

RRC NEWS

DIAGNOSTIC RADIOLOGY



Accreditation Council for Graduate Medical Education

FEBRUARY 2012

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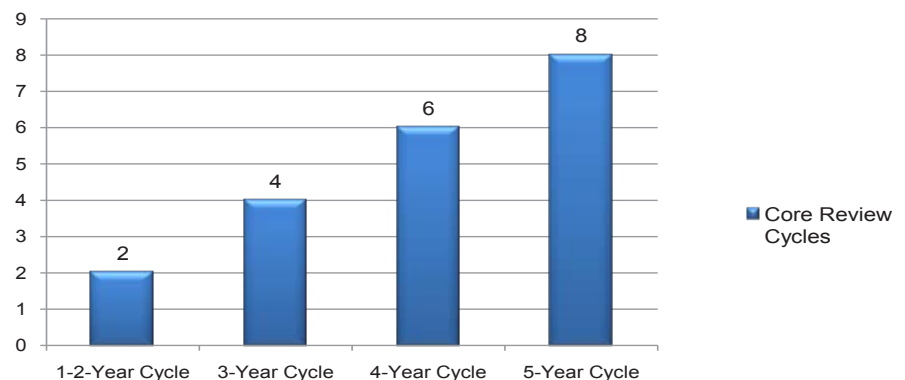
INFORMATION ON THE NEXT ACCREDITATION SYSTEM

The graduate medical education community was introduced to the concept of the “next accreditation system” in March 2010, when ACGME Chief Executive Officer Dr. Thomas Nasca discussed the shift to the next system during his welcoming address at the Annual Educational Conference. The summary of Dr. Nasca’s address can be found [here](#). In brief, the next accreditation system will be very different from the current accreditation system which is associated with episodic site visits and reviews and accreditation cycles between one-five years. The next accreditation system will be more of a continuous accreditation model that will be associated with annual reporting and review of data. The next system will also foster and promote innovation and excellence, much more than the current one does. Program directors should anticipate receiving an update on when and how the next accreditation system will be implemented in the near future.

NOVEMBER 2011 ACCREDITATION ACTIONS

The November 10-12, 2011 Review Committee meeting agenda included the accreditation status reviews of 20 core programs in addition to 10 progress reports. The chart below illustrates the review cycles granted to those 20 programs.

Core Review Cycles - November 2011



(continued on p.2)

MEETING AND AGENDA CLOSING DATES

MEETING: APRIL 5-7, 2012
AGENDA: CLOSED

MEETING: NOVEMBER 8-9, 2012
AGENDA CLOSING: AUGUST 30, 2012

NOTIFICATION DEADLINES

5 DAYS AFTER MEETING:

E-MAIL NOTIFICATION OF REVIEW STATUS/
CYCLE LENGTH AUTOMATICALLY SENT TO
PROGRAM DIRECTOR AND DIO.

60 DAYS AFTER MEETING:

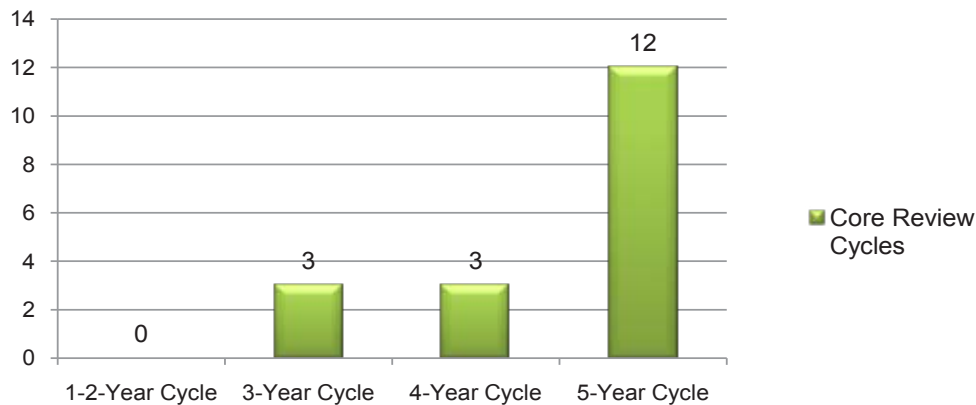
E-MAIL ALERT SENT STATING THAT LETTER
OF NOTIFICATION IS POSTED IN ADS.

