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## rounds

### An Interview with David C. Leach, MD

*In September, the ACGME will say good-bye to its executive director and CEO, David C. Leach, MD, who is retiring. Dr. Leach came to the ACGME in 1997 from the Henry Ford Health System in Detroit, where he was in practice and taught for 28 years; he served as director of medical education for 13 years.*

*During his years as executive director of the ACGME, the organization introduced the six general competencies, launched the Parker J. Palmer Courage to Teach Award, adopted the common duty hour standards, began institutional accreditation, and became an independent 501c3 corporation. Currently the organization is developing the ACGME Learning Portfolio, which will be an online learning portfolio for residents.*

*Dr. Leach and his wife, Jackie, will move to Asheville, North Carolina, where he plans to spend a year making sense of the next chapter of his life. He reports that he has worked nonstop for over 50 years and relishes moving from frenzy to wisdom. He is deeply grateful for the experiences he has had at the ACGME and elsewhere.*

### What drew you to the ACGME?

A headhunter. I was very happy at Henry Ford Health System. I thought I was going to stay there forever, but then a headhunter called and asked if I would look at the job. Paul Batalden, a good friend, said: "If you are offered the position, you have to take the job." Paul pointed out that 1) the mission of the ACGME is very close to my heart; 2) the organization is national in scope; and 3) it has leverage. All three observations proved true.

From the beginning, I was touched by the quality of the community, the level of integrity and professionalism, the sense of accountability. People were very kind to me and anticipated what I needed.

### What were your goals when you started at the ACGME?

To improve patient care. To me, the quality of patient care and the quality of resident formation are inextricably linked. I wanted to introduce practice-based learning and improvement and to strengthen the profession that I love.

### What do you think has been your biggest accomplishment as executive director of the ACGME?

You must understand that in an organization like ACGME no single individual can claim accomplishment. Virtually every initiative is dependent on my fellow employees and

(continued on page 2)

## reminders

### Upcoming Meetings

American Association of  
Family Physicians National  
Conference of Family  
Medicine Residents  
Kansas City, Missouri  
August 1–4, 2007

Accreditation Council for  
Graduate Medical Education  
Fall Board Meeting  
Rosemont, Illinois  
September 10–11, 2007

American Academy  
of Pediatrics  
National Conference  
San Francisco, California  
October 27–30, 2007

volunteers – I quickly learned that there is great wisdom in the crowd, much more wisdom than exists in any single individual. Hosting clarifying conversations was the greatest accomplishment. The skills are hospitality, civility, and respect of diverse points of view.

#### How has the ACGME changed since you joined the organization?

It's gotten bigger. I recruited good people; they recruited good people. We have more space. We have more servers. We use more data and better data in accreditation, and we gather more of it electronically. The ACGME became independent. We have a good strategic plan.

#### What have been the biggest changes in graduate medical education since you started at the ACGME?

The conversations have changed. The competencies, duty hours, and complexity theory are being used to talk about GME. There are more specialties. The Dreyfus model has been introduced for the formation of physicians. People are taking GME more seriously.

#### How will GME change in the next 10 years?

Funding will be threatened. The winning of the Jung lawsuit means that national standards rather than corporate standards were reinforced; this is a hallmark of a profession. We will become more transparent and make it easier for students, residents, and the public to understand the quality of GME. There will be different accreditation models for different programs. The Learning Portfolio will change graduate medical education.

#### What advice would you give to resident physicians?

Vocation is a calling and medicine is a vocation. It demands an individual response – a unique response that deepens over time. In the response you discover yourself – your strengths and gifts, your weaknesses and limitations. Be grateful for the calling; take it seriously. You will be measured by the authenticity of your response.

#### What are your retirement plans?

I will reflect. I agree with Socrates that the unexamined life is not worth living. Reflection requires both time in solitude and time in community and I will seek out both. I will write for clarity. I am moving to a beautiful part of the world. Jackie and I say a prayer every morning; it goes like this: “Thank you, God, for this day. Help us to grow closer to you and to each other in every way.” We will try to do that.

#### Any other thoughts on your retirement?

I will miss the ACGME community. I have a deep affection for those who work here and for our volunteers (most of them). I hope folks will stay in touch. I will learn about the retirement transition and will share my thoughts – some day this will happen to you as well.

