

## Accreditation Council for Graduate Medical Education

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Ingrid Philibert, PhD, MBA  
Editor

## Editor's Note

The first issue of the *ACGMe-Bulletin* was published in 2004, in response to feedback from program directors and designated institutional officials who suggested a need for a compendium of practical information related to resident education and accreditation. The *e-Bulletin* resumes with the May 2010 issue after a hiatus necessitated by the development and publication of the ACGME's new *Journal of Graduate Medical Education*. Major focal areas continue to be clarification of the standards and other elements of the accreditation process, and summaries of "best practices."

We hope this publication contributes to the ACGME's effort to share information and keep our community informed.

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## The Resident Interview Revisited

*Ingrid Philibert*

In a July 2001 *ACGMe-Bulletin* article about the resident interview, Betty Chang, MD, a fellow at Johns Hopkins University and the then resident member of the ACGME Board of Directors, commented on the value of the resident interviews to the accreditation process.<sup>1</sup> In 2010, the 2,000 annual accreditation site visits allowed ACGME site visitors to interview 10,000 to 12,000 residents, giving residents input into the accreditation of their programs.

The aim of all site visit interviews is verification of the information in the program information form (PIF) or institutional review document (IRD). This is critical to the accuracy and objectivity of the accreditation process. Residents are asked questions that address aspects of the program relevant to them. Other than general questions about program strengths and areas for improvement asked at the conclusion of the interview, all questions posed to residents are based on ACGME common and specialty-specific standards.

Peer selection of the residents for the site visit interview continues to be an important element of the effort to ensure the objectivity of the accreditation process. Having the residents who participate in the interview be "selected by their peers" means just that – that all participating residents were selected by their colleagues from among all residents in the program (it is permissible to excuse first-year residents or limit their number if the site visit is early in the academic year). Residents selected by the program director or residents chosen from among a "pre-selected" pool do not constitute peer selection. To verify peer selection, the ACGME site visitors routinely ask the residents how they were selected, and record their responses.

A major change, which has increased resident input over what was provided in 2001, is the ACGME resident survey. In 2010, the survey provides more than 100,000 residents with input into the accreditation process. The survey was implemented in 2004, and since 2008, it has been fielded annually to residents in core programs and subspecialty programs with four or more residents. One objective entails verifying compliance with the duty hour standards, but a more important aim is to broaden resident input into accreditation data collection. As the ACGME contemplates future improvements to the accreditation process, annual data collection tools like the resident survey will become increasingly important and will facilitate longer intervals between accreditation site visits.

### **Verifying the Resident Survey**

Since the implementation of the resident survey, a portion of the resident interviews during accreditation site visits is devoted to verifying the survey responses. For programs where a significant percentage of the residents indicated a potential problem regarding any of the approximately 30 questions in the survey, findings may include the following:

1. Residents report the program has fully or partially corrected the prior deficiency, and provide sufficient information that allows the site visitor to report the details of the improvements;
2. Residents indicate they misunderstood or misinterpreted selected questions, and that their response suggesting non-compliance is not accurate (ongoing improvement in the survey questions has reduced the frequency of this response over the past several years);
3. Residents state they do not agree with the non-compliant survey findings and cannot explain the origins of the information (they may attribute the data to a prior cohort of residents and suggest that they do not share “that group’s” perspective on the program);
4. Residents may appear reluctant to discuss the survey findings or may be reluctant to discuss them in a group setting (reasons may include a hierarchical structure in the program, concerns about retaliation for negative reports, or other factors). Often, the causes cannot be fully assessed by the site visitor.

### **Varying the Interview**

The residents’ perspective is an important element of ACGME accreditation. At the same time, it is important to note that resident input is not used by itself, but along with other information provided by the program and gathered by the site visitor, including the PIF, history, case and experience logs in some specialties, performance on the board examination, and the perspective of the program director, faculty and institutional leaders. The ideal resident interview is one where residents speak freely, there is consensus among the group, the information can be reconciled with data from other sources, and it provides a cohesive picture of how residents perceive their program and education.