*UNTIL THE OFFICIAL LETTER IS POSTED IN ADS,
REVIEW COMMITTEE STAFF MEMBERS ARE UNABLE/NOT
PERMITTED TO DISCUSS THE COMMITTEE’S ACTION OR
SPECIFIC DETAILS OF THE AREAS OF NON-COMPLIANCE.*

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The meeting agenda also included the accreditation status reviews of 18 subspecialty programs. The chart below illustrates the review cycles granted to those programs.

Subspecialty Program Review Cycles - November 2011



2011-2012 PROGRAM INFORMATION

Specialty/Sub	# Programs	Avg. Cycle Length	Filled/Approved Positions
Diagnostic Radiology	187	4.55	4847/5070
Abdominal Radiology	10	4.60	48/52
Cardiothoracic Radiology	0	N/A	N/A
Musculoskeletal Radiology	14	4.35	36/37
Neuroradiology	85	4.49	248/307
Nuclear Radiology	19	4.58	18/35
Pediatric Radiology	46	4.50	85/121
Vascular and Interventional Radiology	92	4.45	215/272

MOST PROGRAM CITATIONS DURING ACADEMIC YEAR 2010-2011

The most frequently cited areas for all core programs reviewed in during the 2010-2011 academic year were:

- **Faculty Qualifications** (e.g., board certification)
- **Scholarly Activity** – faculty and residents
- **Program Director Responsibilities** (e.g., PIF completion, program oversight for program evaluations, faculty evaluations, didactics, case log data)
- **Resources** (e.g., space, equipment, facilities)
- **Procedural Experience** (e.g., procedure documentation, number and types of procedures)

(continued on p.3)

Most Common Subspecialty Citations during Academic Year 2010-2011

	Faculty Qualifications	Curriculum Development	PD Responsibility	Resident Evaluation	Program Evaluation	Didactics	Procedures	Scholarly Activity
Abdominal	x	x						
Endovascular Surgical Neuroradiology			x	x	x			
Neuroradiology				x	x	x		
Pediatric	x		x	x	x			
Nuclear				x	x	x	x	
Musculoskeletal				x	x			x
Vascular/ Interventional					x	x		x

CASE LOGS AND DATA ACCURACY

Lawrence P. Davis, MD, FACR, Chair, Review Committee for Diagnostic Radiology

The ACGME Case Log System for Diagnostic Radiology went live in July 2006. Since then, all programs are required to enter data at least annually for each resident. The number of examinations preliminarily interpreted or dictated by each resident in a representative group of imaging examinations must be entered. The group of index exams include: chest radiographs, CT of the abdomen and pelvis, CTA/MRA, image guided biopsies and drainages, mammography, MRI of the body, MRA of the brain, MRI of the spine, MRI of the knee, US of the abdomen and pelvis, and PET. Please note that not all examinations in these categories are required, only key representative ones. The CPT codes for the specific examinations are listed in the Case Log System and are reviewed annually. Data is accumulated in an aggregate fashion and not on a case-by-case basis as is done by most other specialties that use case logs.

Up to this point, the Review Committee has been in a data collection mode. The Review Committee has not used the data for accreditation decisions. However, this will change. The Review Committee will now start to use the data accumulated over the last five years, and begin to set benchmarks and minimum standards for resident experience.

As the Committee reviewed the data we already have, concern was raised about its accuracy. There are some programs where data entered for individual residents is "ZERO" in specific categories. There are some programs where the data entered is astronomically high, beyond what even faculty member radiologists are likely doing. Most concerning is the fact that in some categories the standard deviation of the data is higher than the mean. This suggests that there is much too much variability in the data.

Accurate data **must** be submitted. The Review Committee urges all program directors and program coordinators to look very carefully at the data being submitted for their own residents. Programs should consider entering the data more frequently than once per year. This will help ensure that errors in entry do not skew a whole year's worth of data. The Committee strongly suggests that all program directors look at every resident's data at the time of his or her semiannual evaluation meeting to make sure it is accurate and that the resident has had an adequate clinical experience during the preceding six months.

The Review Committee will now begin to look at individual program data and will contact a program if there are concerns about the accuracy of its data. This is an extremely important issue. The quality of the data inputted is a vital issue as the Committee moves forward with setting minimum standards.

A new user interface is now ready for diagnostic radiology and ready for use. Additional information and the URL to access it can be found [here](#).

