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Editor's Introduction:

Ingrid Philibert

Depending on where one stands, the world changed a little or a lot on July 1 when the ACGME implemented the long-awaited common program requirements for duty hours. For the first few weeks of July, we weathered a minor storm of media calls, eager to highlight the ACGME's diligent and timely monitoring of the duty hour standards in the context of attention to residents' learning environment and programs' ability to provide high-quality education. This issue of the *Bulletin*, apart from an article about the ACGME's complaints management process related to non-compliance with the duty hour standards and a summary of the report of the ACGME Subcommittee on Duty Hours, does not focus on this "hot topic." Some readers may consider this a welcome break. At the same time, resident hours are mentioned in articles with topics as varied as the general competencies, patient safety, institutional affiliations, and the discussion of physician formation across the educational continuum.

What emerges is that, like the general competencies, attention to duty hours is becoming embedded in the fabric of programs and in our conversations about resident education. It is this "embedded" view of duty hours that is the advantage of the ACGME's approach over a regulatory solution, in which hours would be the sole focus, de-coupled from attention to the other elements of a residency. Perhaps the best example of an embedded view of a concept is presented in Robert Pirsig's classical "Zen and the Art of Motorcycle Maintenance"⁽¹⁾. Pirsig emphasizes that quality is not some external element that is added to a process, like tinsel put on a tree, instead "quality must be the source of the subjects and objects, the cone from which the tree starts." When we are able to apply this concept to efforts to limit resident hours, we will begin the true process of re-engineering resident education and patient care in teaching settings.

(1) Robert Pirsig, 1974 *Zen and the Art of Motorcycle Maintenance*. New York: William Morrow & Co.

"...like the general competencies, attention to duty hours is becoming embedded in the fabric of residency programs and in our conversations about resident education."



David C Leach, MD

Executive Director's Column:

From Qualified to Competent: On the Way and Oriented Toward Fulfillment

The formation of physicians is never complete. Physicians and the profession they represent are forever "on the way," oriented toward fulfillment but not yet there. Medical science strives for, but never achieves, completion. Each patient is unique and presents a new form of human suffering, and individual and community reflections integrate these variables in ways designed to enhance judgment. Given this, what does it mean to say that a physician is competent? Physicians are thought to be competent when they habitually incorporate three elements into their daily

“Physicians are thought to be competent when they habitually incorporate three elements into their daily work: evidence-based medicine; patient-centered care; and reflective practice.”

work: evidence-based medicine; patient-centered care; and reflective practice. All three must be present; they represent very different forms of learning. Competent is different than “qualified,” the latter documents that a physician has achieved certain educational milestones that are associated with the potential to be competent; whereas competence is a demonstrated habit that expresses itself in the physician’s everyday practice. Residents who complete ACGME accredited residency programs and become board certified are qualified. How would one know if they are competent?

Conversations help. Conversations organized around the six general competencies may be particularly helpful. The practice of medicine is deeply enhanced when practitioners share experiences, thoughts and observations about their work. Shared reflections about scientific evidence (and derivative rules) as well as particular patient experiences (context) for each of the six general competencies — patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and system-based practice — contribute to the development of competence in each of these domains. Community observations and reflections clarify the knowledge, experience, and the habits of a resident. Both patient care and the formation of physicians depend on the relationships supporting medical care and education: relationships between doctor and patient; doctor and student; doctor and colleagues; and the profession and society. Medicine is a cooperative art, because the care process complements the body’s natural tendency to heal. To the extent that we treat medicine as a productive art rather than a cooperative one, we compromise those conversations and the care and education they support.

Four general assessment tools seem to be emerging as useful measures of competence: direct observations of the resident over time, especially focused assessments of particular skills; portfolios of residents’ clinical experience; 360-degree evaluations from colleagues, nurses and patients; and cognitive examinations. Each can be both formative and summative, although to the extent that physician formation is never complete, all assessments can be thought of as formative. Adult learning is rooted in experience and analysis of experience. Conversations about assessments of competence enable informed reflection.

The educational continuum described by Dreyfus⁽¹⁾ proceeds from rule-based to context-based behavior. To a certain extent evidence-based medicine creates the rules of medicine, whereas patient-centered care provides context. Sometimes the rules are created via randomized controlled trials that attempt to control

for context. However, experienced clinicians know that good clinical judgment is informed by the particulars of context. It involves “knowing which rule to break and exactly how far to break it to accommodate the reality before you⁽²⁾.” This involves a deep understanding of the details of the patient. The Dreyfus model is operant in the case of medicine, but the science of medicine moves so fast and is so productive that even experienced practitioners find themselves novices every day. The master clinician uses discernment to recognize both patterns of disease and the particulars of the patient. Judgments are informed by both context and emerging science.

A deeper understanding of physician competence can help determine the appropriate length of graduate training, how to support the lifelong continuum of physician formation, and how to respond to challenges such as duty hour reform. The length of graduate training is now determined by the opinions of experts, applied globally to all learners in that specialty. Some specialties have required a certain number of years of training, others have used the cumulative number of cases of various types, but with no assessment of the quality of resident’s management of the case. As programs attempt to come into compliance with reduced duty hours for residents, many are monitoring the volume of cases seen by the residents. These important observations, if enhanced, could inform the development of a new model of graduate medical education. Acknowledgment that physician formation is truly a lifetime pursuit requires assurance that formation will be supported and expected beyond residency, and that it will be more

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directly linked to competency than the current model. Hope is offered by reforms presently underway at the ACCME as well as a broader coalition of professional organizations that is repositioning continuing medical education (CME) under the leadership of Bruce Spivey, MD, Deputy Executive Vice President of the Council of Medical Specialty Societies.

Medical schools usually have faculty who teach medical students, residents and “grown up” doctors. However, much of graduate medical education is conducted in hospitals that lack medical students, and most continuing medical education occurs in settings that lack both students

“(PIIP) allows an individual to identify professional behaviors they would like to enhance or extinguish.”

and residents. Undergraduate, graduate and continuing education are compartmentalized in ways that create barriers to the recognition and support of the educational continuum. Medicine offers a rich selection of conferences about educational experiences, but usually compartmentization persists. Much less frequent are systematic and clarifying conversations about the formation of physicians from novice to master. Such reflections could serve to clarify substance and form in teaching and help us discern the path that best moves us toward fulfillment.

