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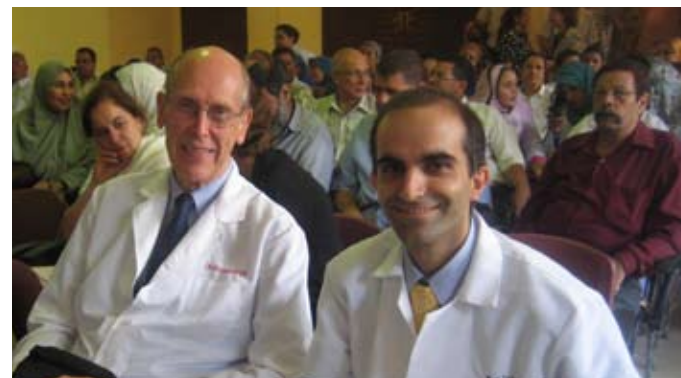
rounds

Resident Feels Gratitude for US GME System After Medical Education Trip to Egypt

As soon as we stepped outside of the Cairo Airport, the disparity struck us almost as quickly as the extreme heat and humidity. Mostly, it was the poverty that was remarkable: twelve people piled into a small 30-year-old sedan ... overcrowded, dilapidated housing. But there were also opulent hotels nearby and the occasional luxury car or limousine. I would soon find out that this disparity existed also in graduate medical education.

As an otolaryngology resident, I was privileged to be traveling with a true champion of international medical education, James Smith, MD, an otolaryngologist from Portland, Oregon, who spent many years of his career building up the otolaryngology community in Singapore and has been on innumerable medical education trips to dozens of countries. We were on a joint tour with the Fellowship, Education and Board Certification International (FEBI) Project and the Barnabas Project of the Christian Medical and Dental Associations. Our trip was designed to teach otolaryngology to primary care physicians at two outlying family practice residency programs in Menouf and Aswan, Egypt.

We were warmly greeted in the Cairo airport by a physician from Harpur Hospital in Menouf. Within minutes he and the van driver were tying our suitcases on the roof of the van



Dr. Smith and Dr. Jabbour attend an assembly and news conference at Harpur Hospital in Menouf, Egypt.

and running to buy us bottles of water to help with the 110-degree heat. After a bumpy three-hour drive, we arrived at Harpur Hospital, which was soon to be celebrating its 100th anniversary since its founding by the Anglican Church.

We were given a quick tour of the hospital and shown the lecture hall (a small library with a few chairs) where we were going to teach the family practice residents. We were also shown a one-room clinic, where we were surprised to find out that we had been scheduled to see patients the following day, some of whom had traveled six hours to see the "American doctors." More surprising, however, was the

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reminders

Upcoming Meetings

American College of Surgeons

San Francisco, California
October 23–27, 2011

American Medical Association Interim Meeting

Honolulu, Hawaii
November 10–13, 2011

Association of American Medical Colleges Annual Meeting

Denver, Colorado
November 4–9, 2011

arrival of two otolaryngology residents from large cities in the south of Egypt, who had traveled eight hours by train to see patients with us in clinic and sit in on the lectures.

The “clinic” would not be recognizable as such by most American residents. It was a 12 ft. by 12 ft. room with two folding chairs in one corner and two folding chairs in another corner and a large desk in the middle of the room (this furniture selection allowed this room to serve as two exam rooms and one consultation room). There was a small table, smaller than a Mayo stand, which included all of the instruments available in the clinic: a head mirror with broken glass, ear speculums, tongue depressors, and an otoscope which occasionally worked.

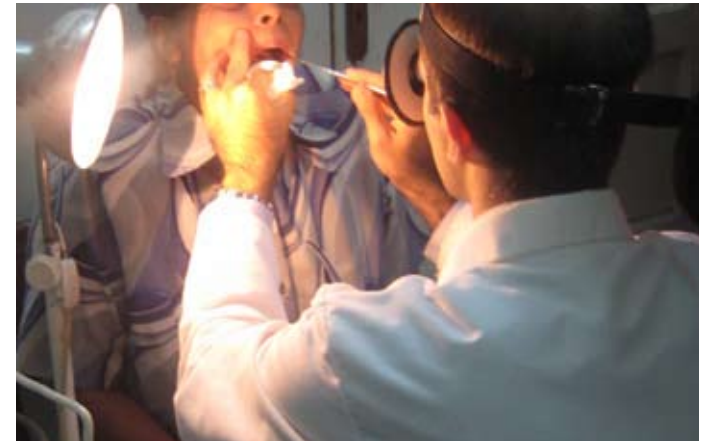
The otolaryngology residents who had traveled so far were very eager to learn. I was impressed with their diagnostic skills. They were wizards with the hand-held otoscope. I soon found out that the reason for this was that they did not have access to an instrument that I rely on daily ... an operative microscope. In fact, they had never seen one. Never!