CLARIFYING REVIEW AND COMMENT PERIOD FOR PROGRAM REQUIREMENT REVISIONS AND NUCLEAR RADIOLOGY REQUIREMENTS POSTED

As most newsletter readers are aware, suggested revisions to program requirements are made available to the community of interest for a period of public comment built into the approximately two-year revision process for a given set of requirements. However, the specifics of this public comment period may not be clear to all.

During the development or revision process for program requirements, which can take up to 24 months to complete, an opportunity exists for members of the public—the community of interest—to review the proposals and provide comments and feedback. The groups which constitute the community of interest, per ACGME Policy, are: member organizations of the ACGME; organizations that nominate candidates for Review Committee membership; designated institutional officials (DIOs); chairs and executive directors of each Review Committee; program directors in the specialty. These groups, as well as any additional specialty organizations identified at the discretion of the Review Committee whose requirements are in-process, are notified of the public comment period via the ACGME's weekly *e-Communication* when the proposed requirements (as well as an Impact Statement) are posted.

The length of the period of public comment is 45 days (for major revisions to existing requirements, new requirements, and focused revisions) from the date of the *e-Communication* announcement. In the case of focused revisions, only comments regarding the portions being changed, and not on the document in whole, will be accepted. The proposed document stays posted on the ACGME website for one full month after the deadline for comments, but once the deadline has passed, no comments need be accepted for consideration. Extensions or exceptions for comments received after the 45 days have passed are made at the discretion of the Review Committee. After the month has passed, the document is moved to the archives section of the web page, where it remains until the final requirements are approved by the ACGME Board of Directors.

The Review Committee evaluates all comments received, and decides which suggestions will be incorporated into the final proposal. Comments received are kept confidential, and are only viewed by members of the Review Committee and the ACGME Committee on Requirements. All comments are addressed, whether accepted or declined, in a

document submitted with the final proposed requirements to the ACGME.

All requirements posted for review and comment can be found on the ACGME website (www.acgme.org), by selecting the left-hand links to "Review and Comment" > "Program Requirements." Posted along with all current documents are the deadlines for comments and the e-mail address to which comments should be submitted.

The Program Requirements for **Nuclear Radiology** are now posted on the ACGME website for [review and comment](#). The deadline date for comments to be submitted for consideration by the Committee is March 7, 2012.

REVIEW COMMITTEE LEADERSHIP CHANGES NEW CHAIR AND VICE CHAIR

Dr. Lawrence Davis was elected chair by the members of the Review Committee for Diagnostic Radiology at the Committee's spring meeting. Dr. Davis's term as chair began July 1, 2011, replacing Dr. Steven Amis who completed his tenure as chair on June 30. The Committee's new vice chair is Dr. Tom Berquist, who replaces Dr. Anne Roberts.

Dr. Davis has many years of experience as a program director at Long Island Jewish Medical Center in New York. He has also served as president of the Association of Program Directors in Radiology (APDR), and as chair and vice president of the Commission on Education of the American College of Radiology (ACR). He brings a wealth of educational know-how and experience to the position. Dr. Davis has been a member of the Review Committee for the past three years, and is well-versed in the program review and accreditation processes. He currently serves as the interim chair of the combined Departments of Radiology throughout the North Shore LIJ Health System. A diagnostic radiologist specializing in nuclear radiology, Dr. Davis brings a thoughtful and thorough approach to ensuring accurate and fair accreditation decisions in his new role on the Committee. He will also no doubt be a wonderful resource for the hundreds of program directors and program coordinators around the country. His term as chair will run for three years.

DR. AMIS COMPLETES TENURE AS MEMBER AND CHAIR OF THE REVIEW COMMITTEE

On June 30, 2011, Dr. Steve Amis completed almost seven years as a member of the Review Committee for Diagnostic Radiology, the last four and a half years as its chair. His extended tenure on the Committee and his term as chair resulted from a reorganization of the group of all Review Committee chairs at the

ACGME. To provide better continuity for the Council of Review Committees, it was decided that chair terms going forward would be three years rather than two. Some chairs had their tenures extended to longer than three years to provide synchronization of eligibility to be chair for other members within their respective Review Committees.