Residents’ importance to the accreditation process is not due to eagerness on their part to reveal negative information. On the contrary, residents on occasion are reluctant to provide information which they feel may compromise their program’s accreditation. This reluctance to speak about potentially non-compliant aspects of their program creates a particular challenge.

When residents appear to be reluctant to speak openly in a group setting, the site visitor has the option to vary the format of the interview, such as moving to small groups (by training year) or interviewing residents individually. When consensus is lacking, site visitors record the responses, explore whether it

relates to different experiences by training year or for different rotations, and seek to reconcile these findings with data from other sources, such as the PIF, documentation collected by the program or the responses from the faculty and program director. If a given resident's experience is different from that of his or her colleagues, and this issue is relevant to the accreditation decision, the results are reported next to the information provided by the peers. Residents are not identified in the site visit report, and site visitors avoid inadvertently disclosing their identity by mentioning particular years of training, rotations or experiences.

### **A Pilot to Increase Resident Input During the Site Visit**

Earlier versions of the Resident Survey had included the option for residents to provide free-text comments, which were seen solely by the ACGME site visitor assigned to the program. In 2009, the ACGME discontinued collecting free-text responses. To explore whether textual comments from residents could be introduced into the site visit interview process, eight members of the ACGME field staff are participating in a small pilot to ask residents (through a note to the program director) to compile a single, program-level list of up to five topics (strengths and areas for improvements) they would like to discuss during the interview. Residents are asked to bring this list to the site visit interview for further discussion.

To date, the lists received have included strengths, problems, and a surprising mix of general questions about the ACGME ranging from upcoming changes in ABMS Member Board requirements and questions about the ACGME and how it functions, to questions about upcoming revisions to the duty hour standards.

The Department of Field Activities plans to evaluate the pilots at the June meeting of ACGME field staff. Please send any questions and comments to June Eubanks, Department of Field Activities, ACGME at [jeubanks@acgme.org](mailto:jeubanks@acgme.org)

<sup>1</sup>Chang B, Philibert I. *The Importance of the Resident Interview to the Accreditation Process*. ACGME Bulletin, July 2001, 4–6.

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## **Clarifying the Confidential Nature of the Information in the Program's Annual Evaluation**

The ACGME has traditionally held that information from sponsoring institution's mid-cycle internal review of each program should not be disclosed during the site visit, to ensure that the internal review promotes a frank and forthright discussion of the program's strengths and opportunities for improvement. Site visitors collect information to confirm that the program completed an internal review, the individuals involved, and the date the information was presented and discussed by the institution's Graduate Medical Education Committee (GMEC).

The purpose of this note is to clarify that ***this expectation of the confidentiality of results also applies to the written action plans for any deficiencies or opportunities for improvement resulting from the required "Program Evaluation and Improvement" (V.C, ACGME Common Program Requirements)***. Under this standard, programs are expected to perform an annual evaluation that covers faculty development, resident and graduate performance and program quality, and prepare a written action plan for any deficiencies or opportunities for improvement discovered. This guidance is becoming important as programs are advancing the thoroughness and quality of these annual reviews.

During the program's accreditation site visit, members of the ACGME field staff will view documentation in the program or faculty meeting minutes to confirm that the required annual evaluation was conducted and discussed, but should ***not be shown the results of the annual review or any action plans***. Programs may choose to highlight improvements that have resulted from the annual Program Evaluation and Improvement as evidence of a well-functioning, ongoing improvement process.

### **Resident Members on Review Committees Add an Important Perspective**

For a number of years all ACGME Review Committees (RCs) have included at least one resident among their membership. Residents are full members of the RC, participate in the accreditation reviews, and offer an important perspective during the review and during deliberations on standards revisions and other RC business.

Individuals eligible for resident membership on an RC, the Transitional Year Committee or the Institutional Review Committee must be enrolled in a residency or fellowship program at the time of appointment, and may not serve more than one year beyond completion of residency or fellowship. The term is a minimum of one year; reappointment is permitted.