“How do you put in pressure equalization tubes?”
I asked naively.

“We don’t know how to do that.”

They had never been taught any procedure other than tonsillectomy and adenoidectomy. They had never seen a flexible fiberoptic endoscope or a rigid nasal endoscope.

I am not sure which emotion was stronger at hearing this news, shock or sadness. My father, who started the FEBl Project (a cooperative effort among academic institutions, health organizations and NGOs to provide ophthalmologists



Dr. Jabbour examines a patient.

and allied health care workers in Egypt with upgraded facilities and equipment, ongoing training and standardized certification), once told me that many ophthalmology residents in Egypt never see a slit lamp before they have to take their practical board exam administered by the government. An ophthalmology resident never seeing a slit-lamp?! I never believed him, until now.

After several days at Harpour, we flew south to Aswan to give many of the same lectures to family practice residents at another residency program at the Germania Hospital. A highlight of this trip was spending time with a faculty member of the residency program, who is an otolaryngologist. He is a deeply sympathetic and patient man who cares for his patients remarkably well given the limited resources available. He has an operative microscope given to him by an American friend, and he has been taught how to perform tympanoplasty. He is actively seeking training to perform

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mastoidectomies, in order to better serve his patients. These patients would be unlikely to be able to travel the several hundred kilometers needed in order to find a physician trained in this procedure.

I continued to ask the question for several weeks, “What is different about the residency training in Egypt compared to that of the US?” “What makes the quality of our training in the US reliably excellent?” Two things continued to surface in my mind: a culture that values training the next generation of physicians and surgeons and a system that is designed to provide quality control for that training.

In Egypt, the salary that physicians receive is appallingly low. In fact, many physicians abandon medicine for this reason in pursuit of industry jobs with better wages. Comparatively, procedures pay well. In a culture where procedural knowledge can provide promise to increase one’s income to a livable wage, there is a fear of training your potential competition, which is more palpable there than in the United States.

In the United States, our specialty boards define the scope of each specialty and the ACGME Residency Review Committees define the essential training components, including key indicator cases for each specialty. Together, these groups provide assurance that an individual has completed training of a depth and breadth that meets the very high standards set by each of these groups. This is

not present in many other countries, such as Egypt, where residency training is defined largely by the length of time spent in training and not by the quality of that training.

I left Egypt with a renewed sense of gratitude for the superlative training that we receive in this country. We are truly blessed to have an excellent system of graduate medical education. We have distinguished leaders from each specialty on the ACGME Residency Review Committees who work tirelessly to guard the highest standards of training for their specialties.

My time in Egypt solidified my strong belief in the responsibility of American medical trainees to share our knowledge and skills in less developed areas of the world, not only through short-term relief trips, but through equipping locals to continue long-term work through medical and surgical education. ■

Written by Noel Jabbour, MD, a resident in otolaryngology at the University of Minnesota and a member of the RRC for Otolaryngology.

Baldwin Series Lecturer Discusses Educational Assessment and the Art of Bonsai

What does educational assessment have in common with the traditional Asian art of bonsai?

Richard Gunderman, MD, PhD, the first speaker in the ACGME's 2011–2012 Baldwin Lecture Series, discussed "Educational Assessment and the Art of Bonsai" at ACGME headquarters on July 13. During a lively, far-ranging presentation, Dr. Gunderman discussed how bonsai, genius and democracy are linked to educational assessment; specifically, the assessment of residency programs. Dr. Gunderman is a professor of radiology, pediatrics, medical education, philosophy, liberal arts and philanthropy at Indiana University. Dr. Gunderman has received several teaching awards and has written numerous books, including *Achieving Excellence in Medical Education*.



Dr. Gunderman

"One of our most precious resources is our ideas," said Dr. Gunderman. He stressed that it is important for residency programs to nurture residents' creativity and curiosity.

Just as the trees that are trimmed and pruned into miniature sculptures are thwarted from reaching their natural height and shape, learners who are discouraged from being curious and taking risks will not reach their full potential – then or in later years.

"By limiting things, we do not only constrain what they are able to do today, but what they are able to do in the future," he noted.