Dr. Amis welcomed the additional time as chair as it enabled him to complete follow-up of the ACGME Monitoring Committee review of our Review Committee, a process which actually "accredits" the Committee to render autonomous accreditation decisions for residency and fellowship programs. All new specialty program requirements which were in the pipeline have been approved and are now effective, and the working relationship between the Committee and the American Board of Radiology (ABR) has been firmed up to make sure that the residency and fellowship requirements and the requirements to qualify for the Board exams are in sync. Finally, according to Dr. Amis, over the past five years or so, the Committee has standardized many of its accreditation processes and tightened many of its requirements, resulting, he believes, in better accreditation decisions and the education of better radiologists as a result.

DR. ANNE C. ROBERTS COMPLETES COMMITTEE TERM

Anne Roberts, MD also completed her Review Committee term on June 30, 2011. Dr. Roberts devoted almost half of her term to serving as the Committee's vice chair. Although Dr. Roberts represented the chair in a number of situations over the years, one of her primary accreditation obligations related to assuming that role when the Dr. Amis recused himself from situations with which he had a conflict or duality of interest. Dr. Roberts, an interventional radiologist, provided essential knowledge and know-how during the process for updating the vascular and interventional radiology program requirements. Dr. Roberts could be counted on to bring her personal warmth and enthusiasm to every meeting in addition to sharing her expertise, vast experience, and unending energy to every task she undertook.

REVIEW COMMITTEE MEMBERSHIP CHANGES

DR. JANNETTE COLLINS COMPLETES HER COMMITTEE TERM

Jannette Collins, MD completed her Review Committee term on June 30, 2011. Early in her tenure, Dr. Collins established herself as an independent thinker whose ethical compass always supported her

path along the professional high road. She contributed her time, expertise, and energy to updating the core program requirements, interviewing directors of programs that were innovative and notable (see the [Spring 2008](#) newsletter), and sharing Review Committee information at the Association for University Radiologists (AUR) annual conference. During her tenure on the Committee, Dr. Collins left her faculty position at the University of Wisconsin to become Chair of Radiology at the University Hospital/ University of Cincinnati College of Medicine. As the Review Committee's most accomplished female athlete, we will miss Dr. Collins' sense of adventure when recounting her summer bike riding tours around the country.

DR. JASON ITRI COMPLETES HIS COMMITTEE TERM

Jason Itri, MD, PhD also completed his Review Committee term on June 30, 2011. During his two-year tenure as the Committee's resident member, Dr. Itri was elected to a leadership position on the Council of Review Committee Residents (CRCR), and participated in the ACGME's Leadership Skills Training Program for Chief Residents, which he strongly recommends for all CRCR leaders. He also serves on the Diagnostic Radiology Milestone Working Group. Dr. Itri was also honored as a recipient of the David C. Leach Award at the ACGME's 2011 Annual Educational Conference. Dr. Itri completed his medical school education at the University of California Los Angeles, and began his abdominal imaging fellowship at the University of Pennsylvania, where he recently completed his residency. Based on his energy level and many accomplishments already, Dr. Itri is expected to make some major contributions to the field in the coming years.

NEW MEMBERS

Five new Review Committee members attended their observational meeting in early April and then the ACGME's New Member Orientation Program on May 2, 2011 in Chicago. The new members are: Dr. Susan John, a pediatric radiologist; Dr. Duane Mezwa, an abdominal radiologist; Dr. Jeanne LaBerge, an interventional radiologist; Dr. Gautham Reddy, a chest radiologist; and Dr. Dan Barr, a radiology resident at the University of Michigan. The new members have been assigned mentors who will assist them with their initial transition to the Review Committee.

ACGME DEPARTMENT REORGANIZATION AND STAFF CHANGES

With the departure of Dr. Jeanne Heard as the Department of Accreditation Services' senior vice

president, the ACGME has begun the reorganization of the department into three sections: hospital-based, medical, and surgical. Three vice presidents have been recruited to lead these new departmental sections. Executive director specialty assignments and staff members have also been realigned so that all specialties assigned to an executive director fall into just one of the sections.

Missy Fleming, PhD, former executive director of the Review Committee for Diagnostic Radiology, left the ACGME in August after over four years of service. Her support staff team included Ms. Norma Rodriguez de Yagcier and Ms. Kelly Carpe. The Review Committee is very thankful for the support they gave the diagnostic radiology community.

The new ACGME staff team started working with the Review Committee in November 2011. [Lynne Meyer, PhD, MPH](#) is the new executive director. Supporting Dr. Meyer are Senior Accreditation Administrator Sara Thomas, Accreditation Administrator Rebecca Becker, MS, and Accreditation Assistant Lauren Johnson. The team is looking forward to working with the diagnostic radiology community. Please do not hesitate to contact any of the staff members if you have any questions. Contact information can be found on page 1 of this newsletter.

