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ACGME Bulletin

ACGME

Accreditation Council for Graduate Medical Education

EDITOR'S INTRODUCTION

The Accreditation Council for Graduate Medical Education publishes the **ACGME Bulletin** 3 to 4 times a year. The Bulletin is distributed free of charge to more than 12,000 individuals involved in residency education and is also available on the ACGME's world wide web site (www.acgme.org) for viewing and printing. The ACGME receives and publishes letters to the editor in the interest of furthering dialogue about accreditation, program quality and matters of general interest in residency education. Inquiries, comments or letters should be addressed to the editor.

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Farewell to the *ACGME Bulletin*

In the last decade, graduate medical education (GME) has undergone significant change, including the application of the 6 general competencies to assess educational outcomes for residents and fellows and setting common duty hour limits for learners in accredited programs. Concurrently, the ACGME transformed the *Bulletin* from a publication that summarized the thrice yearly actions of the Accreditation Council for Graduate Medical Education board of directors to a publication venue for program directors, educators, researchers and innovators; and a source of information on a broad range of topics related to graduate medical education.

The transformation of the ACGME's publication will be completed in the coming weeks, when the ACGME will publish the inaugural issue of the *Journal of Graduate Medical Education,* a peer-reviewed publication dedicated to articles about the education of residents and fellows. With this issue, we say farewell to the *Bulletin*. Information of interest to program and institutional leaders previously included in the *Bulletin* will be published in the *ACGMe-Bulletin,* which will be available via electronic mail and the ACGME web site. Like the *Bulletin,* the new ACGME *Journal* will be provided at no added charge to program directors and designated institutional officials as a benefit of participation in the accreditation process.

"The bit of sadness that accompanies the publication of the final issue is overshadowed by the joy of being able to announce the *Journal* as a new resource for program directors and institutional officials."

As the editor for the past 11 years, I wanted to take this opportunity to thank the authors who chose the *Bulletin* for their articles, not infrequently foregoing publication in a peer reviewed journal. Their contributions enriched the *Bulletin* and I hope they will choose the new *Journal* for future submissions to inform the graduate medical education community. From my perspective as the editor of the *Bulletin,* the bit of sadness that accompanies the publication of the final issue is overshadowed by the joy of being able to announce the *Journal* as a new resource for program directors and institutional officials. ■

Principled Approach to Error Disclosure Aligns with ACGME Competencies, Enhances Safety and Helps Institutions Improve

Julie A. Jacob

Residents who make medical errors may be reluctant to disclose them for reasons including shame, fear of being sued and anxiety about losing their license. At the same time, it is important for residents – and other health care professionals – to disclose errors. Doing so helps individuals learn from the mistake, enables the hospital to adjust its processes to prevent or minimize the chances of this or a similar event re-occurring, provides accountability to patients harmed by errors and helps residents involved in the error to heal emotionally. This was the key message of a presentation entitled "Disclosure of Medical Error in the Context of Institutional 'Just Culture'" at the 2009 ACGME Annual Educational Conference. Timothy McDonald, MD and David Mayer, MD, are the co-executive directors of the University of Illinois at Chicago (UIC) Institute for Patient Safety Excellence. Both are anesthesiologists in academic practice. Dr. McDonald also is the chief safety and risk officer and Dr. Mayer is the associate dean for curriculum at UIC College of Medicine.

A principled approach

The presenters discussed the principled approach to medical error disclosure used at the UIC Medical Center and UIC College of Medicine. They talked about how this approach embodies the ACGME core competencies and provided practical recommendations for how other teaching hospitals can develop a resident adverse event reporting program.

Drs. McDonald and Mayer compared developing a principled adverse event disclosure system to nurturing a crop. First, institutional leaders must "till the soil" by adopting an institution-wide disclosure policy and gaining staff support for the program. Second, the hospital must "plant the seeds" by establishing a step-by-step process for disclosing and investigating medical errors and also by educating and engaging resident physicians on the disclosure process. Finally, the hospital must "nurture the crop" by putting together a support team for residents who disclose errors and setting up a process for analyzing data and investigating the root cause of errors.