(1) Dreyfus, H. 1991. *On the Internet*. New York: Routledge Press.
(2) John Kostis, MD, Personal communication, 2002.

The Action Item Grid - An Indispensable Tool for Tracking Programs' Progress

Ethan Fried, MD

Never was a hackneyed phrase used so accurately as to call the implementation of outcomes measures a "work-in-progress." It is certainly a lot of work. But we are making progress. At the St. Luke's-Roosevelt Hospital Center in New York City we have begun using a tool in our Internal Review process and GME Committee (GMEC) meetings that tracks how each of our programs is implementing their own measures for the general competencies.

The tool is called the Action Item Grid (AIG). At an institution with 29 individual programs to keep track of the AIG is an indispensable tool.

The GMEC has also been approaching the competencies in a systematic way. When the project was first announced, we distributed a needs assessment survey to ask which competency the group felt the most uncomfortable about. This was a great way to begin spreading the word about the competencies. The needs assessment itself eventually formed the basis of a Continuing Medical Education (CME) application that was accepted by the hospital CME Committee. All of our meetings now grant CME credit to the attending faculty.

What Competencies Are Assessed?

According to the needs assessment, the least understood and most feared of the competencies were "Problem Based Learning and Improvement", "Systems Based Practice" and "Professionalism." Over the next few meetings, we tried to collect how some of the programs were measuring each of these competencies. We then put the results together, along with tools some programs were using to measure the less problematic competencies into a competency portfolio containing:

- A competency-driven resident evaluation form adapted from the American Board of Internal Medicine but with descriptors at 1 (unsatisfactory), 5 (average, satisfactory), and 9 (superior).
- An example of a patient satisfaction questionnaire that can be used for 360-degree evaluations of communication skills and professionalism.

- A tool called the "Personal Professionalism Improvement Project" (PIIP) allows an individual to identify professional behaviors they would like to enhance or extinguish and then asks each resident to keep track of these behaviors assigning points each time they are exhibited. The individual tracks points on a time series trial. This project teaches Quality Improvement processes and improves professional behavior; at the same time as it measures each resident's commitment to professionalism.
- A survey instrument called the "Residents Attitudes Toward Health Care Teams" adapted from the journal "Evaluation of the Health Professional." By conducting the survey at the beginning of the academic year and repeating it later in the year, a program can assess whether or not its residents are developing attitudes that are conducive to optimal performance on health care teams.
- A collection of Objective Structured Clinical Exams (OSCEs). These OSCEs differ from traditional OSCEs in that they ask the resident to perform objective driven tasks on non-standardized patients. The tasks are structured, each comes complete with a reading to clarify the objectives and each takes only 15 to 20 minutes to perform. They are witnessed by senior or chief residents or faculty and cover different competencies including patient care, medical knowledge and communication.
- One of the OSCE measures professionalism. The Medical Errors OSCE is supplemented by a reproduced description of different kinds of errors. Each first-year resident in the Internal Medicine program is asked to write a reflective piece about each type of error. The piece must contain who was informed about the error and what plan the resident has to avoid such an error in the future. The essays that have already been produced could form the basis of multiple scholarly works.

How are items identified for the Action Item Grid?

During the Internal Review process, a portion of the Internal Review Workbook we have designed contains a summary of the six general competencies as well as a grid of suggested tools including the ones described above. As each Internal Review is reported out, any citation from the most recent RRC site visit, any additional concern brought out by the Internal Review and each of the general competencies are added to the grid. The program is then asked to comment on every item on the grid and report these comments to the GMEC. Programs are also encouraged to check the grid periodically and share with the committee any new developments that address the items on the AIG.

At the most recent institutional site visit the St. Luke's-Roosevelt Hospital Center was commended on its use of the Action Item Grid and the Internal Review Workbook that outlines the General Competencies and provides a toolbox of measurements for them. The resident

"The resident competency portfolio in conjunction with these other instruments is our main battery of tools to measure and improve the outcomes of all our training programs."

competency portfolio in conjunction with these other instruments is our main battery of tools to measure and improve the outcomes of all our training programs.

Ethan Fried, MD, is the Institutional Director of Graduate Medical Education and the Internal Medicine Residency Program Director at the St. Luke's-Roosevelt Hospital Center in New York City.

Improving the Academic-Clinical Relationship in the Community Setting

Stanley M. Kirson, MD

"The student can never be part of the organization in a hospital in which he is present on sufferance. A teaching hospital will not be controlled by the faculty in term time only..." "Centralized administration of wards, dispensary, and laboratories, as organically one, requires that the school relationship be continuous and unhampered."

~A. Flexner, 1910

Some 93 years later, the words of Flexner still ring true. Flexner focused on medical student education, "graduate medical education" not being a well-defined entity at the time. Although his most powerful and scathing criticisms were toward proprietary medical schools that were in the main successful as business but impoverished in their teaching, he did not overlook the role of hospitals. Flexner fervently expressed that teaching excellence resided in the academic faculties of the medical school, and that the hospital would have to accept the school's educational pre-eminence, although: "the facts are locked up - in the patient, and to the patient, therefore, he (the student) must go ..."

Schools were anointed as the primary purveyors of medical education, and the debate over which aspect of education is most important continues in teaching hospitals, medical schools, and among academic and community faculty.

Education of residents today often involves the grafting of university medical school sponsored programs onto participating hospitals' patient care environments. Both contribute to residents' education, and each is heavily invested and dependent upon the other. The primary issues significant to both include GME costs, educational curricula, quality of care, and the challenges of meeting accreditation requirements. These issues are most poignant when the hospitals engaged in GME are not owned by or closely affiliated with

the medical school. In these cases, the community teaching hospitals tend to be more practice oriented, with less time and resources to devote to academic engagement. These teaching institutions also are not bound by school regulations of their function.

It may not be appropriate to fault community teaching institutions or those within them for "inadequate academic commitment." New models of GME have produced new systems of control and decision-making that did not exist a decade ago. Sponsors and hospitals as employers of residents must manage their financial destinies, but may find themselves less able to do so than even a few years ago.