REVISED COMMON PROGRAM REQUIREMENTS ADDRESS DUTY HOURS

Lawrence P. Davis, MD, FACR, Chair, Review Committee for Diagnostic Radiology

The Common Program Requirements, with notable revisions to the section on duty hours in the learning and working environment, became effective July 1, 2011. Key components of the requirements are:

1. Work hours not to exceed 80 hours per week averaged over a four-week period
2. Maximum of 24 hours of continuous duty for PGY-2s and above, and 16 hours for PGY-1s
3. Call no more often than every third night
4. One day in seven free of all service obligations
5. MUST have eight hours and SHOULD have 10 hours between scheduled duty periods
6. Educate all faculty and residents to recognize signs of fatigue and sleep deprivation

Though not significantly changed from the current Program Requirements for Diagnostic Radiology, there are some significant changes of which all programs should be aware. These include:

1. No more than four hours of call transition allowed (previously this was six hours)
2. No more than six consecutive days of night float (previously this was nine days)

3. "Strategic napping" after 16 hours of continuous duty and during the hours of 10:00p.m. to 8:00a.m. is strongly recommended
4. All internal moonlighting and now all external moonlighting must be accounted for and added into the 80-hour per week total
5. Programs must set guidelines for circumstances and events where residents must communicate with supervising physicians
6. Programs must have a process to ensure continuous patient care in the event that a resident may be unable to perform patient care duties
7. Sponsoring institutions must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home

MILESTONES

Kay Vydareny, MD, American Board of Radiology

The Diagnostic Radiology Milestone Working Group met in March and September 2011 to begin work on milestones for the specialty. Members of the group include Drs. Kay Vydareny, Chair, Steve Amis, Jim Borgstede, Gary Becker, Dorothy Bulas, Lawrence Davis, Jannette Collins, Jennifer Gould, Jason Itri, Jeanne LaBerge, Rick Morin, Duane Mezwa, and Robert Zimmerman, with ACGME staff assistance from Drs. Steve Nestler and Lynne Meyer. The group members spent much of the first meeting trying to define what it is that a diagnostic radiologist does (called "Entrustable Professional Activities" by the ACGME), and then developing milestones for the Patient Care competency. During the second meeting the group drafted milestones for all of the competencies. The group plans to refine these in the next few months and then get feedback from the APDR and other interested parties at the AUR meeting in March 2012. Group members are aware that their task of creating meaningful milestones without overwhelming the program directors with an unreasonable amount of data to be collected is critical to the successful implementation of the project. Diagnostic radiology has been chosen by the ACGME to be one of the specialties that will pilot milestones and the next accreditation system. This means that our specialty will have significant input into the eventual character of the entire project.

LEADERSHIP TRAINING FOR CHIEF RESIDENTS

Gautham Reddy, MD, member, Review Committee for Diagnostic Radiology

The ACGME's Department of Education is partnering with the American Alliance of Academic Chief

Residents in Radiology (A3CR2) to ease the transition into the role of chief resident. The ACGME and A3CR2 will work together to enhance the leadership development component of the A3CR2 program at the annual meeting of the AUR to be held in San Antonio from March 19-22, 2012. The curriculum will begin with a seminar on personal leadership styles and will include focused sessions on group dynamics, conflict resolution, giving and receiving feedback, and stress management. For more information, please visit www.aur.org/A3CR2. The A3CR2 program is designed to motivate residents to seek more education in these areas.

The ACGME Leadership Skills Training Program for Chief Residents will also be offered during the spring of 2012 at locations around the country and will provide three days of in-depth workshops on:

- Dynamics of group function
- Dynamics of working in small and large groups
- Discovering your personal leadership strengths and weaknesses
- Dealing effectively with conflict
- Working with hospital administrators
- Giving and receiving effective feedback
- Dealing more effectively with personal stress

For more information on this ACGME program, visit http://www.acgme.org/acWebsite/meetings/me_lead-erskills.asp.

SUPPORT RESIDENT SERVICE ON NATIONAL COMMITTEES

It has come to the attention of the Review Committee that, in some instances, residents who serve on committees for national medical, specialty, subspecialty, or educational organizations are being required by their residency program to use vacation days or 'paid time off' to attend committee meetings.