The speakers noted that, despite the many reasons why residents may be afraid to admit that they have made an error, a principled, standardized and fair policy for disclosing, investigating and making amends can increase the likelihood that residents will admit errors and contribute to hospital-level improvements in patient safety procedures.

Error disclosure and investigation

The presentation outlined the process of disclosing and investigating medical errors, which entails 5 steps. They include reporting the error, investigating the error, improving the hospital's processes to minimize the likelihood of the error happening again, communicating information about the error to the patient and staff members and providing an apology and remediation to patients harmed by an error or to their families.

Each step in the process is an opportunity for residents to learn and practice the 6 general competencies. For example, disclosing the error is an exercise in interpersonal and communication skills, professionalism and systems-based practice.

Resident support and inclusion in the processes to address the error

It is important to support residents who admit that they have made a mistake and to treat them fairly, the presenters said. Studies have shown that residents who make an error are at an increased risk of depression and are more likely to make another mistake. "Put together a support team that can be called on to give support when there is an adverse patient event," said Dr. McDonald.

"First, institutional leaders must 'till the soil' by adopting an institution-wide policy and gaining staff support for the program."

It also is important for residents to be part of the process of improving procedures to minimize the chances of that particular error happening again. For example, noted Dr. McDonald, after an incident in which an oxygen tank ran low while a patient was being transported to the hospital, residents developed a chart that allows health care team members to quickly and easily calculate how long a tank will provide oxygen.

Finally, making an apology to a patient who has been harmed is a valuable learning experience for residents, one that gives the resident a chance to practice interpersonal and communication skills, professionalism and practice-based learning and improvement. "It's important for the resident to understand the power of an apology," said Dr. Mayer.

The bottom line is that hospitals have 2 choices when it comes to dealing with medical errors, said Dr. McDonald. "Hospitals can either talk about errors and learn from them, or continue to hide from them." ■

Julie A. Jacob is the Manager of Corporate Communications, ACGME.

Restoring Honesty, Trust and Safety in Health Care: Educating the Next Generation of Providers

David B. Mayer, MD and Timothy McDonald, MD, JD

We presented at the 2009 ACGME Annual Educational Conference on a principled approach to managing patient safety incidents and shared a new resident education reporting program implemented at the University of Illinois Medical Center at Chicago (UIMCC) aligned with the 6 ACGME core competencies.[1] We noted that the best approach to managing medical malpractice issues is to improve patient safety and prevent unnecessary harm. An important component of any safety culture is open and honest reporting of unanticipated events, system weaknesses and near-misses. We also feel there is a need to improve communication between physicians and patients when an unanticipated event occurs.

The UIMCC comprehensive program for resident education about error reporting highlighted how the educational program teaches residents the value of reporting unanticipated events, system weaknesses or near misses and how such reports lead directly to improvements in care. Before implementing UIMCC's comprehensive resident reporting program early last year, less than 1 percent of occurrence reports were coming from UIMCC residents. As part of the program, residents are now required to report at least 6 unsafe patient care conditions, near misses or adverse events each year. One month after starting the first pilot of the program, UIMCC received more reports from the small first group of residents than they had received from all UIMCC residents the previous year. The reports contain a rich source of data that has been used to improve processes of care in their health system.

Principles adopted for UIMCC "full disclosure" program include the following::

- Communicate effectively and honestly with patients and families following adverse patient events
- Apologize and compensate quickly and fairly when inappropriate medical care causes injury
- Defend medically appropriate care vigorously
- Reduce patient injuries and claims by learning from the past

(with thanks to Rick Boothman, CRO, University of Michigan)

Participants attending the session at the ACGME Educational Conference discussed barriers to open communication around medical errors. Common barriers include fear of lawsuits, retribution, a culture of "shame and blame", not wanting to "turn in" fellow practitioners, not having enough information to explain what happened and bad publicity. Many also felt that physicians and educators don't know how to openly and effectively discuss errors or harm with patients.