Dr. Gunderman then discussed the parallels between Alexis de Tocqueville's classic 19th-century book on American life, *Democracy in America*, and residency programs. In *Democracy in America*, Tocqueville extolled the virtues of decentralization, said Dr. Gunderman. He believed that democracy was most vibrantly expressed in town hall meetings.

In the same way that democracy has its purest form at the local level, said Dr. Gunderman, graduate medical education is "most real" at the level of individual residency programs. That's why it is important for programs to experiment and innovate, he said.

While it is important to analyze residency programs, as well as other types of educational programs, using standardized methods of assessment, Dr. Gunderman asked "to what degree do we perfect our system of education by homogenizing it and to what degree do we perfect our system of education by fostering diversity and openness and creativity and experimentation"?

It's important that residents have the chance to learn and experiment on their own, he stressed. "It's not what is done for them, but what they do for themselves that is going to be the most formative in the development of a physician."

Dr. Gunderman then addressed the issue of bureaucracy in graduate medical education. The word *bureaucracy* is derived from the French word for "desk," he said, and means "rule of the desk." Bureaucracies have clear lines of authority, act based on rules and define success technically, he said.

However, measuring success simply by quantitative benchmarks ignores the qualitative dimension of success.

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“Maybe we should think twice before relying completely on statistical, quantitative, and statistically analyzable parameters of success,” he said.

He referred to Leo Tolstoy’s famous short story, “The Death of Ivan Illyich” as a scathing criticism of bureaucracy. Bureaucracy, Dr. Gunderman said, leads to “a narrowing of vision” and “intellectual rigidity.” It fosters the belief that there is only one way to do things.

Dr. Gunderman ended his presentation with some musings on genius.

- The difference between talent and genius, he said, is that “talent is the ability to hit the target that no one else can hit; genius is the ability to hit the target that no one else can see.”
- “Genius is about the power to produce, not the power to suffice,” said Dr. Gunderman. “We need to be connoisseurs of medical genius.”
- He ended his presentation by emphasizing the importance of taking risks and innovating in graduate medical education.
- “Accreditation can do many important things. Like everything else that is worthwhile, it entails risk,” Dr. Gunderman concluded. ■

Written by Julie A. Jacob, communications manager for the ACGME.

The Milestone Project Creates a Roadmap for Residents

The journey through residency to independent practice can be a long, winding road. Taxing call nights, intensely emotional episodes and, at times, overwhelming demands for acquiring clinical skills mark the way. Few residents, however, would look to these experiences as a guidepost along the path to board certification. In many ways, a map is needed to guide residents down this road, charting the way forward.

The Milestone Project, a partnership between the ACGME and each specialty certification board, aims to create just such a map for residency. As defined by the project, a milestone is a specific behavior, attribute or outcome in the general competency domains to be demonstrated by residents by a particular point during their residency education. By creating milestones, the vision is to expand available outcome data for accreditation and certification, to enhance accountability to external stakeholders and to increase transparency.

Each specialty accredited by the ACGME is developing specific milestones within the framework of the core competencies. The milestones for each specialty are developed by a working group and an advisory group comprised of program directors, residents, members of the specialty Review Committee, members of the certification board and members of the specialty’s professional organizations. Each Milestone Working Group develops milestones and identifies assessment tools to ascertain skill level within each competency. The goal of partnering with the specialty certification boards is to connect the milestones framework to initial certification, as well as to maintenance of certification.

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Milestones add value

Milestones for residency progression will add significant value to the education process. First, residents will benefit from more explicitly defined expectations. These will facilitate resident self-assessment and self-directed learning. In addition, the milestones framework will provide a mechanism for better feedback from faculty members to residents, as well as more transparency. Program directors will benefit from an enhanced capacity for early identification of and assistance for underperformers. Finally, the milestones framework can guide curriculum development within the specialty.

In terms of accreditation, the Milestone Project is one piece of a model that is moving toward the Next Accreditation System, which is being designed to feature continuous accreditation with longer cycle lengths between site visits. Each program will report milestones progress semi-annually to the ACGME and this data – along with the resident and faculty surveys, case logs and measures of program and institutional infrastructure – will likely comprise the key components of accreditation under the new system.

Several specialty groups have already begun the milestone development process and have drafted milestones ready for review by other members of their broader specialty constituencies. Completion of milestone drafts for most specialties is expected in 2012.

