ACGME Elects New Directors and Appoints Officers**

At its meeting in September 2002, the ACGME elected the following individuals to its Board of Directors: Joseph C. Honet, MD (ABMS); Mr. David Jaffe (AHA) and Mr. Paul B. Gardent (AAMC); Sandra F. Olsen, MD, (AMA, as replacement for Robert Daugherty, MD); and Carlos James Vital, MD (Resident Director). The ACGME also approved the reappointment of Mark A. Kelley, MD; Emmanuel G. Cassimatis, MD; and Agnar Pytte, PhD. to the ACGME Board of Directors.



*Charles Rice, MD, receives the gavel from R. Edward Howell, outgoing chair of the ACGME.*

The ACGME also appointed the following individuals as officers of the Board: Charles L. Rice, MD (AAMC); Chair; Mark L. Dyken, MD, Vice Chair; Emmanuel Cassimatis, MD, Treasurer; and Carol Berkowitz, MD, and Wm. James Howard, MD, as officers of the Council.

The ACGME recognized four directors who completed their terms of office at the meeting. They are R. Edward Howell, who completed his term as the AHA representative to the ACGME and as Chair of the ACGME; Betty Chang, MD, who completed her term as Resident Director; David Glass, MD, who completed his term as ABMS representative and member of the executive committee; and Mr. Dennis Brimhall, who completed his term as AAMC representative.

### **Ad Hoc Committee Appointed to Review New Discipline in Sleep Medicine**

The ACGME has appointed an ad hoc committee to explore development of sleep medicine as an accredited specialty. David Nahrwold, MD, formerly a member of the ACGME Board of Directors will chair the committee.

### **Paul Friedmann, MD, and W. T. Williams, MD, Receive the John C. Gienapp Award**

At its September meeting, the ACGME announced that it had selected Paul Friedmann, MD, and W. T. Williams, MD to be co-recipients of the 2002 John C. Gienapp Award, based on their outstanding contributions to the ACGME over the last several years. The recipients were selected from a list of nominees that had been compiled by broad solicitation of the ACGME, its five member organizations and the residency education community.

### **The Recipients of the 2003 Parker J. Palmer Award**

At the September meeting, the ACGME also announced eleven program directors selected to be the recipients of the second Parker J. Palmer "Courage to Teach" Awards. The award was established in 2001 to recognize outstanding program directors in graduate medical education. The recipients were selected by the ACGME Executive Committee from a list of 200 nominees. Criteria for selection included: demonstrated commitment to education with evidence of successful mentoring; program development and improvement; external recognition; broad letters of support including support from residents; and service to education through participation on national committees and efforts. The names and institutions of the recipients are shown below. Recipients will be honored at an awards dinner at the February 2003 ACGME meeting, and will be invited to participate in a retreat at the Fetzer Institute, Kalamazoo, MI, together with the recipients of the first "Courage to Teach" Awards.



*The ACGME says farewell to Betty Chang, MD, Resident Director.*

## Recipients of the 2002 Parker J. Palmer Award

C. Bruce Alexander, M.D.

Program Director for Pathology,  
The University of Alabama at Birmingham, Birmingham, AL

Keith B. Armitage, M.D.

Program Director for Internal Medicine,  
University Hospitals of Cleveland, Cleveland, OH

Eugene V. Beresin, M.D.

Program Director for Child and Adolescent Psychiatry,  
Massachusetts General Hospital, Boston, MA

Frank J. Eismont, M.D.

Program Director for Orthopaedic Surgery,  
Jackson Memorial Hospital/Jackson Health System, Miami, FL

Steven K. Feske, M.D.

Program Director for Neurology, Brigham and  
Women's Hospital, Boston, MA

Joseph T. Gilhooly, M.D.

Program Director for Pediatrics,  
Oregon Health & Sciences University, Portland, OR

Harold L. Johnston, M.D.