At the beginning of the session, we asked willing residency program director participants to fill out a short survey on their personal experiences related to reporting of adverse events and medical errors. Results from the survey, shown in *Table 1,* highlight the critical need for faculty development programs in this important area of education.

Table 1
Program Directors Perceptions about and Experience with Medical Error Reporting

30% of the attendees believe most errors are caused by individual failures and not system failures.
Almost 90% said that minor errors should be disclosed to patients and **100%** said serious errors should be disclosed.
85% said that disclosure of an error to a patient would make it less likely they would be sued.
93% said that disclosing an error, however, would be very difficult for them to do.
More than 90% believe that reporting of serious and minor errors and near misses would improve patient safety.
68% said their hospitals or organizations have error reporting systems yet **over 35%** of them have never reported an error. **Another 16%** said they only report serious errors despite their beliefs that reporting would improve the safety of their patients.
Less than 20% said that current processes/ mechanisms to inform providers about errors that occur in their system are adequate.
36% said no system changes occur after errors are reported.
92% said that their hospitals do not support their providers in coping with the stress associated with errors.
Over 45% have never personally disclosed an error to a patient or family.
60% said they have not received training on how to disclose an error to a patient or family member.

Table 2

Which of the Following Factors Might Make it Less Likely that You Would Disclose a Serious Error to a Patient?

	Frequency	Percent	Valid Percent
1. If the patient is unaware of that the error happened	0	0.0	0.0
2. If I think the patient would not want to know about the error	2	7.7	10.0
3. If I think the patient would become angry with me if I did so	0	0.0	0.0
4. If I didn't know the patient very well	0	0.0	0.0
5. If I think I might get sued	0	0.0	0.0
6. If I think the patient would not understand what I was telling them	5	19.2	25.0
1 and 5	1	3.8	5.0
1 and 6	2	7.7	10.0
2 and 6	3	11.5	15.0
4 and 6	2	7.7	10.0
1, 5 and 6	1	3.8	5.0
2, 4 and 6	1	3.8	5.0
3, 5 and 6	1	3.8	5.0
4, 5 and 6	1	3.8	5.0
All of the above	1	3.8	5.0
Total	20	76.9	100.0
No response	6	23.1	
Total	26	100.0	

The value of open and honest disclosure when patient safety events occur was also discussed with participants.

Participants also responded to a question about factors and circumstances that would reduce the likelihood of disclosing and error. The results are shown in *Table 2*. Discussion during the workshop showed the audience felt open and honest disclosure can restore trust between patient and physician and between members of the healthcare team. They also thought an open and honest approach would allow for earlier resolution of claims, increased organizational accountability and responsibility and would help heal and bring closure to patients, families and care providers.

Our session concluded by discussing difficulties associated with developing a culture of safety that includes open and honest disclosure of unanticipated harm. It takes courage by care providers and strong support from leadership to foster an environment where people are willing to report errors and participate in open and honest disclosure without fear

Table 3

Attitudes About and Experience with Communicating About Medical Errors

Current mechanisms to inform health care providers about errors that occur in their hospitals or health care organizations are adequate.

	Frequency	%	Valid %
Strongly disagree	10	38.5	38.5
Disagree	11	42.3	42.3
Agree	5	19.2	19.2
Total	26	100.0	100.0

At my hospital or health care organization, system changes to improve patient safety occur after errors are reported

	Frequency	%	Valid %
Disagree	9	34.6	36.0
Agree	16	61.5	64.0
Total	25	96.2	100.0
No response	1	3.8	
Total	26	100.0	

Have you received any education or training on how to disclose errors to patients?

	Frequency	%	Valid %
No	15	57.7	60.0
Yes	10	38.5	40.0
Total	25	96.2	100.0
No response	1	3.8	
Total	26	100.0	

Have you ever personally disclosed a serious error to a patient?