Milestones integral to future program accreditation

The Milestone Project offers a tremendous opportunity for residents and program directors to more clearly understand the expectations of residency education and progress toward board certification. In addition, this framework will form an integral part of future program accreditation. For more information about the project in your specialty, ask your program director or look for updates and articles in your Review Committee's newsletter. ■

Written by Charles D. Scales Jr., MD, first-year fellow in the Robert Wood Johnson Foundation Clinical Scholars Program at the University of California, Los Angeles, and Timothy P. Brigham, MDiv, PhD, senior vice president, education, at the ACGME.

Residency Programs Embed Quality and Safety into Training

The Institute of Medicine (IOM) highlighted the impact of preventable medical errors on health care quality in America more than a decade ago in *To Err is Human: Building a Safer Health System*. In this report, the IOM recommended that health professional licensing bodies incorporate competence and knowledge of safety practices into examination and licensing, and that professional societies develop curricula on patient safety and encourage its adoption into training and certification requirements¹. The IOM subsequently issued *Crossing the Quality Chasm* in 2001, in which it made specific recommendations to redesign the training of health professionals by emphasizing the teaching of evidence-based practice and providing more opportunities for interdisciplinary training. Most of these recommendations were addressed when the Accreditation Council of Graduate Medical Education (ACGME) first introduced the six core competencies, with the practice-based learning and improvement, interpersonal and communication skills, and systems-based practice competencies providing an opportunity for residency programs to incorporate quality and safety (Q&S) education and practice into training². The purpose of this article is to highlight innovative ways in which residency programs and academic institutions have successfully incorporated Q&S into residency training.

Good Catch program

In the pediatrics residency training program at the Albert Einstein College of Medicine, residents participate in the department's "Good Catch" program. The goal of the program is to encourage reporting of a mistake before

patient harm occurs, also known as a near-miss. The pediatric residents keep a log of near-misses and review the aggregated data to identify system errors and develop solutions. To encourage reporting, residents are introduced to the concepts of a "reporting culture" and "just culture" through didactic lectures. An example of how the "Good Catch" program was used to improve the hospital system began with an error identified by residents in the hospital's computer system – all pediatric doses were listed incorrectly because the computer algorithm did not have pediatric doses, and many pediatric medications are not officially approved for pediatric use. The residents notified the performance improvement committee and a fix was created to reduce inappropriate error messages. The "Good Catch" program has been presented nationally and is highlighted by the Residency Review Committee for Pediatrics as a notable practice.

Healthcare Matrix

The Healthcare Matrix was initially developed at Vanderbilt University and has been used at many institutions, including the project authors' current organization, University of Texas MD Anderson Cancer Center, as a way to link patient outcomes with the ACGME core competencies³. The Matrix is a 36-cell table with the IOM Aims for Improvement listed along the top (Safe, Timely, Effective, Efficient, Equitable, Patient-Centered) and the ACGME core competencies listed along the left. Residents are instructed to use the Matrix for a particular patient to identify opportunities for improvements in care and education. The Practice-Based Learning and Improvement row informs the learner about what should be added to the action from the analysis of deficiencies in care. Once an action plan is formed, the Plan-Do-Study-Act cycle is used to guide improvement efforts.

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As an example, the Healthcare Matrix was used to analyze an event in which a patient with multiple co-morbidities died during a scheduled tracheostomy tube change due to airway blockage. Matrix analysis of the event determined that standardized tracheostomy orders were not available, red rubber catheters used for suction were too flexible and thus insufficient, and communication between the Medical Intensive Care Unit (MICU) staff and Ear, Nose and Throat (ENT) physicians was inadequate. The action plan included developing new ENT tracheostomy orders, determining what essential materials are best for tracheostomy tube changes, ensuring that orders are known throughout the department, and ensuring effective communication between ENT and other departments, with responsible groups, timelines and completion dates listed. There was never another event like this one, which speaks highly of this resident-driven improvement project.

Quality improvement and M&M conferences

The Mercy family medicine residency program implemented a quality improvement (QI)-focused approach to morbidity and mortality (M&M) conferences to provide a safe venue for residents to identify areas of improvement, as well as to promote professionalism, ethical integrity and transparency in assessing and improving patient care⁴. Using a standardized M&M planning worksheet, resident and attending physician teams identified core competencies involved in patient care issues, root causes, and suggestions for improvement. Residents also critically evaluated peer practice using a peer review tool and presented case summaries with suggestions for improvement at monthly QI meetings. These suggestions were then communicated by the designated institutional official (DIO) and QI directors to the appropriate individuals and departments to facilitate institutional system changes.