Sponsoring and participating institutions share the upward struggle against a tide of new regulations that are rearranging the conduct of education. Accountability has a new impact, and programs are discovering not always comfortable ways of doing things, as they redefine themselves. Accrediting requirements from the ACGME's to those of the Joint Commission on the Accreditation of Health Care Organizations

(JCAHO) and those of State Boards have tightened, especially in defining quality of patient care and resident training. New regulations like the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) have added required activities for hospitals that affect their residency programs.

Among the complaints are: Who pays?; Who is responsible, accountable and in control?; How do we set priorities? How do we manage them?; How do we maintain respect, civility and cooperation on a day-to-day basis? These challenges are often thought of as unwelcome diversions and some consider them obstacles to the success of a residency. Assuming that the principal goals are the same for most residencies (high-quality patient care through high-quality resident training), how can we define diverse and conflicting viewpoints and multiple demands? There are three notable concepts to assist us: mission and custom, community education, and dependence and trust.

First, defining their mission is something medical schools and hospitals do differently. Each frames its role by what it has been chartered and trained to do, by its historical tradition and customary behaviors, and by the values it respects. Medical schools believe in a hierarchical relationship between teacher and pupil, in the creation of a student/resident/practitioner continuum of learning, and in the science of investigation, learning and inquisitiveness, as a hallmark of academic strength. Hospitals see their mission in providing the safe, efficient, high quality, low cost care that patients demand and are willing to pay for. This requires the provision of a comforting and efficient

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patient care system, but one that also manages costs, length of stay, census and patient flow, technology transfer, quality and other operational parameters. From the outset, the success of the graduate medical education enterprise depends upon a successful reconciliation of these different values and ideals.

Secondly, community education defines participating institutions as community teaching hospitals that exist with or without a central university hospital. These arrangements can be complicated by varieties of market and external factors, entrepreneurial efforts, and managed care relationships, as well as frequent and rapid change in all of these elements. In this fluid setting, the medical

school seldom has an even playing field. Schools often feel they inhabit "rented" space and are accountable for rules not of their own making. Their community obligation to train residents in multiple venues may dilute resources, and create inefficiency. At the same time, the role of the community participating institutions now often includes activism. These institutions are no longer willing to quietly and uncritically pay the freight for resident education. Issues embedded include the higher costs of institutions that provide graduate medical education, potential concerns about the quality of care in settings where residents participate in patient care and, increasingly, the growing requirements for compliance, oversight and accountability coming from

regulatory and accrediting organizations and government. Adding to the burden, the ACGME's new common duty hour standards have the potential of perturbing and straining sponsor-participating institution relationships, because in some disciplines, the core systems of hospital operations must be changed or program accreditation is threatened.

Interdependence and collaboration for institutions under separate ownership require deep and abiding trust between the partners. Trust and trustworthiness mandate that decisions benefit all and can be trusted to be what they were said to be. Honesty, candor, collective and shared opinion, and tolerance are terms that come to mind in defining trust. Altruism and sacrifice are part of this equation. Putting your horse before

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someone else's cart is not easy. These allegiances depend heavily on the quality of the interpersonal relationships between the partners' representatives. Yet, these relationships are often time- and energy-consuming to develop and maintain, and when damaged, are difficult to mend. They can become the barrier to a successful relationship.

Where does the answer lie? Certainly, as the ACGME and JCAHO move closer together in forging a bond between training and patient care, medical schools and their community teaching hospitals must do the same. To look at these matters, several potential characteristics of medical school - community teaching hospital relationships were used as the basis for an interview session to explore the relationships around residency education between the University of Nevada School of Medicine as the sponsoring institution and six affiliated teaching hospitals in Reno and Las Vegas. They comprised: (1) rules and regulations; (2) educational quality; (3) service and patient care issues; (4) resident support services; (5) duty hour compliance; (6) responsibilities and commitments on the part of both parties in the relationship; and (7) the working relationship between the medical school and the hospitals.

Interviewing hospital and medical school leadership using these criteria provided insight to the relationship between the sponsoring institution and the participating hospitals. Although the process we used was subjective, it was valuable in framing attitudes and expectations that will help define and rank institutional relationships. For example, the institutions with the greatest investment in residency education had ranking scores somewhat lower than institutions with fewer residents. This observation may well reflect the more acute problems and stresses associated with the greater complexity at major participating institutions, which results in greater tension and dissatisfaction. On the other hand, some participating institutions with smaller roles expressed great interest and delight in their participation and insight into the significance of resident training. All participants interviewed agreed that bias and culture differences significantly interfered with the conduct of GME. Though refinement of this process is clearly needed, it forms a framework for proceeding further.

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"Interdependence and collaboration for institutions under separate ownership require deep and abiding trust between the partners."

What are our next steps? To assist the medical school in improving its relationships with participating hospitals and their residency education enterprise, clarity of purpose and persistence will be key elements. The points below serve as guiding principles for the next iteration in redefining and refining these relationships:

1. Unify an explicit mission, including teaching and patient care; portray this as a need, and as a condition for both sponsoring and participating institutions before full cooperation can be achieved.
2. Set goals and priorities together and actively implement them. Long- and short-term planning should be established and meetings to implement this agenda should be ongoing and persistent. Everyone should commit to this effort, and objectives should not be allowed to lapse or falter.
3. Responsibilities and accountabilities must be redefined with appropriate inter-institutional agreements.
4. Redundancies among programs, services and finances must be minimized.
5. The planning and decisions of both sponsoring and participating institutions should be approved at the highest level (Trustees, Regents, Healthcare System, and the University) to insure support of and adherence to the goals. The commitment and timetable and objectives must have their explicit approval. The leadership and planning team(s) must have credibility and input at these levels.

