resident review

February 2006

Accreditation Council for Graduate Medical Education

rounds

Resident surveys help ACGME assess programs

No one knows better than the residents themselves what a residency program is like, and that's why, three years ago the ACGME began administering a confidential Internet-based resident survey. The goal of the survey project was to gather resident input and use that information in the accreditation process.

The resident survey includes questions on duty hours, the work environment (supervision, rounds, etc.), the educational environment, faculty, and general competency assessment. There are 40 questions, which residents typically complete within 15 minutes. Residents have about five weeks to complete the survey.

In 2004 the ACGME surveyed 25,176 residents in 1,489 programs, and in 2005 the Council surveyed 33,204 residents in 1,954 programs. Resident surveys were originally required for programs tentatively scheduled for a site visit. However, due to logistical issues scheduling site visits, surveys now do not necessarily coincide with a site visit.

This year, between January and June, the ACGME will survey approximately 48,000 residents in 4,575 programs. Unlike the past two years, when only those programs having four or more active residents were surveyed, programs having at least one active resident are now eligible for participation.

Program directors are notified directly by the ACGME that residents in their program must take the survey; program directors are given usernames and passwords for the residents. Residents must change their assigned usernames and passwords as they log in to complete the survey. At least 70% of residents in a program must respond to the survey and program directors receive periodic e-mails informing them of the percentage of their residents having completed it. A list of residents who have not yet taken the survey is available to program directors until the end of the response period.

At the end of the response period, aggregated program data reports are available for ACGME field staff, which do site visits for program accreditation. The survey is designed primarily to help the field staff verify and clarify information from residents, and to help guide their resident interviews during program site visits. The field staff provide a detailed written report on all aspects of the program, including resident input, to the residency review committee. That committee, a team of physician volunteers who make accreditation decisions for programs within their specialty, then makes accreditation decisions based upon all of the available information from program directors, residents, and field staff.

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Resident Review is published four times a year by the Accreditation Council for Graduate Medical Education. Opinions stated in the newsletter do not necessarily reflect the policies of the ACGME. Comments and suggestions should be sent to Julie Jacob, manager of communications, juliej@acgme.org.

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reminders

Upcoming Meetings

Association of American Medical Colleges Organization of Resident Representatives Spring Professional Development Conference
Charlotte, North Carolina
March 19–21, 2006

American Medical Association Annual Meeting
Chicago, Illinois
June 10–14, 2006

Accreditation Council for Graduate Medical Education Summer Board of Directors Meeting
Chicago, Illinois
June 26–27, 2006

Aggregate data reports may also be available to individual programs. If 70% of residents in a program that has at least four residents complete the survey, the program's director and designated institutional official (person who is in charge of all residency programs at an institution) have access to aggregate data from the survey. These data may help program directors gauge how their program is doing and highlight areas of potential concern (for example, several residents may report they receive inadequate supervision). No data are available to the program, nor to the institution, for the smaller (fewer than four residents) programs and those having less than a 70% response rate.

More information regarding the resident survey can be found on the ACGME Web site at http://www.acgme.org/acWebsite/Resident_Survey/res_Index.asp

Residents have a role to play in shaping the future of resident education

The expectations, goals, and format of residency training in the United States have undergone a dramatic change at the outset of this millennium. Whereas residency in almost all fields of medicine was relatively static during the past four decades, the past five years have incorporated dramatic changes in both the requirements and nature of both specialty and subspecialty training.