One of the primary goals of this initiative was to promote quality of care and patient safety by incorporating the ACGME core competencies into learning opportunities that also promote leadership, research and scholarly activity.

Housestaff Quality Council

In 2008, an institution-wide Housestaff Quality Council (HQC) was created by the Department of Anesthesiology at New York–Presbyterian Hospital to improve patient care and safety by creating a culture that promotes greater housestaff participation in Q&S activities⁵. The objectives of the HQC were to 1) educate institutional leaders on ways to improve patient care and safety by creating a culture promoting greater housestaff participation, 2) propose an innovative communication process that provides two-way communication with hospital administration and key clinical departments and 3) create best practices for quality initiatives. Initial quality improvement projects for the Council were medication reconciliation and early diagnosis and treatment of clostridium difficile infection. Each year, the HQC engages in additional QI initiatives involving housestaff in six main quality focus areas: medication safety, communication, infection prevention and control, efficiency and patient flow, surgical and procedural safety, and environmental health and safety. Last year, Dr. Peter Fleischut and his team were recipients of the ACGME's David C. Leach Award for contributions to resident education for their Housestaff Quality Council.

Healthcare Leadership in Quality Track

The Healthcare Leadership in Quality (HLQ) Track was implemented two years ago in the Department of Internal Medicine (IM) at the Hospital of the University of Pennsylvania to provide residents with the opportunity to gain knowledge,

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skills and hands-on experience in Q&S methodology and practice. Residents in IM apply for the program during their intern year and begin the longitudinal 2-year track during their second year of residency. The first major component of the HLQ track is a series of seminars providing a broad overview of various Q&S topics, from critiquing quality measures to applying concepts of Lean methodology. The second major component is integration into the hospital Q&S microsystems through involvement with Unit-Based Clinical Leadership (UBCL) teams. UBCL teams are multidisciplinary groups that bring together a physician leader, nurse manager, and safety and quality manager in all units throughout the hospital. These UBCL teams work on quality and safety initiatives that are both unit- and hospital-driven. The HLQ Track residents become members of UBCL teams and play an active role in UBCL activities, including attending regular meetings, participating in root-cause-analysis events and working on implementing quality and safety initiatives.

The third major component involves completion of a quality project with a minimal requirement of an abstract. This year, the residents, along with nurses, pharmacists, social workers and case managers, received three days of training by performance improvement specialists to begin work on redesigning the discharge process toward the goal of the Perfect Patient Discharge.

QI initiatives serve as best practices

While the IOM and ACGME provided a general framework to incorporate Q&S education and practice into residency training, the responsibility for developing specific tools, programs and specialized curricula falls on individual

programs and academic institutions. The benefit of this approach is that it fosters innovation and creativity. This article highlights several ways in which departments have successfully incorporated Q&S into residency training. In a sense, these unique QI initiatives serve as “best practices” that residency programs across the country can learn from and improve upon. Residents function at the sharp end of patient care and encounter threats to patient safety and opportunities for improvement on a daily basis. By engaging residents more completely in Q&S practices during training, we will increase opportunities to identify and reduce preventable adverse events, improve acceptance and success of quality improvement initiatives, facilitate exchange of ideas between residents and hospital leadership, and develop the next generation of physician leaders. ■

Written by Jason N. Itri, MD, PhD, abdominal imaging fellow at the University of Pennsylvania Hospital, vice chair of the Council of Review Committee Residents and a member of the Milestones Committee for Radiology.

¹ Kohn LT, Corrigan J, Donaldson MS. To err is human : building a safer health system. Washington, D.C.: National Academy Press; 2000.

² Outcome Project: General Competencies. Accreditation Council of Graduate Medical Education; 1999 [cited 2011 August 23]; Available from: <http://www.acgme.org/outcome/comp/compmin.asp>.

³ Bingham JW, Quinn D. Linking Outcomes of Care and the ACGME Core Competencies: A Matric Solution. Available from: http://www.acgme.org/outcome/implement/rsvp_current55.asp.

⁴ Stausmire JM. Integrating Clinical Practice, QI, and the Competencies into the M&M Conference. Available from: http://www.acgme.org/outcome/implement/rsvp_current53.asp.

⁵ Fleischut PM, Evans AS, Faggiani SL, Lazar EJ, Kerr GE. Anesthesiology department leads culture change at a hospital system level to improve quality and patient safety. *Anesthesiol Clin*. 2011 Mar;29(1):153-67.