These five points are critical. Medicine and medical education are changing rapidly. Adapting to these changes requires focusing on the prominent factors in graduate medical education: curricula, patient experiences, funding, accreditation, technologic and other advancements in medical care, the six general competencies, legal and regulatory requirements, research and the "value" of residency training to participating

"Mission, community education and trust are the domains where we can find the foundations of cooperative behavior, so much needed in these turbulent times."

hospitals and their constituents. Mission, community education and trust are the domains where we can find the foundations of cooperative behavior, much needed in these turbulent times. We would be wise to remember their underlying message. We also need to be aware that expectations can be set carelessly high, and may be unmet if we ignore how and why we deal with one another.

Stanley M. Kirson, MD, is the Designated Institutional Official for the University of Nevada School of Medicine.

Have You RSVP-d Yet?

Patricia Surdyk, PhD

"Can you give me some idea about what others are doing to implement the competencies and to improve assessment?" Hardly a day passes when an ACGME staff member fails to hear this question from an interested caller. While useful answers can be found in the medical education literature and through various specialty-specific websites, another easily accessible and valuable source of real-life implementation experience is the RSVP section of the ACGME Outcome Project website, located at (<http://www.acgme.org/outcome/implement/rsvp.asp>). "Recognizing Success via Implementation" or RSVP, provides a platform for sharing ideas open to all residency programs. Each contribution describes an effort to teach and assess one or more of the general competencies. Submissions to RSVP undergo review by a panel of ACGME staff who determine whether the abstract responds to the submission criteria and provides sufficient detail to help those who might consider implementing a similar project in their program.

"...a Personal Education Plan for residents who need to improve their performance on In-Training Exams."

Interested in remediation related to Medical Knowledge? The latest contribution to RSVP describes a *Personal Education Plan* for residents who need to improve their performance on In-Training Exams. Nancy Barrett, EdD, Coordinator of Instructional Development for the Internal Medicine Residency Program at the University of Illinois at Champaign-Urbana, also includes a web site where you can review materials related to developing this helpful remediation strategy.

Have a question about portfolios as an evaluation tool? James Clardy, MD, Psychiatry Program Director and Patricia O'Sullivan, Assistant Director, Office of Educational Development at the University of Arkansas, share their experience in using portfolios as one means of assessing competence in psychiatry. The process of developing the portfolio can be adapted for other specialties.

"...portfolios as one means of assessing psychiatric competence."

Wondering how to integrate Practice-based Learning and Improvement and Systems-based Practice? In her submission, Eva Schaff, MD, Assistant Professor, University of North Carolina at Chapel Hill, outlines a continuity clinic project that resulted in

"...a continuity clinic project that resulted in improvements to the immunization process in the pediatric continuity clinic."

improvements to the immunization process in the pediatric continuity clinic.

These are only a few examples of the individual projects found on RSVP. In addition, poster winners from the last two years of the ACGME's Annual Educational Conference describe particularly noteworthy and creative ideas. Each of the individual submissions and the posters offer excellent, practical examples from the field with a direct link to the authors for further discussion.

The quality and usefulness of RSVP depends solely on the contributions we receive. The GME community benefits from your contribution. Please RSVP!

ACGME Receives the First Complaints Related to New Duty Hour Standards

Marsha Miller

On July 1, 2003, in many programs the residents' workweek changed. New requirements limiting residents to 80 hours per week averaged over a four-week period were implemented by programs and will be enforced by the ACGME. More detailed information may be found under Resident Duty Hours at <http://www.acgme.org>.

In the first few days of implementation, the ACGME received several complaints. In order to act quickly and consistently, the ACGME developed a complaint management process. This process includes a sequence of steps to determine the validity and seriousness of the complaint.

Some complainants expressed fear of retaliation and some were, therefore, reluctant to provide their names. The ACGME takes seriously violations of duty hours, and has a "whistle-blower" protection policy. Anonymous complainants are encouraged to identify themselves, but occasionally complaints can be supported by other means.

Marsha Miller, ACGME Complaints Officer, in collaboration with the Director of RRC Activities and the specialty RRC Executive Director follows the complaint management process summarized below:

- Check current accreditation status;
- Review history of program and institution for previous duty hour violations;
- Attempt to identify anonymous complainant or obtain independent documentation;
- Check Web Accreditation Data System for program's response

to duty hour questions; Check the Computer Assisted Accreditation Review (CAAR) for internal medicine programs;

- Alert the specialty Residency Review Committee Chair about alleged violations;
- Provide the complaint (removing all complainant identification) to the program director and designated institutional official; response due in seven days;
- If warranted by the seriousness of the complaint, plan the ACGME response with the Chair of the RRC Council and/or Chair of the IRC- immediate site visit; initiate egregious violation procedures; progress report; require supporting documentation, etc.;
- Log complaint(s) into data base.

The ACGME recognizes that this change has not been easy, but ensuring *good learning for good health care* is worthwhile.

Highlights from the June 2003

ACGME Meeting

Duty Hour Subcommittee Provides First Report to the ACGME Board

Wm. James Howard, MD, representing the ACGME's Subcommittee on Duty Hours, provided a preliminary report on the committee's work in meeting its charge of advising the ACGME on issues related to the implementation of the new common duty hour standards. The report addressed collection and use of data on duty hours; timely follow-up in instances of non-compliance; communicating with residents and the public; and internal monitoring to ensure consistent application of the standards across RRCs. The Subcommittee recommended an annual survey of all accredited programs would be useful in monitoring compliance with the duty hour standards. In the fall of 2002 a voluntary survey of all programs yielded a 71 percent response rate from more than 3,900 accredited core programs. Response rates varied among specialties, and were higher for specialties with lower duty hours. The mandatory survey for all accredited programs will consist of just four questions that relate to the numeric elements of the duty hour standards. The information will be collected from program directors using the Web Accreditation Data System (WebADS), and the designated institutional officials (DIOs) of the sponsoring institutions will be asked to verify the information. The ACGME also will collect duty hour data through its resident survey to facilitate cross-validation.

Because of the importance of timely follow-up, the Subcommittee developed an

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"The mandatory survey for all accredited programs will consist of just four questions that relate to the numeric elements of the duty hour standards."