Resident members are also members of the ACGME Council of Review Committee Residents (CRCR), which meets twice each year; it advises the ACGME Board, providing valuable input and feedback about resident matters, and education and accreditation. The appointment process for new resident members begins more than one year before the expiration of the current residents' term. The deadline for the nomination is September 1, 2010. Interested residents or individuals interested in nominating a resident should consult the guidance on RRC appointments on the ACGME web site ([http://www.acgme.org/acWebsite/resInfo/ri\\_residentSelection106.pdf](http://www.acgme.org/acWebsite/resInfo/ri_residentSelection106.pdf)).

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## **Excerpts from the 2010 ACGME Educational Conference**

### **Adult Learners Benefit from a Self-Directed Approach to Learning**

*Julie A. Jacob*

Faculty members at teaching hospitals teach adults – residents, patients, and other faculty members – but they often instinctively use the style of teaching they remember from their days as students in grade school and high school.

However, the teaching style that works well with children and teenagers doesn't work as well with adults, who prefer a more independent, informal, learner-oriented style of learning, said Heather Peters, MEd, PhD, who presented a session on working with adult learners at the 2010 ACGME Annual Educational Conference, held March 4–7 in Nashville, Tennessee. Dr. Peters is an education specialist at the University of California San Francisco Fresno Medical Education Program.

In contrast to children, who learn best through structured teacher-centered learning, called pedagogy, adults often prefer a less structured, learner-centered method of learning called andragogy, said Dr. Peters.

That is, adult learners generally like setting their own learning goals and having a teacher who acts as a resource and a guide, instead of an authority figure directing the learning.

Of course, that doesn't mean giving residents free rein on what they want to learn, said Dr. Peters. What it does mean, however, is that a faculty member could ask a resident, "which goal would you like

to work on this week” then “give them a choice of which goal they want to work on from the list of goals they must master,” suggested Dr. Peters.

Dr. Peters discussed the theory of the experiential learning cycle developed by educational theorist David A. Kolb, PhD, in the 1980s. Dr. Kolb theorized that learners go through four stages in the learning process: concrete experience, reflective observation, abstract conceptualization, and active experimentation.

In other words, Dr. Peters explained, students are taught something by the teacher, try it themselves, reflect on how it went, and try out what they have learned in other situations.

Although levels of development vary among adults, in general, adult learners are more self-directed, independent, and internally motivated than juvenile learners. Therefore, adults generally learn best, she said, when “others respect and acknowledge their skills, experience, values and motives, and when they are treated in ways that are consistent with their existing descriptions of who they are and what they are capable of doing.”

*Julie A. Jacob is the ACGME's Director of Corporate Communications.*

### **Emotional Intelligence Plays Role in Mastering the Competencies, Says Speaker at Annual Educational Conference**

*Julie A. Jacob*

Being a competent physician involves more than medical knowledge – it also requires skills in emotional intelligence, which can and should be taught in residency programs, said Bryan L. Martin, DO, a speaker at the 2010 ACGME Annual Educational Conference in Nashville, Tennessee. Dr. Martin, a professor of clinical medicine and pediatrics and director of the allergy immunology fellowship program at Ohio State University, presented the session “Emotional Intelligence and Medical Education: How Does EQ Fit into the Paradigm of the Competencies?”

Although emotional intelligence sounds like a vague concept, the book *Emotional Intelligence* by Daniel Goleman breaks down emotional intelligence into four components: self-awareness, self-management, social awareness, and social management.

- Self-awareness is knowing one's strengths and limitations, welcoming constructive feedback, and having self-confidence.
- Self-management is controlling impulses, delaying gratification, adeptly handling multiple tasks, and taking the initiative.
- Social awareness is being attuned to other people's emotions and perspectives, as well as the unspoken rules and culture of an organization.
- Social management is influencing and inspiring other people, working well in teams, and resolving conflicts effectively.