Welcome to Resident's Corner, a new section for answering questions frequently asked by residents and fellows. In each issue of Resident Review we will answer one such question, which will be added to a comprehensive FAQ document that will serve as a resource for future residents and fellows. In this issue, the common question being addressed is:

Can the ACGME Intervene and Adjudicate Disputes Between Residents/Fellows and Program Directors?

The simple answer is “no.” The ACGME and its Review Committees only address matters regarding compliance with published accreditation requirements that relate to program quality and do not adjudicate disputes between individual persons and programs or sponsoring institutions regarding admission, appointment, credit, promotion or dismissal of faculty members, residents or fellows. Instead, the ACGME requires that sponsoring institutions and programs provide an educational and work environment in which residents/fellows may raise and resolve issues without fear of intimidation or retaliation.

What does the ACGME require of programs and institutions regarding disputes that may threaten a resident's or fellow's career? The ACGME Institutional Requirements describe one mechanism used – grievance and due process:

D.4.e) Grievance procedures and due process: The Sponsoring Institution must provide residents with fair, reasonable, and readily available written institutional policies and procedures for grievance and due process. These policies and procedures must minimize conflict of interest by adjudicating parties in addressing:

II.D.4.e).(1) Academic or other disciplinary actions taken against residents that could result in dismissal, non-renewal of a resident's agreement, non-promotion of a resident to the next level of training, or other actions that could significantly threaten a resident's intended career development; and,

II.D.4.e).(2) Adjudication of resident complaints and grievances related to the work environment or issues related to the program or faculty and fellows.

In a nutshell, the ACGME has educational oversight – not administrative oversight. This means that the institution must provide readily available written institutional policies and procedures for grievance and due process that address academic or other disciplinary actions. These policies and procedures outline the steps a program director must take to inform a resident or

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fellow of an academic or disciplinary action – most often probation, non-renewal of contract or termination of residency or fellowship – and the steps the resident or fellow must take to submit a formal grievance and receive due process. Grievance and due process policies and procedures vary by institution, but the following three steps are common:

- The resident's/fellow's grievance is heard by both the program director and the department chair, and they make a decision.
- If the resident/fellow does not agree with the decision, the grievance rises to the next level, which means contacting the designated institutional official (DIO) in the graduate medical education office. At this stage, a panel of faculty members, including at least one resident/fellow, hears the grievance and renders a decision.
- If the resident/fellow does not agree with the panel's decision, the dean or some higher official may review all of the documentation and make the final decision. Occasionally, the dean reviews the panel's decision regardless of whether this third step is taken, and issues a final decision.

Because there is variation in the process among institutions, it is important to be familiar with the grievance and due process steps in order to use every resource available to solve disputes within the institution.

Grievance and due process policies and procedures often are described and distributed during a program's formal orientation. They can also be found in the resident and fellow handbook, which many institutions make available on their websites. Sometimes, grievance and due process policy procedures are outlined in the resident and fellow contract. It is important to know where they can be found in your own institution and to become familiar with them.

In addition, there are ways to raise concerns about your program without submitting a formal grievance to the institution. Every institution must have an organization or forum in place so that residents and fellows can raise and resolve issues in a confidential and protected manner. The ACGME has Institutional Requirements to make sure there are other channels for resolving issues:

II.F. Resident Educational and Work Environment

II.F.1. The Sponsoring Institution and its programs must provide an educational and work environment in which residents may raise and resolve issues without fear of intimidation or retaliation. Mechanisms to ensure this environment must include:

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II.F.1.a) An organization or other forum for residents to communicate and exchange information on their educational and work environment, their programs, and other resident issues.

II.F.1.b) A process by which individual residents can address concerns in a confidential and protected manner.

So what does the ACGME do? The ACGME makes certain that residents and fellows have grievance and due process policies and procedures which programs and institutions must follow, as well as a forum to address concerns in a confidential and protected manner. If such policies and procedures or a forum do not exist within your program or institution, the ACGME wants to know so that it can work to improve the program's quality and your work environment.

Be an informed resident and fellow – know your rights to grievance and due process. If you cannot locate your grievance and due process policies and procedures, please contact your institution's DIO in the graduate medical education office. If you are still unsuccessful, please contact the ACGME's Office of Resident Services for assistance at residentservices@acgme.org. ■

Written by Marsha Miller, MA, associate vice president, Office of Resident Services, at the ACGME.