In Memoriam - Dr. Marvin Dunn

The Way It Is

There's a thread you follow.
It goes among things that change.
But it doesn't change.
People wonder about what you are pursuing.
You have to explain about the thread.
But it is hard for others to see.
While you hold it you can't get lost.
Tragedies happen; people get hurt or die;
and you suffer and get old.
Nothing you do can stop time's unfolding.
You don't ever let go of the thread. ~ William Stafford

With great sadness the ACGME must inform the residency education community that Marvin R. Dunn, MD, died on July 29, 2003. Dr. Dunn was the ACGME's Director of RRC Activities, a nationally renowned figure in organized medicine, and a dear colleague and friend to those of us at the ACGME and to the members of the graduate medical community. He was a national resource. In September 1998, the ACGME was fortunate to have Dr. Dunn join the staff. He brought vast experience, deep wisdom, an unflinching sense of humor, and the capacity to see goodness in everyone. His concern for residents was unflinching – he was the country's best resident advocate. As the ACGME developed its duty hour standards and moved to a competence-based method of evaluating programs, he kept the impact on the resident in the forefront of our conversations. He had a deep respect for the role of the Residency Review Committees in strengthening the formation of residents, and kept the RRCs and the ACGME on task to improve the quality of life for residents.

Prior to joining the ACGME, Dr. Dunn served as the AMA's Director of Graduate Medical Education. During his distinguished career, Dr. Dunn, a board-certified pathologist, also served as vice president for health sciences and dean of the College of Medicine at the University of South Florida. Other academic positions he held included dean of the University of Texas Medical School at San Antonio, and acting dean and associate dean for academic affairs at the University of California at San Diego School of Medicine.

Dr. Dunn will be greatly missed by all at the ACGME. Please join us in remembering a friend and colleague.

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ACGME Approves New Subspecialty of Psychosomatic Medicine and Revised Program Requirements Otolaryngology and Urology

The ACGME approved revisions to the Program Requirements for residency education in Otolaryngology and Urology. The revised program requirements for both specialties went into effect on July 1, 2003.

The Council also approved the program requirements for Psychosomatic Medicine as a new subspecialty of psychiatry. Practitioners in this newly accredited subspecialty will devote their time to care for psychiatric disorders in patients with medical, surgical, obstetrical and neurological conditions, particularly for patients with concurrent complex medical illnesses or chronic health conditions. The requirements for this new subspecialty became effective June 24, 2003, and the ACGME will now receive applications from institutions that wish to operate accredited subspecialty programs in this discipline.

Institutional Requirements

The Committee acknowledged the Institutional Review Committee's decision to place a moratorium on revisions to the Institutional Requirements for the coming three years.

Specialty-Specific Refinements to the Duty Hour Standards

The ACGME approved specialty-specific revisions in the language within the common program requirements that addresses resident duty hours. The revisions relate to the activities residents may participate in during the period of up to 6 hours at the end of overnight call. One clarification involved a refined definition of "new patient" to make it more appropriate to the scope of clinical activities in that specialty. Some RRCs developed specialty-specific definitions of "new patient". Others opted to retain the general definition of new patient as "a patient for whom the resident has not previously provided care." A document showing the specialty-specific refinements to the common program requirements for resident duty hours can be found on the ACGME Web site (<http://www.acgme.org>), under Resident Duty Hours, Specialty-Specific Duty Hour Language.

New Procedures for Rebuttal of Citations Related to Proposed Adverse Accreditation Actions

The ACGME approved a revision in the procedures for rebuttal of citations in adverse accreditation actions to permit the RRCs to consider corrections of citations at the request of the program or sponsoring institution, in response to additional information provided to the RRC. As previously, when an RRC determines that an adverse action is warranted, the Committee notifies the program director and the Designated Institutional Official of the sponsoring institution, and includes in the document the citations that form the basis for the proposed adverse action, a copy of the site visit report, and the date by which the program may submit a written response.

The program then may provide the RRC with written information revising or expanding factual information previously submitted that demonstrates that the cited areas of noncompliance did not exist at the time of the site visit or were corrected since the time the RRC reviewed the program. The program essentially states that it is in compliance with the standards on the date that the letter is being sent. The RRC will then determine whether the information may be considered without verification through a site visit. In its evaluation of the program, the RRC will consider the new information, which may lead to a reversal of the proposed adverse action.

In keeping with the ACGME's existing procedures, after being informed of a confirmed adverse action, the program director must inform the residents in the program and all applicants who have been invited to interview with the program that the adverse action has been confirmed. Notification of residents and applicants is still required in instances where the program plans to appeal the action. The revised letter notifying the program of the RRC's decision to confirm the adverse action contains information on the right of the program to appeal the decision to the ACGME. The new procedure for rebuttals and appeals of adverse actions went into effect for any adverse actions proposed after June 24, 2003.

Shortened Program Information Form Approved for Stable Plastic Surgery Programs

The ACGME Board of Directors approved for permanent implementation a project by the RRC for Plastic Surgery to use an abbreviated program information form (PIF) for stable programs in excellent standing with the ACGME. This follows the successful completion of a pilot using the shortened PIF. The goal of the pilot was to explore whether a short PIF could be successfully used for program reviews. It encompassed review of 18 programs that used a shortened PIF requiring significantly less data collection and preparation time, and that then underwent an on-site inspection by a member of the ACGME field staff. The pilot demonstrated that use of an abbreviated form did not have a detrimental effect on the review process and provided a thorough assessment of the program. During the pilot phase. Two programs were placed on probation following review using the shortened PIF. Program directors, RRC members and the members of the ACGME field staff found the use of the short PIF highly acceptable.

Based on the success of the pilot, the ACGME approved streamlining the accreditation process for stable plastic surgery programs through the use of an abbreviated PIF. The Board also asked that the ACGME, through its Monitoring Committee, further discuss how use of a shortened PIF may be adopted or adapted by other Residency Review Committees.

algorithm that consistently applies the common standards in situations where non-compliance may be discovered, including data surveillance, the site visit, and complaints about alleged non-compliance (see the article *ACGME*

Receives First Complaints Related to New Duty Hour Standards on page 7 of this issue of the *ACGME Bulletin*).

The algorithm is based on the ACGME's existing accreditation process, placing responsibility and authority with the RRCs. It describes the actions taken by the RRCs, IRC and ACGME, and defines the actions expected of programs and institutions when instances of non-compliance are discovered, and the actions that may be taken by the ACGME if the program or institution fails to come into substantial compliance.