	Frequency	%	Valid %
0 = No	11	42.3	45.8
1 = Yes	13	50.0	54.2
Total	24	92.3	100.0
No response	2	7.7	
Total	26	100.0	

For the most recent serious error you disclosed, how satisfied were you with how this disclosure conversation went?

	Frequency	%	Valid %
Very dissatisfied	1	3.8	4.3
Somewhat dissatisfied	2	7.7	8.7
Somewhat satisfied	8	30.8	34.8
Very satisfied	5	19.2	21.7
Not applicable	7	26.9	30.4
Total	23	88.5	100.0
No response	3	11.5	
Total	26	100.0	

I experienced relief after disclosing this error to the patient.

	Frequency	%	Valid %
Strongly disagree	1	3.8	4.3
Not applicable	11	42.3	47.8
Agree	8	30.8	34.8
Strongly agree	3	11.5	13.0
Total	23	88.5	100.0
No response	3	11.5	
Total	26	100.0	

of retribution. Hospitals can encourage this behavior by implementing the following changes in their patient care and educational systems:

- Making reporting errors a standardized process
- Making it an expectation – not an exception
- Teaching and training the principles to everyone
- Establishing a safe and just culture that supports providers while maintaining accountability for reckless behavior and reckless choices
- Anticipating fears and emotions of those involved in an adverse event
- Adding incentives and subtracting disincentives
- Celebrating organizational improvements that result from open and honest disclosure.

"According to the presenters, the only people for whom corrective action should be considered are those involved in reckless decision-making and behavior and not those involved in system-related events."

At UIMCC a patient communication consult team is available 24/7 to begin acting on most reported events whether they are associated with harm or not, investigate them through interviews with care providers and patients and their families and finally help conduct open disclosure discussions. The team is made up of people with a high degree of emotional intelligence who can plan and lead the discussions. The advantage of this approach is that the people leading the meetings have a lot of experience in doing so and do it well. Most care providers aren't involved in this type of situation often enough to be comfortable with leading the discussion, although they always should be included on the team when the process is initiated.

We polled attendees about their personal experience with disclosing health care errors. The results are shown in *Table 3*. We noted that open and honest disclosure should be thought of as a process, not a single event. There will probably be a series of meetings with patients and families since what truly happened is usually not known right after the event. There should be one contact or liaison that leads regular and timely communication with the patient and family throughout the process.

The team looks at all reported events to see what could be done differently. When investigating an unanticipated event, the team uses Reason's Safe Practices Algorithm to determine if the event was attributable to conscious violation of a safe procedure, or whether correct procedures were available, workable and routinely used in the care of the patient. There may be times when people develop and use workarounds more frequently than following the correct standard procedure – referred to as the "normalization of deviance." According to the presenters, the only people for whom corrective action should be considered are those involved in reckless decision making and behavior and not those involved in system-related events. This type of "just culture" encourages staff to feel free to report errors without fear of retribution.

UIMCC has created an Institute of Patient Safety Excellence (IPSE). The UIC's campus has 6 health science schools, which allows for team-based, inter-disciplinary safety discussions and training. The Institute wraps patient safety around its three-part mission of clinical process improvement, education and research. IPSE's goals are to make patient care safer, improve the processes and systems associated with care and to educate all healthcare providers about these safety and quality improvements. ■

David B. Mayer, MS, is an Associate Professor of Anesthesiology and the Associate Dean for Curriculum, Dr. Timothy McDonald, MD, JD, is the Chief Safety and Risk Officer for Health Affairs, University of Illinois Medical Center at Chicago (UIMCC).

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Chart Audits in an Internal Medicine Resident Outpatient Continuity Practice: Successes and Lessons Learned

Jennifer R. Kogan, MD, FACP and Jeffrey R. Jaeger MD, FACP

"Physician report cards," based on audits of patient medical records, have long been used to document quality of care at the level of the practicing physician, physician group and health plan[1]. Long before the term "practice-based learning and improvement" became part of the vernacular, physicians used these reports to modify care delivery and, hopefully, improve patient outcomes[2,3]. Published reports of improvement in documentation and compliance with guidelines led to the recommendation that chart audits be used as an educational tool during residency training[4–6].