The Review Committee views committee service as a form of scholarly activity which should be supported by residency programs. Programs are not expected to provide financial support for travel to committee meetings, but programs should allow residents adequate time away from clinical service to both prepare for and attend committee meetings.

PROGRAM DIRECTOR QUALIFICATIONS FOR RADIOLOGY SUBSPECIALTIES

Duane Mezwa, MD, member, Review Committee for Diagnostic Radiology

All diagnostic radiology program directors know that they must have the requisite ABR certification in diagnostic radiology. However, subspecialty program directors of neuroradiology, nuclear radiology, pediatric

radiology, and vascular interventional radiology programs must also have a Certificate of Added Qualification (CAQ). Program directors who do not meet this requirement will be cited for non-compliance.

PHYSICIAN TEACHING: NON-CORE VS. CORE FACULTY MEMBERS

Gautham Reddy, MD, member, Review Committee for Diagnostic Radiology

All physician faculty members must devote sufficient time to fulfill their educational responsibilities, demonstrate a strong interest in education, maintain an environment conducive to educating residents and fellows in each of the ACGME competency areas, participate in faculty development programs to enhance teaching effectiveness and scholarship, engage in scholarship, regularly participate in conferences, and support residents in pursuing scholarly activities. Faculty members who do not fulfill these requirements must not be involved in teaching residents or fellows.

A portion of the faculty (up to 25 people) must be designated as core faculty members. The core faculty must be able to evaluate the ACGME competency domains, work closely with the program director, develop and implement evaluation methods, and devote at least 15 hours each week to resident education and program administration.

All physician faculty members, whether core faculty members or not, must be certified by the ABR, or be in the process of becoming ABR-certified. A program will be cited if it has any physician faculty members who do not meet this requirement. (Certification by the American Board of Nuclear Medicine is considered to be an acceptable qualification for subspecialists in nuclear radiology.) International board certification is not considered to be equivalent to ABR certification and is not an acceptable qualification.

The Physician Faculty Roster on the program information form (PIF) must include all physician faculty members who have a significant teaching or mentoring role in the program.

PROFESSIONALISM AND ABR EXAM SECURITY

Gautham Reddy, MD, member, Review Committee for Diagnostic Radiology, and Kay Vydareny, MD, American Board of Radiology

The Review Committee expects programs to evaluate residents in the six core competency areas, including professionalism. One of the components of professionalism is adherence to ethical principles, and

it is expected that all residents will comply with the updated ABR Exam Security Policy (see <http://theabr.org>). Programs must not support or allow any form of recording, use, or dissemination of ABR examination questions.

This may represent a break with past practice at many programs, but the ABR believes that examination results should reflect a candidate's knowledge, skill, and understanding, rather than his or her ability to obtain and study from unauthorized study materials such as recalled questions from past exams. To fulfill its mission to serve the public, the ABR needs to ensure the integrity of its certification decisions, and the Review Committee supports the ABR in this regard. Beginning in 2012, department chairs, program directors, program coordinators, and residents in every ACGME-accredited program will be asked to sign attestations that they understand and will abide by the ABR exam security policy.

Residents who violate the exam security policy may be subject to sanction by the ABR, including judgment as unacceptable for certification and legal action for violation of copyright.

SITE VISITS AFTER JULY 1, 2011

The July 2011 ACGME-Bulletin described several changes to site visits that took effect after July 1, 2011. These include: a new section of the PIF in ADS containing a brief set of questions on resident duty hours, supervision, and other key elements of the new common program requirements; an updated [document checklist](#); use of the Tracer Method to verify and clarify information during the site visit; full implementation of a pilot to collect resident input during site visits through a list of five strengths and five opportunities for improvement forwarded to the field representative prior to the site visit; and announcement of a pilot to change the sequencing of site visit interviews such that residents will be interviewed immediately following a brief introductory meeting with the program director.

For programs with site visits scheduled for 2012, the 2012 Resident Survey and the Faculty Survey that was implemented in late 2011 include new questions on compliance with the new Common Program Requirements.

For more information, please see the July 2011 [ACGME-Bulletin](#).

COMPLEMENT INCREASE REQUESTS

The Review Committee now considers complement change requests *not associated with a program review* as they are received. Normally, the Committee will respond to a request within approximately two-

to-three weeks. Occasionally, requests will need to be reviewed at the time of the Review Committee's next meeting. If that is the case, Review Committee staff members at the ACGME will contact the program directly with that information.