To respond to interest in information on successful ways to reduce

resident hours, the report recommended that the ACGME compile information on "innovative approaches" in this area for publication on its Web site and a Web page to display this information has been developed. The ACGME depends on the assistance of programs and institutions in sharing information on their innovative approaches. A form for submitting them can be found at <http://www.acgme.org> under "Resident Duty Hours," "Innovative Approaches."

The Board of Directors agreed with the Committee's recommendation that procedures currently in effect for program accreditation and institutional review, procedures for addressing complaints against residency programs, and procedures for rapid response to alleged egregious accreditation violations or catastrophic institutional events shall be used for duty hours. The final report of the Subcommittee on Duty Hours will be presented to the ACGME Board of Directors at its September meeting.

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Retreat Held for Parker J. Palmer Award Recipients

The Executive Director stated the Parker J. Palmer retreat was held at the Fetzer Institute in Michigan for this year's recipients of the Parker J. Palmer Award. Parker J. Palmer chaired the meeting. In addition to the award recipients, the retreat was attended by two members of the Executive Committee, Wm J. Howard, MD, and Carol Berkowitz, MD, and members of the ACGME staff.

ACGME Communications Task Force Issues Report

Mark Dyken, MD, Chair of the Strategic Communications Task Force, and Julie Jacob, Communications Manager and staff to the committee, provided the report of the Task Force to the ACGME Board of Directors. The Task Force recommended several initiatives to enhance the ACGME's communications with key constituencies. The key points of the strategic communications plan include a new ACGME logo and graphic identity, expanded communications with the news media regarding the ACGME's role and initiatives, and enhanced communication with residents and medical students.

Communication with residents will emphasize the ACGME's function and the benefits the accreditation process produces for residents and applicants by ensuring that programs meet standards for educational content, supervision and duty hours and the working environment. The communications plan will be implemented over the coming months. The new graphic identity for the ACGME will result in a redesign of the printed materials produced by the Council as well as a re-design of the ACGME Web site.

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ACGME Professionalism

Conference

A few spaces are still left for *Fostering Professionalism: Challenges and Opportunities*, a conference co-sponsored by the ACGME and the American Board of Medical Specialties. Information on the conference and a registration form can be found on the ACGME home page at <http://www.acgme.org>. The conference is designed for individuals in medical education and credentialing interested in teaching and assessing professionalism in undergraduate, graduate, and continuing medical education learning environments.

Briefly: National and International News About Residency Education

Britain Plans 2004 Implementation of EU Work Hour Limits

On July 19, 2003, the European journal *The Economist* included a short article about further reductions in resident duty hours in Great Britain, where resident work hours this August were reduced to 56 hours per week. The 56-hour limit does not include call, and physicians in training may be in the hospital for another 16 hours weekly, so long as the added time is spent sleeping while on call. The new rules are merely an intermediate step toward Great Britain's implementation of the European Union (EU) limits on work hours by August 1, 2004. After that date, resident hours must be limited to 48 hours per week including call. The article mentioned concerns about the impact of the changes on the ability of Britain's National Health System to care for all patients requiring services; and reported that the Royal College of Physicians has called for delaying the implementation of the EU work hours for another three to six years, to allow the nation to train more physicians.

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Mining the General Competencies for Patient Safety

Ingrid Philibert

Introduction

In the Spring 2003 issue of the *ACGME Bulletin*, *Moving Beyond Professionalism: Mining for Bioethics and Humanities in the ACGME General Competencies* by David Doukas, PhD,¹ illuminated the language of the general competencies addressing ethics and humanities in medicine. This article adopts Dr. Doukas' approach to explore the elements of the competencies that pertain to patient safety, and continues with a more general discussion of patient safety in the context of accreditation in health care.

Dr. Doukas asserted that the general competencies "are woven with a sustained thread of medical ethics throughout all of its sections." Similarly, concepts articulated in all six general competencies are identical to the experts' recommendations for creating a safer care environment. Examples include physicians' evaluation of their own patient care in section on **Practice-Based Learning and Improvement**; effective information exchange and teaming with patients, their families, and other health professionals within **Interpersonal and Communication Skills**; and awareness of and responsiveness to the larger context and system of health care in the section on **Systems-Based Practice**.²

Patient Safety in the ACGME Requirements

The goals of high-quality education and safe patient care provide the organizational framework for the ACGME standards. The ACGME promotes safe patient care in settings where residents train through requirements for

"...accreditation in health care evolved from a desire to increase patient safety, beginning with a focus on the quality and safety of surgical care."

educational curricula; appropriate supervision of care; mandating that residents be observed and certified to perform procedures; and through standards for periodic evaluation throughout the residency. Historically, accreditation in health care evolved from a desire to increase patient safety, beginning with a focus on the quality and safety of surgical care. The efforts of Ernest A. Codman, MD, a Massachusetts surgeon, to assess surgical safety

“This may leave some wondering whether there is adequate mention, whether instructors and learners understand the references in the general competencies, or whether there is need for more explicit standards for curricula related to patient safety.”

the concepts of medical error and patient safety.⁵ This may leave some wondering whether there is adequate mention, whether instructors and learners understand the references in the general competencies, or whether there is need for more explicit standards for curricula related to patient safety.

A thorough look should convince the reader that the major concepts related to patient safety – those mentioned above and others – are present in the competencies, though they are not organized together or identified under a header “patient safety.” One reason for this is historical. The formulation of the general competencies was essentially completed by 1997, two years before the publication of the IOM Report *To Err Is Human* resulted in a national focus on patient safety by health care institutions, industry leaders and accrediting organizations.⁶ A second reason is the role of the competencies as “organizing principles that permit conversations about our work (the education of residents),” an observation first made by the late Dr. Marvin Dunn.⁷ The competencies serve as a framework for the development of curricula, and as parameters for resident evaluation. Patient safety is a broad construct that comprises a range of specific recommendations, including enhancing communication, verification of information, elements of professionalism, while at the same time depending on proficiency in the

contributed to the development of the American College of Surgeons’ hospital standardization program. This program ultimately evolved into the Joint Commission on the Accreditation of Health Care Organizations (JCAHO).³

Readers of the ACGME’s standards will not find them larded with references to “patient safety.” Explicit mention of patient safety is largely absent, even in specialties like Anesthesiology where the leadership has worked formally to enhance the safety of anesthesia care since 1984.⁴ Patient safety is mentioned only once – in the requirements for Obstetrics and Gynecology, where it occurs in the context of resident supervision, not education about

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competencies “Medical Knowledge” and “Patient Care.” Making patient care safer requires co-existence and integration of principles residing across the six competencies. It may not be well served by a few explicit standards separate from these existing concepts.