Program Director for Family Practice,  
Alaska Family Practice/Providence Hospital, Anchorage, AK

Henry J. Schultz, M.D.

Program Director for Internal Medicine (retired),  
Mayo Clinic, Rochester, MN

John L. Tarpley, M.D.

Program Director for General Surgery,  
Vanderbilt University, Nashville, TN

Bennett S. Vogelman, M.D.

Program Director for Internal Medicine,  
University of Wisconsin, Milwaukee, WI

Kathleen Watson, M.D.

Program Director for Internal Medicine,  
University of Minnesota, Minneapolis, MN

## Institute of Health Care Improvement/ACGME Conference

The Executive Director reported that the Institute of Health Care Improvement has invited the ACGME to host a joint conference December 7-8, 2002 in Orlando, FL to address two of the general competencies: Practice-based learning and improvement and systems-based practice. The meeting will feature workshops of the two competencies by David Leach, MD, Susan Swing, PhD, and Paul Batalden, MD. Twenty-six program director associations have selected two to four program directors to attend.

## ACGME 203 Annual Conference and Workshop

The 2003 ACGME Annual Conference and Workshop will be held March 5-7, 2003 at the Hyatt Regency McCormick Place Chicago. A major portion of the conference will be devoted to resident duty hours and programs' and institutions efforts to implement the new standards, as well as curricula for patient safety and related topics. Additional information concerning room rates, conference registration fees, and contents of the program should be available on the ACGME website [www.acgme.org](http://www.acgme.org) by November 15. The ACGME will offer on-line registration for the conference in January. 

## A Few More Frequently Asked Questions about Resident Duty Hours

Ingrid Philibert

In September, the proposed standards approved at the meeting of the ACGME Board of Directors were disseminated to the member organizations, the resident education community, and the public for final comment. Comments will be received until December 31, 2002 and will be reviewed at the February 2003 meeting of the ACGME. At that time the final standards will be approved. The ACGME will publicize the final standards as soon as possible after the meeting. In the interim, there will be no changes to the language on our web site.

Below are a few additional responses to commonly asked questions about the proposed ACGME common standards for resident duty hours that will become effective July 1, 2003. The replies are based on the intent of the ACGME Work Group on Duty Hours as it developed its report and the suggested standards contained in it. Readers should be aware that minor changes in the standards made between now and the February 2003 ACGME meeting may affect some answers.

**Question:** *The proposed ACGME duty hours standards call for a 10-hour rest period between duty period; the regulations for New York State specify only eight hours of rest. Similarly, the ACGME have established a period of up to six hours for debrief-*

*ing and education after a 24-hour continuous duty period, while New York's 405 rules allow only three hours. Which standards will apply to programs in New York State after July 1, 2003?*

**"To comply with both the New York State regulations and the ACGME requirements, in each instance, programs in New York will need to comply with the more restrictive standard."**

**Answer:** To comply with both the New York State regulations and the ACGME requirements, in each instance, programs in New York will need to comply with the more restrictive standard. For the two specific examples provided, this will require that programs in New York State need to offer a 10-hour rest period between duty periods (in lieu of the State-mandated eight hours of rest) and limit the period for transfer of care, educational debriefing and didactic activities at the end of call to a maximum of three hours.

**Question:** *What is the current ACGME interpretation of the use of the added period of up to six hours at the end of a 24-hour duty and on-call shift?*

**Answer:** At the September meeting, the ACGME formally clarified the intended use of the added time of up to six hours at the end of an on-call period. In addition to allowing residents to participate in required continuity clinics, the standards also allow surgical residents to remain in the operating room or procedure area (e.g., Labor and Delivery) to complete a case.