## resources

## Useful Web Sites

Association of American  
Medical Colleges

[www.aamc.org/members/orr](http://www.aamc.org/members/orr)

American Medical  
Association Section on  
Residents and Fellows

[www.ama-assn.org/ama/  
pub/category/15.html](http://www.ama-assn.org/ama/pub/category/15.html)

Educational Commission on  
Foreign Medical Graduates

[www.ecfm.org](http://www.ecfm.org)

National Resident  
Matching Program

[www.nrmp.org](http://www.nrmp.org)

## Communication is Key When Coping with a Program Closure

When a residency program is slated to close, it is critical to keep residents informed about what is happening, said Jay Yanoff, EdD, the designated institutional official and chief graduate medical education officer at Hahnemann University Hospital/Drexel University College of Medicine in Philadelphia.

In the past few years, Dr. Yanoff has experienced two rounds of residency program closures. In 2004, Tenet Healthcare Corp., which owns Hahnemann University Hospital, sold the Medical College of Pennsylvania Hospital, which later closed. Hahnemann University Hospital added the residents from the MCP Hospital to its existing programs. Then last December, Tenet announced that it was selling Graduate Hospital to the University of Pennsylvania Health System, which is converting the hospital into a rehabilitation center. Dr. Yanoff, who was named the interim DIO at Graduate, had to find slots in other programs for 60 residents. The remaining 50 residents at the hospital graduated in June 2007.

Long before the official announcement, the faculty and residents at Graduate Hospital in Philadelphia knew that the hospital was for sale. However, Graduate's owner, Tenet Corp., for legal reasons could provide only general information. Nonetheless, as soon as he found out about it, Dr. Yanoff called the ACGME's executive director, David C. Leach, MD, and sent him a letter apprising him of the situation. Dr. Yanoff also immediately called a meeting with the residents to share what he did know.

"The residents already knew because their program directors had been on edge," said Dr. Yanoff. "One of the things you'll find out is that rumors will fly faster than the truth. We advised them of everything we knew, and every Wednesday I gave them an update."

The residents understandably were upset and worried about how they were going to continue their graduate medical education.

"First there is shock and denial," said Dr. Yanoff. "Then they go through a lot of anger. Then they go through the bargaining stage, then they are depressed, and then they are in acceptance – 'let's get on with this.'"

Dr. Yanoff, ACGME review committee executive directors, and Graduate Hospital program directors worked together to find places for the displaced residents. The residents themselves also called programs and institutions that they were interested in to inquire about available positions.

"The ACGME was enormously helpful," says Dr. Yanoff. "We worked with the executive directors of the review committees for internal medicine and surgery, Bill Rodak, PhD, and Larry Sulton, PhD. They knew the situation, and they were on top of it. Placing the internal medicine residents was easier than surgery because surgical residents have to go to a program that has enough volume to take another resident."

(continued on page 4)

## resources (continued)

**Physician Blogs**

Blogborygmi

<http://blogborygmi.blogspot.com>

DB's Medical Rants

[www.medrants.com](http://www.medrants.com)

Grunt Doc

[www.gruntdoc.com](http://www.gruntdoc.com)

Kevin MD

[www.kevinmd.com](http://www.kevinmd.com)Wall Street Journal  
Health Blog<http://blogs.wsj.com/health>

Every resident has been placed in another program, he said. Ten transferred to programs at Hahnemann, and the rest found positions at other programs around the country. Although the closure of the residency programs at Graduate was an upsetting experience for the residents, most ended up very happy in their new programs, said Dr. Yanoff.

For example, he said, a resident whose family lived in Detroit joined a residency program in Detroit, and a resident from Washington, D.C., found a place in a residency program in her hometown.

“Our feeling is that everyone, and I mean everyone, has ended up in a situation that was better than it was before,” said Dr. Yanoff.

Dr. Yanoff advises that residents faced with the closure of their program take the following steps:

- Pay attention to what is going on and listen to what your program director tells you.
- Try to remain calm and focused.
- Make sure the administrators are giving you information. If the administration is not forthcoming, contact the ACGME.
- Start looking for potential programs as soon as possible.

## reference

**ACGME Definitions****ECFMG Number**

The identification number assigned by the Educational Commission for Foreign Medical Graduates (ECFMG) to each international medical graduate physician who receives a certification from ECFMG.

**Elective**

An educational experience approved for inclusion in the program curriculum and selected by the resident in consultation with the program director.

**Faculty**

Any individuals who have received a formal assignment to teach resident physicians. In some institutions appointment to the medical staff of the hospital constitutes appointment to the faculty.