In 1998 the University of Pennsylvania implemented a chart audit project in our Internal Medicine resident outpatient continuity practice. Charts of residents' continuity patients were audited as part of a randomized controlled trial. The study goal was to determine the effectiveness of an audit report card as a feedback tool to improve preventive health and chronic disease management[7]. Trained abstractors audited 10 charts per resident on 78 process measures. Residents in the intervention group received data regarding individual and practice-level performance in a 10–15 minute feedback session given by their outpatient preceptor; control group residents did not receive feedback. Disappointingly, this enhanced data-based feedback did not result in meaningful practice change, as measured by a follow-up chart audit performed one year later comparing intervention and control residents.

In 2001, the ACGME mandated that residency programs demonstrate trainees' competency in practice-based learning and improvement (PBLI). Residency programs are now expected to demonstrate that their residents can investigate and evaluate their care of patients, continuously improve patient care based on self-evaluation, systematically analyze their practice and use quality improvement (QI) methods to improve practice performance. As such, we have continued to use resident chart audits and report cards as part of a broader PBLI and QI curriculum.

Penn residents now abstract 15 of their **own** outpatient continuity patients' charts annually. The program is now in its fourth year. Eliminating the cost of trained abstractors has increased feasibility and increasing the number of abstracted charts per resident has helped to improve audit generalizability[8]. Initially performed on a Microsoft Excel template, the audit is now web-based and designed on Microsoft's Sharepoint platform. Residents can sign on to the audit from any hospital-based computer and can toggle between the clinic's electronic medical record and the audit. A "How To" guide is posted on the audit homepage to assist with completion. Once their audit is complete, residents are asked to identify targets for improvement. PGY-3's are asked to reflect on their outpatient practice experience and suggest strategies for future improvement.

Audit domains include chart completeness (e.g., documentation of problem list, medications, allergies); adherence to prevention and screening guidelines (e.g., colon, cervical, breast and prostate cancer screening); immunizations (influenza, pneumococcal, tetanus); and widely-accepted indicators of appropriate chronic disease management (e.g., beta blocker use in coronary artery disease, HgA1C and lipid values in diabetic patients). The audit instrument has been modified over time to include more robust questions intended to promote reflection and goal-setting, along with clearer advice about what constitutes a "Yes" or a "No" for each parameter (e.g. "a mammogram that is ordered but not completed is a 'No'"). Importantly, however, relatively stable audit parameters over time have allowed longitudinal review of trends spanning an entire residency cycle. Audit data is stored in a password-protected database that can be queried by the program administration. The application generates both individual reports (for use in end-of-year evaluation and feedback) and group reports which can be sorted by practice, PGY year, or calendar year.

Early on, we recognized that the small numbers of abstracted charts per resident compromised the ability of individual residents to draw conclusions from their own data, let alone devise and implement meaningful practice changes. Also, individual reports were likely to result in individual solutions, rather than the attention to systems change that sustainable improvement requires. To improve the systems approach to QI and practice improvement, practice-wide reports are distributed each spring and discussed by residents and faculty at structured pre-clinic conferences. A teaching guide helps residents (and faculty) review summarized abstraction data, interpret the findings, develop hypotheses about practice variations across sites, identify areas for improvement and develop practice level strategies to address them. Practices use these conferences to choose practice-wide targets for improvement. Two practices are now engaged in QI projects based on prior audit reports (targeting pneumococcal vaccination and lipid management in diabetics) and residents continue to use the audit data in proposing further system changes.

"The discussion of data at the practice level has promoted residents' identification with the practice as a professional home whose improvement is worthy of their attention."