The current standard states the use of the up to 6 hours is to "maintain continuity of medical and surgical care," and surgical residents can participate in the "first case" of the day, e.g., begin an operation after the 24 hour mark if they have been previously caring for that patient because this falls under the rubric "surgical continuity." Participating in "first cases" is appropriate, so long as the time for debriefing, continuity of care and the expected time for the case taken together do

**"...it will not be acceptable for residents to regularly start long cases at five and one-half hours after the end of the 24-hour period."**

not exceed six hours. The ACGME understands that cases may run over the schedule time, and this will be taken into consideration. At the same time, it will not be acceptable for residents to regularly start long cases at five and one-half hours after the end of the 24-hour period.

**Question:** *The proposed standards allow residents to attend required continuity of care clinics in the six hours post-call. Will residents be allowed to attend other specialty care clinics during that time, such as clinics they participate in as part of a subspecialty rotation?*

Residents' participation in ambulatory clinics after a 24-hour continuous duty period is limited to required continuity clinics in specialties that have required longitudinal ambulatory care experiences, and where curtailing participation by residents who are post-call would create a major scheduling problem and/or reduce the continuity of care experience for these residents. While difficult to predict, it is not likely that this will be expanded to clinics that do not meet one or both of the following requirements: (1) residents longitudinally follow an identified panel of patients over several years; and/or (2) a continuity experience is required for the majority of the months in a given training year.

**Question:** *I read the ACGME will offer exception to the 80-hour weekly limit for all programs in the specialty. When will this option become available and how will it work?*

**Answer:** At its September meeting, the ACGME Board of Directors decided that for now the option to extend duty hours by up to 10 percent above the 80-hour limit would be offered only at the program level. The Board placed a moratorium of approximately one year on requests to extend duty hours for all programs in a given specialty, to give specialties an opportunity to determine if programs will be able to comply with an 80-hour weekly limit.

The option to apply for specialty-wide exceptions will be available at some time after July 2003. It will be available for a given specialty at the request of its RRC. Requests will need to be based on a sound educational rationale, and will require the approval of the ACGME's Program Requirements Committee and Board of Directors.

**Question:** *The proposed standards state requests by individual programs for an exception to go above the 80-hour limit will need to be endorsed by the sponsoring institution's graduate medical education committee (GMEC), and also require approval by the RRC. How soon will the ACGME receive these requests, and will requests be evaluated through a paper review or require a site visit? Can requests be made in early 2003 for a July 1, 2003 effective date for the exception?*

**Answer:** The ACGME anticipates that it will receive these requests for exceptions to the weekly duty hour limit from individual programs, to allow programs to have approval for an exception by July 1, 2003. The ACGME's standards have vested the establishment of policies and the process for granting exceptions with the individual RRCs. Program directors interested in obtaining a program-level duty hour exception should contact their RRC staff in the near future to get a sense of the time line for this process and other guidance the RRC can provide.

**Question:** *How will the proposed duty hour standards count hours spent performing research that occurs during clinical assignments?*

**Answer:** How duty hours during research assignments are considered will vary by individual RRC, and will also depend on whether the research is a required element of the residency program, and whether it is performed as part of a dedicated research assignment, or in conjunction with a clinical rotation. Generally, the ACGME duty hour standards pertain to all required hours in the program (the two exceptions at present are reading and self-learning, and pager call that does not require the resident to come into the hospital). Thus, if the research rotation is a formal part of the program, the combined hours (research and patient care) will need to comply with the weekly limit on hours and all other pertinent standards. If residents conduct their own research, the hours would be identical to other personal pursuits and would not count. Using a "common sense approach," one would expect that the combined hours still meet the test for a reasonably alert and rested resident if that individual participates in patient care.

The ACGME is aware that there may be an emerging gray area where research and clinical assignments overlap in new ways, such as residents on research rotations asked to cover "night float." Currently, the standards in many specialties do not prohibit this, but the same common sense approach mentioned above would put a limit on clinical assignments during research rotations, e.g., a resident who provides eight to ten hours of night float each night for six days a week should have no other responsibilities. It is possible that future iterations of the duty hour standards (in years to come) may need to include more specific language in this area.