*Definitions are from the ACGME Glossary. The entire glossary is posted online at [http://www.acgme.org/acWebsite/about/ab\\_ACGMEglossary\\_07\\_05.pdf](http://www.acgme.org/acWebsite/about/ab_ACGMEglossary_07_05.pdf)*

**Residents and Faculty Must Bridge the Generation Gap Over Duty Hour Standards**

*By Craig A. Nicholson, MD*

Since the adoption of mandatory duty hour restrictions by the ACGME in July 2003, many articles have been published looking at the effect of duty hour restrictions on patient care, education, and resident life. As a graduating urology resident I have seen the adoption of the duty hour standards and have seen some of the responses by programs, residents, and both academic and private attending physicians.

As duty hour restrictions were introduced, programs struggled to respond and to find ways in which to continue covering ever-increasing service demands with less resident availability. Physician extenders were added and new work schedules, including night float systems, were adopted in order to cover service demands, and the excellent patient care provided by our teaching hospitals has continued.

Following the initial efforts focused mainly on providing coverage and maintaining patient care activities, systems to continue the educational mission began to be developed. Although good evidence relating to duty hours and their effect on education is hard to come by, it appears probable that, with innovation and planning, resident education does not need to be compromised.

As I have witnessed the introduction of strict duty hour restrictions, perhaps one of the greatest challenges I have seen has been the division or even rift that has often developed between residents and teachers. Compliance with restrictions, at least initially, was often seen as a sign of weakness or as a demonstration of a lack of commitment to both patients and the specialty. Particularly in surgical specialties, where duty hours had been notoriously high, these “generation gaps” have developed – or perhaps existing gaps have been made wider. I believe these gaps can, as much as time and scheduling issues, affect the quality of resident education. A belief that residents lack the commitment required on the part of teachers, or a belief that their efforts are not appreciated on the part of residents, cannot help but affect the educational dynamic. As we continue to modify duty hour restrictions and continue to adapt to these restrictions, efforts to bridge these gaps must be made.

*Dr. Nicholson is a urology resident at the University of Rochester Medical Center and a resident member of the Residency Review Committee for Urology.*

## Both Technical and Emotional Skills Needed to Achieve Dreyfus Model

By Taliva Martin, MD

After years of learning to assimilate massive quantities of information in university and medical school training, residency finally pushes us to transition from student to doctor. The combination of skills necessary to produce a competent physician is beyond pure factual knowledge and is outlined by the ACGME in the six competencies, forming the guideline for evaluation of graduating doctors. Despite the inclusiveness of this or any measurement tool, it cannot capture the intensity and emotional impact of the learning process. Although less addressed than aspects like test taking, research, or manual skill proficiency, when struggles come in residency it is often around issues of fear, responsibility, and failure.

At the ACGME Learning Design Conference in September 2006, Hubert Dreyfus, professor of philosophy in the graduate school at the University of California, Berkeley addressed this phenomenon of emotional investment as it pertains to learning using a model of “Six Stages of Skill Acquisition”.

Stage 1: **Novice** – acts based on learned rules applied to context-free features

Stage 2: **Advanced beginner** – incorporates situational aspects, used maxims based on coaching

Stage 3: **Competent** – adopts a perspective, *emotionally invests in actions*

Stage 4: **Proficiency** – immediately sees issue and appropriate plan, reasons out what to do

Stage 5: **Expertise** – performs appropriate action, no problem solving, no reasoning

Stage 6: **Mastery** – understands what is meant to be a physician; understands the broadest context, understands what is at stake

According to his research, it is at the level of **competency** where emotional aspects of learning move the learner to higher levels. He states:

*“There are, in fact, more situations than can be named or precisely defined, so no one can prepare a list of types of possible situations and what to do or look for in each. Competent performers, therefore, must decide for themselves in each situation what plan or perspective to adopt without being sure that it will turn out to be appropriate.*

*Given this uncertainty, coping becomes frightening rather than merely exhausting. Prior to this stage, if the rules don't work, the performer, rather than feeling remorse for his mistakes, can rationalize that he hadn't been given adequate rules. But, since at this stage, the result depends on the learner's choice of perspective, the learner feels*

(continued on page 7)

*responsible for his or her choice. Often, the choice leads to confusion and failure. But sometimes things work out well, and the competent student then experiences a kind of elation unknown to the beginner. So the learner is naturally frightened, elated, disappointed, or discouraged by the results of his or her choice of perspective. And, as the competent student becomes more and more emotionally involved in his task, it becomes increasingly difficult for him to draw back and adopt the detached maxim-following stance of the advanced beginner.*

*Only at the level of competence is there an emotional investment in the choice of action.”*

Interestingly, current ACGME language uses achievement of “competency” as our goal which, in the model, is the point where logic and analysis meet emotional investment. We all have had the experience of making the right diagnosis or performing the perfect case and the feeling of pride that follows. These stories are easily broadcast through our peer group. But what about the failures, complications, incorrect diagnoses? We may analyze these freely for the technical mistake, the rule that was broken. But how often do we contemplate the guilt or embarrassment or fear of doing harm – especially in surgical specialties that are traditionally less accepting of words involving emotion?