These are old ideas, said Dr. Martin, who noted that the four parts of emotional intelligence are similar to advice given in the Chinese text *Tao Te Ching*, which was written in the sixth century B.C.

Strong emotional intelligence skills are part of all the general competencies, he said. Good emotional intelligence skills are needed in many situations that physicians deal with every day, said Dr. Martin, such as breaking bad news to a patient, talking with a patient's family, and resolving a conflict with a colleague.

Dr. Martin highlighted several methods for teaching residents to be more aware of their own emotions, as well as the emotions of those they work with.

One way to help residents improve their emotional intelligence skills is to show residents pictures of various situations they may encounter at work. For example, he said, residents can be shown pictures of doctors breaking bad news to a patient. The faculty member leading the session can ask the residents questions such as: Who is in the picture? What is happening? How do you know? These questions will trigger discussions about the residents' communication styles and various ways in which sensitive situations can be approached.

Dr. Martin also recommended showing residents clips from television shows about physicians and then discussing scenes depicting conversations between doctors and patients, doctors and doctors, or doctors and other health care professionals.

"Video modeling is very informative and illustrative and doesn't involve blame," he said.

Sessions in which residents practice their communication skills with actors posing as patients are also helpful.

Finally, documenting patient encounters in learning portfolios help residents improve their emotional intelligence by giving them a place to record and reflect on their work.

"The idea of reflection is one of the most important things in learning portfolios," said Dr. Martin. "This is an EQ skill."

### **Innovations in the Resident Hand-off and Other Areas of Resident Education – Winning Posters from the 2010 Marvin R. Dunn Poster Session**

From March 4–7, 2010, more than 1,600 program directors, designated institutional officials, coordinators and other individuals in graduate medical education attended the 2010 ACGME Educational Conference in Nashville. The conference featured the Marvin R. Dunn Poster Session, and selected award winning posters are summarized below to highlight the variety of high-quality posters on topics related to residency education that were presented at the conference.

Four posters addressed the patient hand-off. In a "lean" approach to the hand-off document, Meredith Riebschleger and colleagues from CS Mott Children's Hospital at the University of Michigan describe an iterative process using Plan-Do-Study-Act (PDSA) cycles to improve the patient hand-offs in the inpatient setting, which produced a new "lean" document to support the hand-off.<sup>1</sup> A second initiative to improve the hand-off by Shirley Kalwaney and others at Inova Fairfax Hospital, Falls Church, VA, implemented a secure, standardized web-based sign-out tool that can be utilized by all members of the medical team during an inpatient rotation.<sup>2</sup> A third poster on improving the hand-off by Nancy Havas and colleagues from the Medical College of Wisconsin address transitions in primary care, going beyond the inpatient hospital setting, and also included an educational program on care transitions for educators in primary care that addresses transitions from the patient's primary medical home.<sup>3</sup> J. Gene Chen and colleagues at Duke University used in situ scenarios of cardiac surgery hand-offs in the PICU with scripted events and extensive debriefings to test the benefits of a structured approach for delivering patient information during the transfer among teams.<sup>4</sup>

Three posters related to resident duty hour limits. Mark Gennis and colleagues from Aurora Health Care, Milwaukee, compared residents' and nurses' perceptions of call from home versus in-house call,<sup>5</sup> and Matthew Quigley, Drexel University School of Medicine, and colleagues developed a software application running on a mobile device that sought to assess resident fatigue by measuring performance

known to be affected by fatigue such as reaction time, persistence, accuracy, and speed.<sup>6</sup> Baldwin, Daugherty and Ryan from the ACGME and Rush University Medical School surveyed residents in a selected set of internal medicine, surgery, pediatrics and obstetrics-gynecology programs about aspects of their work and sleep patterns and use of their personal time. The 544 residents who responded fit into three groups. Two groups focused on social relationships and exercise and household and family, respectively, and a third “low-activity” group appeared to have few interests beyond the residency program.<sup>7</sup>