**Question:** Will the ACGME continue to have standards in the individual program requirements after the common duty hour standards become effective? In some cases, the common standards are more flexible than the program requirements, e.g., internal medicine limits on-call frequency to one day in three, without averaging. Which standards will prevail after July 1, 2003?

**Answer:** The report of the ACGME Work Group on Resident Duty Hours explicitly stated that the intent of the common standards was to create a minimum requirement for all specialties, to apply where no standard presently exists. Emergency Medicine, for example, will continue to enforce a 72-hour limit of which only 60 hours can be patient care, and anesthesiology will continue to enforce more restrictive limits of not providing anesthesia on the morning post-call. Language in the current program requirements that is identical or nearly identical to the common duty hour standards will be superseded by the common standards. This is to ensure that the language of the requirement is the same across all specialties, and not a "must" in some and a "should" or "desirable" in others. 

## **Editor's Occasional Column:**

### **Duty Hours - "The Good, the Bad and the Ugly"**

Ingrid Philibert

Over the past months, the ACGME staff has observed the activities in the resident education community to prepare for the implementation of the new common duty hour standards. This short article summarizes a few of these observations.

#### ***The Good - Well Begun Is Half Done***

At a time when the effective date of the duty hour standards is nine months in the future, a remarkable trend is that programs and institutions have begun thoughtful efforts to comply. At many, duty hours are moving toward the proposed limit, in the realization that an early start will give education and patient care activities more time to adapt to the new constraints. These efforts are producing valuable learning. Enhancing our collective understanding about compliance benefits from a forum to disseminate this information. One was provided at a conference

sponsored by the Association of American Medical Colleges (AAMC) this September to discuss the organizational, operational and cultural changes to facilitate duty hour compliance. Most helpful for attendees looking for best practices were examples of redesigning care and education in surgery, internal medicine and from a global institutional perspective, led by Debra DaRosa, MD, Northwestern University; Susan Wall, MD, UCSF; and Christine Abrass, MD, University of Washington.

**"In October, OSHA officially deferred to ACGME accreditation as the mechanism to establish and enforce duty hour limits to promote patient safety, learning and resident well-being."**

A recent decision by the Occupational Safety and Health Administration (OSHA) has lent added significance to teaching institutions' and the ACGME's efforts to implement and promote adherence to the new duty hour standards. In October, OSHA officially deferred to ACGME accreditation as the mechanism to establish and enforce duty hour limits to promote patient safety, learning and resident well-being.<sup>(1)</sup> This makes it critical that efforts to comply with the standards achieve their intended goals. Also noteworthy is a position statement on duty hours approved in June by the American College of Surgeons.<sup>(2)</sup> The statement emphasized an important principle for resident education: "quality patient care...is dependent on quality graduate education." Recognizing this co-dependence – because quality of resident education is equally dependent on that of patient care – the College notes that reliance on residents to perform non-educational or routine tasks has contributed to long duty hours, and stresses that hospitals must have sufficient staffing to perform these functions, in keeping with the ACGME requirement that sponsoring institutions must provide services and develop systems to minimize the work of residents that is extraneous to their educational program. Surgeons who have consistently made a case that surgical education requires long hours, and who have acknowledged that they face a compliance challenge, are now working to identify and address approaches that will facilitate reductions in hours for their residents.

#### ***The Bad and the Ugly - "Mispliance" and "Malpliance"***

In our observation of institutions efforts to comply and in hearing about their plans for future activities to reduce resident hours, some of the efforts we learn about are not in keeping with the intent of the standards. An informal conversation with Jim Reason, PhD, known for his work on human error, produced two intuitively appealing terms for these activities –

"mispliance" and "malpliance," in lieu of compliance. They are described below.