The Dreyfus framework in many ways normalizes this part of our learning experience and elevates the euphoria of success as *well* as the sinking feeling of our failures. They are both essential to development. Rather than running from the failures, we can help ourselves by finding ways of processing them through mentorship, informal peer gatherings, moderated group sessions, or personal reflection. These skills will serve us throughout our professional life. Perhaps finding better avenues of expression will allow us all to achieve mastery of our craft.

*Dr. Martin is a resident member of the Residency Review Committee for Ophthalmology and a fourth-year resident at California Pacific Medical Center in San Francisco.*

## **Resident Member of RRC for Internal Medicine Says Position is a Way to “Impact the Future of Medicine”**

*By Karen Hsu Blatman, MD*

### **Why did you decide to apply to be a resident member of the Residency Review Committee for Internal Medicine?**

I had been involved with curriculum committees in medical school and have always been interested in medical education. Medical education today represents the future of medicine. A residency review committee is a good place to devote time and energy to most efficiently impact the future of medicine.

### **Did you know much about the ACGME before you applied? What were your impressions of the ACGME?**

I knew that the ACGME was the accrediting body of the U.S. residency programs. I had only tangential contact with the ACGME, particularly when I was on the American Medical Association's Council of Medical Education.

### **What did you need to do to apply?**

My appointment was through the AMA. The AMA Resident and Fellows Section solicited applications from all its members. For the RRC-IM, there are two resident representatives that are appointed by the three sponsoring bodies, the AMA, the American College of Physicians, and the American Board of Internal Medicine. The next resident member will be nominated by the ACP.

### **What was your first meeting like?**

My appointment officially started in January 2007. Prior to our first meeting we sit in for two meetings as an observer. The RRC for Internal Medicine meets four times a year. Our next meeting in July 2007 is a policy-only meeting. The committee will be working on revising the Internal Medicine Program Requirements. Our other three meetings are primarily devoted to program reviews.

A huge chunk of our time is focused on residency and fellowship program reviews. During my first observation period, I was just amazed at how much was done by the RRC members prior to arriving at the meeting. The RRC for Internal Medicine reviews about 200 to 250 programs at each meeting. Each regular member reviews 10 programs to discuss at the next meeting. When I review programs, they are co-reviewed by one of the non-resident committee members.

(continued on page 9)

**What struck you the most about the RRC meeting? Was it like you had expected or was it different?**

I was most impressed with the members of the committee. I was struck by the depth of their insight in the context of their perspectives as program directors, department chairs, and associate deans. I also really appreciated how much they are advocates for the well being of the residents. This is truly a group of committed, thoughtful medical educators who spend literally thousands of unpaid man- and woman-hours helping to ensure a high quality of resident education in America.

**What have you learned by serving as a resident member of the RRC for Internal Medicine?**

I have been able to appreciate why some of the rules are the way they are. I have also learned to appreciate what it means for a program to be on a five-year cycle versus a two-year cycle. As a medical student, I would have liked to have had more insight into what the accreditation cycles meant. I have also learned how important the information from the resident surveys and from the site visits with residents is to helping us understand if there are problems in the program. I also have learned how good the site visitors are in conveying those problems in an anonymous way so we can address them without pointing fingers at the whistleblower.

I have learned that the key to success for the RRC is somewhat out of the control of its members. The most important information comes from the residents themselves. Success therefore relies on the candidness of the residents and program directors. If the information the RRC collects is inaccurate or incomplete, then any analysis of this information is destined to be flawed.

*Dr. Hsu Blatman is a resident member of the Residency Review Committee for Internal Medicine and a second-year resident in internal medicine at the University of Virginia Health System in Charlottesville, Virginia.*

*For information on how to apply to serve on one of the ACGME's 28 review committees, please go to [http://www.acgme.org/acWebsite/resInfo/ri\\_residentSelection106.pdf](http://www.acgme.org/acWebsite/resInfo/ri_residentSelection106.pdf)*