As a reminder, temporary complement increase requests are meant for temporary situations, such as for residents who are off-cycle, or whose graduation date has been extended due to leave or remediation, or to accommodate a transferring resident from a closed program. Temporary increases should be limited to one position for a maximum of one year unless unique circumstances such as accommodating residents from closed programs occur.

Please be sure to enter all requests through the ACGME's Accreditation Data System (ADS). Click [here](#) for further information on complement increase requests.

RESIDENT SURVEY INFORMATION UPDATES

The aggregate **2009-2011 Combined Resident Survey Results** reports for those programs with fewer than four active residents are now available.

All **2010-2011 Resident Survey Individual Program** reports with a new trend graph were reposted during December. This graph shows non-compliance by category area and year and is available to program directors, DIOs, and field staff members. The values shown for each year are the mean percentages of non-compliant residents, by category, for the program. The bars represent the mean non-compliance nationally (for all residents in all programs).

Programs may view resident survey reports within ADS by selecting the "Resident/Fellow Survey" menu from the left-hand side and clicking the "Aggregate Report" link. DIOs may view these reports by selecting the "Program & Resident Info" menu from the left-hand side, clicking the "View and Update Sponsored Programs" link, and selecting the report link for each program under the "Resident/Fellow Survey Report" column.

ADS is accessible by going to the ACGME homepage, selecting "Data Collections Systems," and then "[ADS](#)" from the left-hand menu, and then clicking the "Login" link.

Please e-mail WebADS@acgme.org with any questions or concerns.

USE OF RESIDENT SURVEY DATA

A common topic facing Review Committees is the disposition of Resident Survey results and how these results may impact a program's accreditation status.

The ACGME and its Review Committees consider residents' engaged participation in this annual survey both important and valuable.

Use in Program Evaluation: Review Committees, programs, and sponsoring institutions consider residents' evaluations of their programs important sources of information about program quality. Since the implementation of the annual ACGME Resident Survey in 2004, many programs and sponsoring institutions have used its results to focus improvement efforts. After the survey results have been aggregated, program directors, and DIOs can view a summary of the results for their individual programs or institutions, and implement action plans to address issues of concern.

Use during Accreditation Site Visits: During site visits, ACGME field staff representatives use the results of the ACGME Resident Survey, along with other information provided by the program or institution, during resident interviews and to identify potential issues for inclusion in the site visit report.

Use by the ACGME and Review Committees: Beginning in 2009, the Council of Review Committees and ACGME senior leadership discussed methods for aggregating data from multiple areas of the survey as a way for Review Committees to assess interim (between site visits) information about programs and sponsoring institutions. Aggregation of individual survey questions into areas of program functioning (faculty, evaluation, educational content, resources, duty hours) offers a way to learn about areas and patterns of non-compliance that may be present in a program, and that are not driven by any single item.

Results Available in the ACGME Accreditation Data System (ADS): DIOs and program directors are encouraged to continue using the results of the ACGME Resident Survey as an ongoing quality improvement tool. Multiple reports are available within ADS to provide this resource to programs and institutions:

- **Resident Survey Individual Program Reports**
These also display the national non-compliance percentages for all residents.
- **Resident Survey National Data Overall**
- **Aggregate Institution Level Resident Survey Reports**
- **Aggregate 2007-2010 Combined Resident Survey Results**
- **Resident Survey National Data by Core Specialty**—along with national data for specialty-specific questions for all residents within a given specialty.

A MOMENT OF REFLECTION: THE ACGME'S COURAGE TO TEACH AWARD

The ACGME's Parker J. Palmer Courage to Teach Awards Program was created by the ACGME's former CEO Dr. David C. Leach to: 1) honor and celebrate program directors; 2) bring about renewal in education so that program directors reclaimed their teaching roles; 3) create a safe place for reflective practice and contemplation for medical educators; and, 4) encourage program directors to start movements revitalizing teaching in graduate medical education within their own institutions. Current CEO Dr. Thomas J. Nasca supports these ideals and carries on the good work of recognizing outstanding physician educators.

During its Annual Educational Conference on March 2, 2012, in Orlando, Florida, the ACGME will recognize the top ten outstanding program directors to receive the 2012 ACGME Parker J. Palmer Courage to Teach Award at a special awards luncheon and ceremony. The ACGME and its Review Committees congratulate the new awardees, and wish to call attention to the specialties that have had program directors receive this prestigious award. There are many exceptional program directors across specialties that the GME community wishes to honor and celebrate—they just need to be nominated!