The resident chart audit program has been successful in promoting reflection on care delivery for a panel of the residents' own patients. The residents attend to the data and the reports because it is truly reflective of patient care for

which they are primarily responsible. There is widespread acceptance of audit data validity as the residents know that they and their colleagues tabulated the data. The discussion of data at the practice level has promoted residents' identification with the practice as a professional home whose improvement is worthy of their attention. A key component of ongoing success with the audits has been our institutional leadership which has supported faculty time and effort for this initiative. Support for a dedicated IT professional with an appreciation for the complexities of the electronic medical record and residency training has been critical. An institutional culture that promotes practice assessment and that supports the concept of QI has also strengthened the process.

Challenges to the audit curriculum include the lack of confidence among many faculty in teaching and modeling the concepts of quality improvement. We continue to search for appealing and appropriate CME vehicles to promote faculty mastery and ownership of the material. Many residents are primarily focused on inpatient care and do not identify the outpatient practice as a major priority for improvement. Therefore, a future goal is to modify the audit application for use in the inpatient setting.

We continue to use medical record audits to teach, model and document competency in Practice-Based Learning and Improvement. The audit has become part of our institutional culture and we are excited to continue to make use of this tool in our efforts to train and graduate physicians who are prepared for professional lives that will include expectations of continual practice performance assessment and quality improvement. ■

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An Educational Retreat Program for Achieving Competency-Based Education: The Medical College of Wisconsin Core Skills Program

Kurt Pfeifer, MD, Susan Davids, MD, MPH and Michael Frank, MD

In the last decade, graduate medical education (GME) has undergone significant scrutiny and reorganization. Beginning in 1999 with the Accreditation Council for Graduate Medical Education (ACGME) Outcome Project, training programs have been required to structure educational experiences around 6 general competencies to assure that residents develop all skills required for the practice of medicine. Although the content of GME was not altered, the Outcome Project required more structured educational methods and more rigorous evaluation than had been commonly utilized for teaching topics such as communication skills, professionalism and healthcare systems. In addition to these curricular changes, in 2003 the ACGME instated regulations that limited the duty hours of resident physicians.

Concurrent with these increased educational requirements and duty hour restrictions, changes in economic forces and practice standards have further complicated medical training. Although regulations have decreased the total duration of work for resident physicians, pressures to shorten length-of-stay and greater technological complexity demand a comparably larger amount of time dedicated to patient care. Furthermore, advances in medicine have greatly increased the skills and knowledge that trainees must master before entering practice. Combined with natural variability in resident and faculty skill sets, these factors create serious challenges for GME.

Assuring optimal training of the next generation of physicians requires innovative approaches to education. As recent studies have described, classic teaching venues, such as grand rounds, noon conference and bedside rounds, have either lost their effectiveness or disappeared altogether in today's hectic academic hospitals. GME programs will have to adapt to the inconsistency of clinical teaching opportunities and learner abilities to achieve a base set of competencies that allows the development of advanced skills. In other words, the chance element must be removed from GME. Instead of assuming that residents will get the time to attend lectures that are critical to their learning or will encounter a highly instructional patient care situation with the best teacher for the learning objective, programs must guarantee that all residents get dedicated, optimized education in core areas.

Meeting this challenge requires substantial investments of time and money, so it is logical for training programs to pool resources for accomplishing educational goals common to all. Cross-disciplinary collaboration also enriches the

educational experience of residents and promotes a supportive academic atmosphere. At the Medical College of Wisconsin we developed the Core Skills Program as a new, multidisciplinary educational model to target these challenges.

Program development

Needs Assessment. Utilizing in-training examination and board certification scores and faculty, resident and nursing feedback, a needs assessment was performed to determine which skills, knowledge and attitudes required improved education within the internal medicine residency program. Faculty and residents further characterized these educational needs based on the level of training for which they were most to them. Topics selected as most important to first-year residents were critical either for provision of basic patient care or for acquisition of advanced skills, whereas subjects chosen for the final year of training were most important to the physician preparing to enter practice. The targeted subjects were then reviewed with other residency programs at our institution to determine overlapping curricular needs and resources. The departments of neurology, anesthesiology, surgery, psychiatry and physical medicine and rehabilitation subsequently participated.