Evolving ideas of the length of training, the quality of resident life, the balance between work and family, the increasing diversity of those entering the medical profession and the proliferation of subspecialty and superspecialty choices has fundamentally changed the landscape of medical education. Technology and advances in science have revolutionized

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Resident Physicians on Duty by Specialty (2004–2005)

Specialty	%	Specialty	%	Specialty	%
Allergy & Immunology	0.3%	Neurology	1.8%	Plastic Surgery	0.7%
Anesthesiology	5.8%	Nuclear Medicine	0.2%	Preventive Medicine	0.4%
Colon & Rectal Surgery	0.1%	Obstetrics & Gynecology	5.4%	Psychiatry	5.4%
Dermatology	1.2%	Ophthalmology	1.6%	Radiation Oncology	0.6%
Emergency Medicine	4.8%	Orthopaedic Surgery	3.6%	Radiology – Diagnostic	4.9%
Family Practice	11.2%	Otolaryngology	1.2%	Surgery – General	8.7%
Internal Medicine	25.3%	Pathology – Anatomic & Clinical	2.6%	Thoracic Surgery	0.4%
Medical Genetics	0.1%	Pediatrics	9.0%	Urology	1.1%
Neurological Surgery	0.9%	Physical Medicine & Rehabilitation	1.3%	Transitional Year	1.5%

response

ACGME Contacts

Case Logs assistance
helpdesk@acgme.org

Resident Review feedback
juliej@acgme.org

Questions about the general competencies
outcomes@acgme.org

Resident complaints
mmiller@acgme.org

Resident Survey questions
ressurvey@acgme.org

both the way we learn and the breadth of content that either has to be mastered or accessed to provide state-of-the-art care to our patients.

This year the ACGME – the sole organization responsible for offering accreditation for those institutions and programs engaged in the education and training of tomorrow's physicians – celebrates its 25th anniversary. In years past, there was little uniformity or information regarding the quality and scope of post-graduate medical education in this country. Through the course of the formation of 27 individualized residency review committees (RRCs) and the Institutional Review Committee (IRC), the implementation of peer-guided oversight, and the incorporation of resident representation, the ACGME has aided in the establishment of some basic level of uniformity and quality throughout America's postgraduate medical education system.

The challenge for us, as residents and future physician educators, is to provide careful oversight and insight into the very processes that are being evaluated and implemented as policy for the future training of America's physicians. The special privilege and burden has been placed upon us to weigh carefully the myriad policies, guidelines, and criteria that are being developed in the spirit of improving graduate medical education. We must not take for granted the unique opportunity to both be a part of the process and to have the ability to leave a lasting impact upon future generations of physicians.

The key issues that I see before us are:

Advocacy – We as residents must be our own best advocates. We must take an active role in policy making and policy deliberation. Residents today have more voice and more representation through all levels of organized medicine than ever before. Every major specialty society, council, governing body, and accreditation organization has some form of resident representation. This opportunity and chance for advocacy on our own behalf must not be squandered.

Communication – Residents are arguably some of the busiest, hardest working individuals in modern society. The time demands, stresses, and requirements of most residency training is beyond what most of our colleagues in other professions can imagine. Despite this, we must make every effort to establish and maintain communication with our fellow physicians both within and beyond our specialty. It is only by recognizing common challenges, opportunities, and goals that residents can improve the quality and scope of their education.

Quality Improvement – Those of us in medicine must make use of the tremendous opportunity that technology has offered us to improve both the quality of our education and the quality of the care we provide America's patients. It is only by implementing continuous quality improvement measures, such as lifelong learning portfolios, patient simulators, quality measurement, and process improvement as well as many other technology based efforts, that we will be able to continue to improve our educational environment. We as medical residents in the new millennium must strive to continue to develop new models of education and patient care while ensuring that the quality and the scope of our training remain the very best in the world.

Written by V. Seenu Reddy, MD, MBA. Dr. Reddy recently completed his residency in thoracic surgery at the University of Texas Health Science Center in San Antonio, Texas, and is an assistant professor of thoracic surgery at the center. He is chair of the ACGME's Council of Review Committee Residents.

resources

Web sites of Interest

Association of American Medical Colleges
www.aamc.org/members/orr

American Medical Association Section on Residents and Fellows
www.ama-assn.org/ama/pub/category/15.html

Educational Commission on Foreign Medical Graduates
www.ecfmg.org

National Resident Matching Program
www.nrmp.org

Better communication between medical students and ACGME will help students in their residency program decisions

The Accreditation Council of Graduate Medical Education (ACGME) plays an important role in resident education through the accreditation process. The ACGME's goal is to enhance resident education. Unfortunately, many residents and medical students know little to nothing about the ACGME. I will admit that it wasn't until the publicity of the duty hour regulations that I became aware of the ACGME. Even then, I wasn't truly aware of the important role the ACGME plays in resident education until elected onto the Residency Review Committee for Neurology.