Given the constraints most teaching hospitals face, reducing resident hours is easier said than done. Success cannot be limited to hospitals that are able to hire sufficient mid-level practitioners to take over the non-education and repetitive tasks performed by residents. In a recent "Sounding Board" article in the *New England Journal of Medicine*, Debra Weinstein, MD, noted that, "Many institutions will try to preserve the contributions of residents to patient care at its current level, despite a reduction in their work hours."<sup>(3)</sup>

Dr. Weinstein's comment is realistic, in the context of teaching hospitals' financial pressures and personnel shortages and the difficulty of replacing residents. Yet taken to its ultimate meaning – residents' contribution to patient care remains at 100%, while resident hours are reduced 10%, 20% or even 30% – this approach is an example of "malpliance." Another is a program that achieves a call frequency of every fourth night, by having the on-call resident cover two institutions that could be 20 or 30 city blocks apart. Malpliance thus is an effort at compliance that violates the intent of standard, while preserving a shell of ostensible strict adherence. It ignores the potential detrimental effect of this on education and patient care. Achieving compliance by having on-call residents cover a larger number of patients or provide cross-coverage is an approach that will be used by many institutions. Yet, there are limits to the number of patients one resident can cover. At the same time, reorganizing call can be an effective approach if the institution is sensitive to its limitations and to the reduction in resident "involvement" in their patients it may produce.

In contrast, mispliance is simply a misdirected attempt at compliance. Even a good-faith effort to comply can have unintended consequences. Keeping resident duty hours within the stipulated limits is comparable to keeping a car within the lane markers of a highway.

**"Even a good-faith effort to comply can have unintended consequences."**

**"Reducing resident hours is easier said than done, given the constraints most teaching hospitals face. "**

With tighter lanes or new drivers, a lot of attention is focused on this activity, but it cannot be at the expense of attending to other relevant factors like the speed limit, oncoming cars or a near-empty gas tank. Compliance efforts that focus solely on duty hours, to the detriment of other considerations for high-quality education, are not likely to achieve their intended goals. An early narrow

focus on resident hours in the context of New York State's "405" regulations may have contributed to the finding that limits on resident hours resulted in reductions in the quality of care in teaching hospitals, including higher rates of complications after adjusting for severity of illness.<sup>(4,5)</sup> Another study found that reduced resident continuity of care was associated with adverse patient outcomes.<sup>(6)</sup> The concept that underlies both observations is a presumption that residents are the de facto, and sometimes sole, provider of care, and diminishing their involvement reduces the quality of care. What this negates is the role of faculty as the individuals ultimately responsible for the patient. We believe the role of attending physicians will expand in a system of constrained resident hours. This will add to the competing commitments of faculty physicians, who already feel pressure to be productive in multiple venues.

One thing is clear: much remains to be learned about how programs and institutions can achieve high-quality patient care and education with reduced resident hours. In the coming months and years, we will benefit from the learning and the examples, positive and not so positive, that emerge from the activities of the early adopters, and from New York State and ACGME accredited specialties with existing duty hours limits. All of these will serve as learning laboratories for the new common duty hours standards.

#### Sources:



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<sup>(2)</sup> American College of Surgeons. Statement on Residency Work Hours. Bulletin of the American College of Surgeons. Vol. 87, No. 9, September 2002

<sup>(3)</sup> Weinstein DF. Duty hours for resident physicians - Tough choices for teaching hospitals. *N Engl J Med*. 2002; 347:1275-78.

<sup>(4)</sup> Laine, A Goldman, L Soukup, JR Hayes, JG. The impact of a regulation restricting medical house staff working hours on the quality of patient care. *JAMA*. 1993; 269:374-378.

<sup>(5)</sup> Conigliaro J, Frishman WH, Lazar EJ, Croen L. Internal medicine housestaff and attending physician perceptions of the impact of the New York State Section 405 regulations on working conditions and supervision of residents in two training programs. *J Gen Internal Med* 1993; 8(9):502-507.

<sup>(6)</sup> Petersen LA, Brennan TA, O'Neil AC, Cook EF, Lee TH. Does housestaff discontinuity of care increase the risk for preventable adverse events. *Ann Intern Med* 1994; 121:866-72