"Central to the entire educational program were the principles of providing a distraction-free environment and fostering interactive learning in small groups. Therefore, each phase was run over continuous days when residents could be relieved of all other duties."

Curriculum Generation and Scheduling. Faculty with teaching expertise in the selected educational areas were identified through resident evaluations and invited to participate in the program. Collaborating with these faculty we created a three-phase program of educational modules that utilized a variety of teaching methods and was targeted to residents at each stage of training *(Figure 1)*. Central to the entire educational program were the principles of providing a distraction-free environment and fostering interactive learning in small groups. Therefore, each phase was run over continuous days when residents could be relieved of all other duties. Coordination of annual rotation scheduling with Core Skills Program planning assured minimal disruption of clinical services and required resident experiences. Each phase was run at least 3 times to allow scheduling of only 12–15 learners per session.

Evaluation. Participating residents completed pre- and post-intervention skills self-assessments for all learning objectives in the program. Residents also completed pre- and post-intervention multiple-choice examinations, objective structured clinical examinations (OSCEs) and simulator testing. Additionally, program faculty and residents completed satisfaction surveys asking them to compare this educational program to others they had experienced.

Outcomes

Greater Faculty and Learner Satisfaction. Data from faculty and resident surveys has indicated a very high level of satisfaction with the program. Nearly all faculty (92%) and residents (89%) rated the program as more effective than other programs with a similar focus they had previously encountered. Faculty commented on learners being much more engaged and felt their time as a teacher was much better utilized in this forum. Likewise, residents reported greater satisfaction with learning in the small group environment with educational objectives targeted to their level of need. Retrospective surveys performed one year following each phase showed sustained satisfaction and recognition that the program provided a strong foundation of core skills and knowledge that facilitated more advanced learning in other rotations.

Improved Performance on Objective Testing. Results of resident skills self-assessments showed a consistent increase across all curricular areas and ACGME general competencies following participation in the Core Skills Program. Resident performance on multiple-choice examinations and simulator testing was similarly improved following completion of the program. Although only used for the last 2 years, OSCEs have also demonstrated the program's effectiveness in delivering skill in interpersonal communication and professionalism to residents.

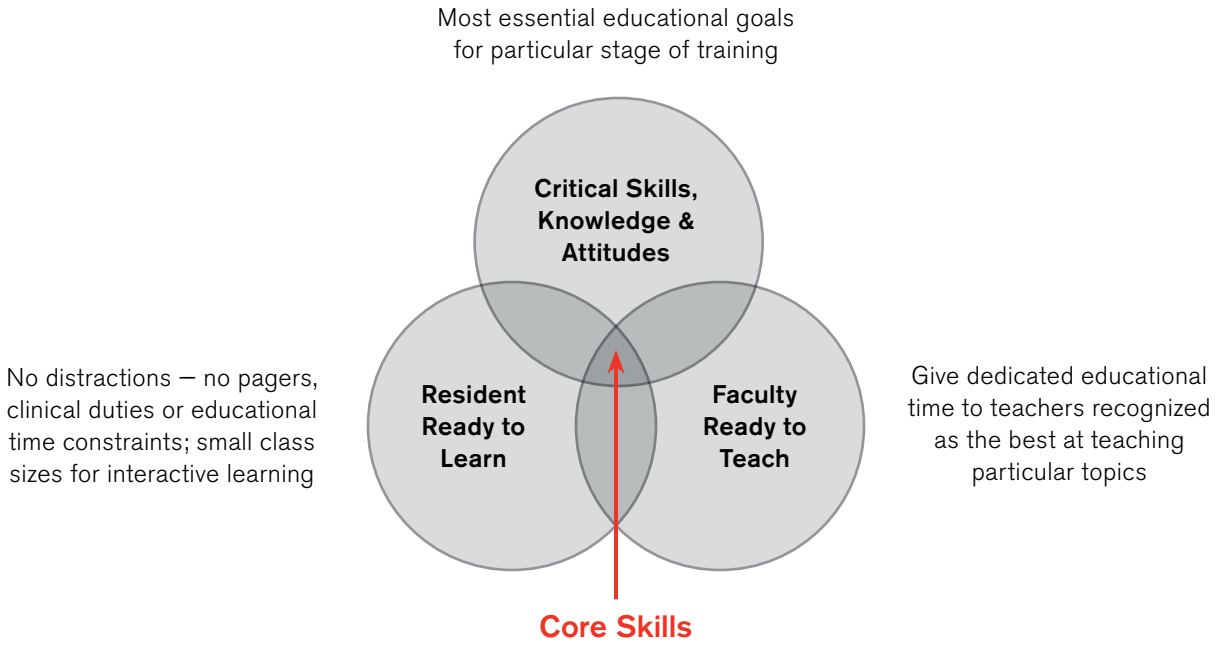
Provision of a Home for "Orphan Curricula." Initial needs assessment identified several curricular areas that were covered insufficiently and were incorporated into the program. Areas such as goal setting discussions, teaching skills and career planning are extremely important but belong to no particular rotation or department and require more time and smaller groups than provided by conferences or other venues. Within the Core Skills Program, these core curricula found a home where they received the time and emphasis to guarantee exposure to all residents.