Many medical students make decisions on residency programs based on word of mouth and the American Medical Association's Fellowship and Residency Electronic Interactive Database (FREIDA). I feel few medical students take advantage of the resources the ACGME provides them and review the accreditation status of residency programs. I do not feel this is solely the medical students fault. Advisors, fellow residents, and other medical school staff do not consistently direct medical students to the ACGME. The ACGME also needs to continue to play an active role in improving awareness among students.

Program directors frequently are intimidated by the ACGME and consequently do not frequently refer residents and medical students to the ACGME. The negative attitude directed towards the ACGME from residency programs' faculty could influence residents and medical students. It becomes easy to lose sight that the ACGME is there to protect and improve graduate medical education.

Therefore, it is important for the ACGME to improve its relationship with program directors and medical schools. A mentor role needs to emerge. The ACGME should enhance communication between residency programs and the ACGME. Additionally, we need to strive to heighten the awareness, interest, and understanding of the ACGME program initiatives with residents and medical students.

Written by Cynthia Bodkin, MD, resident member of the RRC for Neurology and vice-chair of the Committee of Review Committee Residents.

reference

Important Definitions

Accreditation
A voluntary process of evaluation and review performed by a non-governmental agency of peers.

Applicant
An MD or DO invited to interview with a GME program.

At-Home Call (Pager Call)
Call taken from outside the assigned institution.

Definitions are taken from the ACGME Bylaws, Policies and Procedures, and Glossary

Residents can steer the course of graduate medical education

Just over seven years ago, Dr. Jordan Cohen, President of the Association of American Medical Colleges (AAMC), challenged those involved in residency training to "Honor the 'E' in GME[1]" Since that time programs and hospitals have struggled to adapt to new requirements. In an article recently published in the *Journal of the American Medical Association,* Kenneth Ludmerer and Michael Johns reviewed the evolution of graduate medical education and its current state.[2] Graduate medical education is a large ship that is difficult to steer and is often, unfortunately, subject to the prevailing winds.

Helping to bring about needed change is the responsibility of everyone involved in graduate medical education – administrators, teachers and learners. Discussions of the "big picture" make sense, but the smaller steps that need to take place are more difficult to plan and to take. As the ship moves on we just hope it ends up close to where we need to be.

So what specifically can residents or "learners" in the process do? As a start I would suggest the following three things:

First, stay committed to patient care and to personal education. The short years of residency and fellowship are fleeting and are soon gone. Working to acquire as much knowledge, skill, and competency as possible during this time will be rewarded over a career. The "Compact Between Resident Physicians and Their Teachers[3]" recently released by the AAMC begins with these "resident commitments."

Second, commit to leaving your program better because you were there. Frustration and a desire to just "get out" comes easily after years of hard labor but we all have a responsibility to those coming behind us. Help with curriculum reform, put together a list of "pearls of wisdom," donate books to a resident library – find some way to make things a little better.

Third, know your own specialties program requirements. Both common requirements and specialty specific requirements are published on the ACGME Web site, www.acgme.org. Knowing what is required of an accredited program is the first step in working towards program improvement. Continuing improvement of curriculum requires a joint effort between teachers and learners.

A change in the direction of our ship can only come if we all agree on and work towards a destination – years in a residency program can and should get us more than close.

Written by Craig A. Nicholson, MD, resident member of the RRC for Urology.

1 Cohen J. Honoring the 'E' in GME. *Acad Med.* 1999;74:108–113.
2 Ludmerer K., Johns M. Reforming Graduate Medical Education. *JAMA.* 2005;294:1083–1087.
3 AAMC. Compact Between Resident Physicians and Their Teachers. www.aamc.org/residentcompact. 2005