A poster from the University of Florida (Lister et al.) described an assessment and skills building program that prepares entering neurological surgery residents for the role in patient care.<sup>8</sup> It focuses on key bedside procedures, initial surgical skills, placement of ventriculostomies, preparing residents to recognize and handle emergent patient situations, and assessing their ability to perform a neurological assessment using an OSCE. In another curricular enhancement, James Salem and colleagues at Summa Health System in Ohio used the Chronic Care Model (CCM) to redesign the resident continuity clinic. The initiative also redesigned the chronic care curriculum, assessed resident competencies in interdisciplinary team skills and measured improvements in patient care that resulted from the intervention.<sup>9</sup>

Lisa Schnettler and colleagues at Rainbow Babies and Children’s Hospital in Cleveland assessed changes in faculty perception of pediatric residents’ abilities to make clinical decisions, focusing on supervisory residents in the areas of independent decision-making, use of evidence-based medicine, leadership and patient care skills.<sup>10</sup>

#### Posters

<sup>1</sup>*Trimming the fat: a “lean” approach to the hand-off document.* Meredith Riebschleger, Deipanjani Nandi, Francis McBee Orzulak, Hilary Haftel; CS Mott Children’s Hospital, University of Michigan.

<sup>2</sup>*A pilot study of a web-based sign-out tool to improve quality and teamwork during patient hand-offs.* Shirley Kalwaney, MD, Chalapathy Venkatesan, MD, Kati Bernedo, BA, and Michael J Sheridan, ScD; Inova Fairfax Hospital, Falls Church, VA.

<sup>3</sup>*A step closer: a curriculum for primary care transitions in patient care.* Nancy Havas, MD, Karen Nelson, MD, Emily Densmore, MD, David Klehm, MD, Deborah Simpson, PhD; Medical College of Wisconsin.

<sup>4</sup>*Improving hand-off communication: development of a simulation-based educational program.* J Gene Chen, MD, David A Turner, MD, Melanie C Wright, PhD, Richard J Ing, MB, BCh, Andrew J Lodge, MD, James Jagers, MD, P Brian Smith, MD, MHS, Kshitij P Mistry, MD, MSc; Duke University Medical Center.

<sup>5</sup>*Night call from home compared to in-house call: a survey of residents and nursing perceptions of patient care.* Mark Gennis, MD, Jeffrey Jordan, MD, Richard Battiola, MD, Mary Hagle, Faye Zwiag, RN, BSN, MBA, Linda Cottreau, RN, MSN; Aurora Health Care, Milwaukee, WI

<sup>6</sup>*Innovative use of mobile devices to assess and track resident fatigue.* Matthew R Quigley, MD, Michael Y Oh, MD; Drexel University School of Medicine, Philadelphia, PA, Krishna Narayan, MBA; NSC Partners LLC, Maui, HI.

<sup>7</sup>*What residents do with their off-duty time?* DeWitt C Baldwin Jr, MD, Patrick M Ryan, MD; ACGME, Steven R Daugherty, PhD; Rush University Medical School, Chicago, IL.

<sup>8</sup>*Transition from medical student to resident: results from an orientation for neurosurgery residents.* Richard Lister, MD, MBA, Gwen Lombard, PhD; University of Florida.

<sup>9</sup>*Education and patient care benefits from curriculum redesign and application of the chronic care model in a resident continuity clinic.* James Salem, MD, FACE, Ronald Jones MD, FACP, Sana Hasan, DO, David Sweet, MD, FACP, Lynn Clough, PhD; Summa Health System, Akron, OH, NEOUCOM, Rootstown, OH.

<sup>10</sup>*Mentoring autonomy: a resident rotation in independent decision making.* Lisa Schnettler, MD, Joseph Zickafoose, MD, MaryAnn O’Riordan, Ethan Leonard, MD, Martha Wright, MD, Rainbow Babies and Children’s Hospital, Cleveland, OH.