The Role of Residents

The JCAHO, which accredits health care organizations across a broad range of functions, adopted standards for patient safety in 2001. The standards address leadership, staff education, team training, and reporting of medical errors and outcomes of care.

As providers of care residents are subject to the JCAHO safety standards, though many residents do not appear to be aware of this.⁸

At least as important residents’ role as providers is their role as learners in a formal education program. The IOM’s recent effort to assess the education of health professionals opted not to address

“At least as important residents’ role as providers is their role as learners in a formal education program.”

patient safety as a distinct area.⁹ Instead, it used a competency-based approach, recommending that education and accreditation/certification of trainees and practitioners in the health professions focus on five areas: patient-centered care, functioning as part an interdisciplinary team, evidence-based medicine, improving the quality of care, and effective use of information technology.

Many hospitals have started comprehensive efforts to increase resident knowledge about patient safety, and most have instituted at minimum lectures on safety and errors in health care. There are a few cross-institutional efforts. One of them, the efforts by the VA’s National Center for Patient Safety to develop and test a patient safety curriculum for residents and medical students was described in the Fall 2002 issue of the *ACGME Bulletin*.¹⁰

Accreditation Standards and Change in the Health Care System

In the late 1990s, JCAHO began to assess its standards, finding that about 50 percent of them were directly related to patient safety,¹¹ including standards for restraint and seclusion; fire and emergency preparedness; life safety; infection control; medication management; management of surgery, anesthesia and transfusion services; staffing coverage and competency management. However, concurrent analysis of JCAHO's sentinel events¹² database, and review of safety management in other high-risk industries suggested the need for additional "explicit" patient safety standards, added in July 2001.¹³ The added safety standards address analysis and re-design of vulnerable patient systems, such as medication ordering, preparation and dispensing; and institutions' and providers' responsibility to disclose the outcomes of care – both intended and unintended.

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Safety Culture or Safety Cult

"We must create a cult of patient safety." A speaker's slip of the tongue while advocating for a "culture of safety" at a recent meeting of patient safety experts inadvertently expressed the thoughts of some – that focus on safety is akin to a cult. It highlights tension between the "initiated" and "doubters" that still characterizes the patient safety debate. Causes include an inadequate understanding of the goals of the patient safety movement; a generation gap between the supporters of institution-wide patient safety initiatives advocating root cause analysis (RCA) and those who view errors more traditionally as the realm of the morbidity and mortality conference; and safety hyped by consultants, along with "quality," "productivity," and "clinical re-engineering."

Inadequate understanding may be the most common cause. Many of the recommendations to address patient safety are new and complex. Some are misunderstood. An example is the confusion between "internal reporting" and "public disclosure" of patient errors. The Joint Commission's mandates internal reporting of errors, recommending that mandatory reporting be limited to serious adverse events and noting that internal

“Wu et al. about reporting of errors by medical residents found that 54 percent discussed the error with their attending physicians, and 24 percent informed patients or their families.”

reporting to explore causes and prevent recurrences is protected from discovery.¹⁴ Access by JCAHO and others in the context of quality assurance activities does not waive this protection under state or federal law.

Disclosing health care errors or unintended outcomes of care to patients and their families is more controversial. JCAHO's patient safety standards require full disclosure to patients of outcomes of care, including unanticipated outcomes, while not mandating reporting of errors and "near misses" that do not affect the patient.¹⁵ This requirement is challenging, in the context of the ongoing debate among safety experts, patient advocates and health professionals about the benefits and drawbacks of disclosing errors to patients. A recent article by Wu et al. about reporting of errors by medical residents found that 54 percent discussed the error with their attending physicians, and 24 percent informed patients or their families.¹⁶ Training health care professionals, including residents, in how to handle patient disclosures, and the fact that disclosure may waive the protection of the information from discovery are just two of the issues raised by this approach to promote patient safety

Residency education occurs in an environment where individual organizations and residency programs can lead the way in formulating approaches to promote patient safety, including residents and others disclosing errors and unintended outcomes to patients. At the same time, this draws attention to the problem for accrediting organizations that must respond to emerging principles such as disclosure to patients as a tool in promoting safety. The dilemma result from the fact that a "let all flowers bloom" permissive approach is an insufficient response for an accrediting organization, while formulation of "minimum" standards needs to be sensitive to what all institutions can be expected to meet.

“To highlight safety as yet another "new mandate" may not be an adequate approach and may cast doubt on credible existing efforts.”

Conclusion - Responding to the Patient Safety Imperative

William Hazlitt has said: "To give a reason for anything is to breed a doubt of it." Many health professionals besides Ernest A. Codman, MD, have worked to make care safer, years before the national focus following the publication of the IOM report. To highlight safety as yet another "new mandate" may not be an adequate approach and may cast doubt on credible existing efforts. Moreover, an organizational focus on patient safety does not guarantee desired results. This has been chillingly demonstrated in cases of serious medical errors occurring in institutions that initiated major patient safety campaigns.

What does this mean for residents' learning environment and the complex clinical systems in teaching institutions, and what does it suggest for the ACGME's standard-setting process? The range of JCAHO and ACGME standards that already implicitly address patient safety makes it clear that what is needed goes

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beyond a few named safety standards. Like those of other accrediting organizations, the ACGME's standards undergo periodic refinement in response to emerging information about new methodologies, patient care modalities, and other issues relevant to resident education. The most recent update addressed the effects of sleep loss and fatigue on patient safety, learning and resident well-being by establishing common requirements for resident duty hours. It is conceivable that in the coming months, the ACGME may further examine its standards, to explore whether additional explicit standards or a referencing of the existing JCAHO patient safety standards would benefit safety patient care and high-quality resident education.