Over the past 11 years, the ACGME has recognized 112 outstanding program directors with its Parker J. Palmer Courage to Teach Award. Following are the 2012 recipients:

Felix Ankel, MD	Program Director for Emergency Medicine, Health Partners/Region Hospital, St. Paul, Minnesota
Stephanie Call, MD	Program Director for Internal Medicine, Virginia Commonwealth University, Richmond, Virginia
Grace Caputo, MD	Program Director for Pediatrics, Phoenix Children's Hospital/ Maricopa Medical Center, Phoenix, Arizona
David Gantt, MD	Program Director for Cardiovascular Disease, Texas A&M University, Temple, Texas
Waguih IsHak, MD	Program Director for Psychiatry, Cedars-Sinai Medical Center, Los Angeles, California
Alan Louie, MD	Program Director for Psychiatry, San Mateo County Behavioral Health and Recovery Service, San Mateo, California

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Mary Klingensmith	Program Director for Surgery, Washington University, St. Louis, Missouri
Charles Seelig, MD	Program Director for Internal Medicine, Greenwich Hospital, Greenwich, Connecticut
Rebecca Swan, MD	Program Director for Pediatrics, Vanderbilt University, Nashville, Tennessee
Andrew Varney, MD	Program Director for Internal Medicine, Southern Illinois University, Carbondale, Illinois

The following core specialties and subspecialties have had one or more program directors receive an ACGME teaching award:

Anesthesiology	3
Dermatology	1
Diagnostic Radiology	1
Emergency Medicine	7
Family Medicine	9
Geriatrics	1
Internal Medicine	22
Cardiovascular Disease	1
Hematology-Oncology	1
Nephrology	1
Pulmonary and Critical Care Medicine	1
Neurological Surgery	3
Neurology	3
Obstetrics and Gynecology	3
Ophthalmology	4
Orthopaedic Surgery	3
Pathology	2
Cytopathology	1
Pediatrics	10
Neonatology	1
Pediatric Emergency Medicine	1
Pediatric Infectious Diseases	1
Physical Medicine and Rehabilitation	3
Preventive Medicine	2
Psychiatry	6
Child and Adolescent Psychiatry	2
Surgery	16
Transitional Year	1
Urology	2

The nomination process for the 2013 awards began in January 2012, and nomination forms are available on the ACGME website (click on "Awards" from the [homepage](#) menu) for all award categories. If you know of a deserving program director, please complete the simple form and nominate him or her! The ACGME would like to fill the above grid with exceptional program directors from all specialties and subspecialties. They deserve recognition.

DUALITY OF INTEREST TAKEN SERIOUSLY BY REVIEW COMMITTEE

While 'conflict of interest' implies a financial situation which can improperly influence the decision of the member of an organization, 'duality of interest' implies any other situation which can influence a decision.

Examples of duality of interest for a Review Committee member can include being from the same state in which a program under review is located, having worked in an institution housing a program under review, or having a close relationship with the department chair or program director of a program under review.

When reviewing programs, members of the Review Committee for Diagnostic Radiology recuse themselves when there is a duality of interest that might influence their decisions regarding a program's accreditation status. Recusals always occur for those Committee members from the same state as the program under review to avoid any conflicts of interest. ACGME staff members provide periodic education on and monitoring of conflict and duality of interest for all Review Committees to ensure the policy on this issue is constantly in mind, and always governs the way in which business is conducted during meetings.

RRC NEWS PROVIDES TIMELY AND CURRENT REVIEW COMMITTEE AND SPECIALTY UPDATES, AS WELL AS GENERAL ACGME INFORMATION AND EXPLANATIONS OF ITS SYSTEMS, POLICIES, AND PROCEDURES. IT ALSO SERVES AS A VEHICLE FOR COMMUNICATION BETWEEN THE REVIEW COMMITTEE AND ITS CONSTITUENTS.

PLEASE CONTACT THE EDITOR WITH SUGGESTIONS OR COMMENTS ABOUT THIS NEWSLETTER: MSCHWAB@ACGME.ORG.

NEWSLETTERS ARE TYPICALLY AVAILABLE FOLLOWING A REVIEW COMMITTEE MEETING, BETWEEN ONCE AND THREE TIMES PER YEAR.