Decisions about how to advance patient safety in teaching settings must be made in the context of the environment in which residencies operate. For example, a standard mandating "open internal reporting of errors" will require a culture that protects the reporter and the information that is being reported, and avoids punitive measures or idle suggestions for the resident to "be more careful next time."

Safe patient care in the complex systems of a teaching hospital calls for attention to all factors that influence

individual, team and system performance. That residents can play a role in this has been demonstrated by the success of efforts to solicit residents' suggestions for how to reduce errors in teaching settings.¹⁷ This places the source of the solution within the system. The effective approach may ultimately be one that makes patient safety an "embedded concept," inseparable from the other elements of the patient care process, as described by Robert Pirsig.¹⁸ "Mining" the general competencies for patient safety shows that the competencies, which are themselves an emerging phenomenon, incorporate patient safety and could expand to do this more explicitly. The competencies' greatest "asset" in promoting patient safety may be that they focus learning and evaluation beyond medical knowledge and patient care, and make explicit the need for communication, team work, and coming to terms with the accuracy and precision demanded of professionals in a high-risk industry in ways that recognize the limits of human cognition. This view of the competencies vis a vis efforts to promote patient safety is similar to a suggestion Donald Berwick, MD, President of the Institute for Healthcare Improvement (IHI) made in 1998: Increase knowledge in the world, so as to reduce reliance on knowledge in the head.¹⁹

- 1 Doukas, D. Moving Beyond Professionalism: Mining for Bioethics and Humanities in the ACGME General Competencies. ACGME Bulletin. Spring 2003. Chicago, IL: ACGME.
- 2 Accreditation Council for Graduate Medical Education, Competencies and Outcome Assessment. (<http://www.acgme.org/Outcome/> accessed July 28, 2003).
- 3 JCAHO. Ernest A Codman. <http://www.jcaho.org/accredited+organizations/codman+award/> accessed July 28, 2003).
- 4 Siker, E. S. History of the Anesthesia Patient Safety Foundation (APSF). June 15, 2001 (<http://gasnet.med.yale.edu/apsf/foundation/history/history.html> accessed July 28, 2003).
- 5 Program Requirements for Obstetrics and Gynecology. I.A.4.a. Supervision of residents is required to ensure proper (1) quality of care, (2) education, (3) patient safety, and (4) fulfillment of responsibility of the attending physicians to their patients....
- 6 Susan Swing, PhD, ACGME Director of Research, Personal communication, 2003.

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- 7 Leach, D. Seeking the Simplicity on the Other Side of Complexity. ACGME Bulletin. Fall 2001. Chicago, IL: ACGME.
- 8 Personal conversations with a convenience sample of residents, 2003.
- 9 Institute of Medicine. *Health Professions Education A Bridge to Quality*. (2003) Washington, DC: National Academies Press.
- 10 Gosbee, J. A Patient Safety Curriculum for Residents and Students: The VA Healthcare System's Pilot Project. ACGME Bulletin, Fall 2002. Chicago, IL: ACGME.
- 11 JCAHO. Our Commitment to Patient Safety. (<http://www.jcaho.org/general+public/> accessed July 28, 2003).
- 12 The JCAHO Glossary defines a sentinel event as "an unexpected occurrence involving death or serious physical or psychological injury, or the risk." (<http://www.jcaho.org/accredited+organizations/hospitals/sentinel+events/glossary.htm>, accessed July 28, 2003)
- 13 Rick Croteau, Executive Director for Strategic Initiatives, JCAHO, Personal communication, August 4, 2003.
- 14 JCAHO. Position Statement on Reporting of Patient Errors. (http://www.jcaho.org/accredited+organizations/patient+safety/hc_errors.htm, accessed July 28, 2003).
- 15 Rick Croteau, Executive Director for Strategic Initiatives, JCAHO, Personal communication, August 4, 2003.
- 16 Wu AW, Folkman S, McPhee SJ, Lo B. Do house officers learn from their mistakes? *Quality and Safety in Health Care*. 2003 June, 12(3):221-6; discussion 227-8.
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- 18 Pirsig R. *Zen and the Art of Motorcycle Maintenance*. 1974. New York: William Morrow & Co.
- 19 Berwick DM, Presentation, Cleveland, 1998.

Letters to the Editor:

The ACGME Bulletin is interested in furthering dialogue about matters in residency education through including Letters to the Editor about articles in the Bulletin, and the issues addressed in them. Letters may also assist us in learning when we have covered an issue well, and when we have failed to do so. Please send letters to the editor to iphilibert@acgme.org. Many thanks.

Phronesis and Professionalism

I write to commend the Bulletin and David J. Doukas, M.D. for the article: "*Moving Beyond Professionalism: Mining for Bioethics and Humanities in the ACGME General Competencies*." His thoughtful discussion adds much to the conversation. However, I write also to challenge his statement that, "Missing is practical wisdom (phronesis), the ordering virtue that discerns how the other virtues can be used to best effect." In my opinion phronesis is captured in the competency "practice-based learning and improvement;" in fact phronesis is at the heart of practice-based learning and improvement. The concept is crucial to medicine; our real value as physicians comes not from knowledge and skill (which are prerequisite), but from our capacity to make good clinical judgments – to determine the best means to the best end.

Phronesis is also translated as prudence; Aquinas translated it as "reason made perfect in cognition of reality (truth)." In other words, it is reason made perfect in practice-based learning and improvement. It is using the particulars of a given patient to inform judgment rather than using the disease model in the abstract. It is a constant clarification of the best steps forward in this particular case. John Kostis, MD has said it is "knowing exactly which rule to break, and exactly how far to break it, to accommodate the reality before you." This is the intent of practice-based learning and improvement - clarification of reality to enhance judgment. This competency favors Aristotle – begin with experience – rather than Plato – begin with the ideal.

*David C. Leach, MD
Chicago, Illinois*

**"Phronesis...
is reason made
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improvement."**