Opportunity for Faculty Development. The program also provided a unique opportunity for faculty interested in developing new curricula or utilizing innovative teaching methods. With an optimized learning environment free of distractions and with residents of a set experience level for each session, faculty were better enabled to target teaching to their learners' needs. They also were able to use the program's built-in robust evaluation system to determine the efficacy of their techniques. Several faculty have subsequently presented the outcomes of their Core Skills Program modules at national meetings.

Figure 1
The Medical College of Wisconsin Core Skills Program

Phase I **PGY-1 Residents** **Early Fall** (repeated 4 times yearly — each time over a continuous 5-day period)	**Phase II** **PGY-2 Residents** **Late Fall/Early Winter** (repeated 3 times yearly — each time over a continuous 3-day period)	**Phase III** **PGY-3 Residents** **Spring** (repeated 3 times yearly — each time over a continuous 5-day period)
Common Cardiovascular Diseases	Basics of Biostatics	Board Preparation — High-Yield Review
Common Pulmonary Diseases	VTE and Anticoagulation Management	Medical Ethics
Common Gastrointestinal Diseases	Sleep Medicine	Planning for Practice/Fellowship
Common Neurologic Diseases	Cultural Aspects of Patient Care	Disability Evaluations
Common Hematologic Diseases	Residents as Teachers II	Prognostication
Common Renal Diseases	Research Methods	Spirituality in Medicine
Inpatient Diabetes Mellitus Management	Understanding Medicare/Medicaid	Risk Management in Private Practice
Arterial Blood Gas Analysis	Medical Billing	Overview of Civic Legal System
ECG Interpretation	Home Care Utilization	Caring for the "Difficult" Patient
Appropriate Antibiotic and Culture Utilization	Disclosure of Unintended Outcomes	
PFT Interpretation	Goal Setting Discussions	
Chest Radiography Interpretation	Medical Record Documentation	
Abdominal Radiography Interpretation	Physician Contracts	
Nutritional Supplementation	Physician Reimbursement	
Pain Management		
Breaking Bad News		
Interpersonal Dynamics		
Career Planning		
Giving & Receiving Constructive Criticism		
Residents as Teachers		
Introduction to Evidence-Based Medicine		
Risk Management: Informed Consent		

Table 2
Alignment of Educational Parameters Within the Core Skills Program



Conclusions

The Medical College of Wisconsin's Core Skills Program has been an integral part of our residency training program for over 4 years. The key to its success has been achievement of the alignment of ready learner, optimized learning environment and expert faculty *(Figure 2)*. Returning to the classroom to teach clinical skills and knowledge may seem contradictory to the focus on patient-centered care described in ACGME program requirements and other position papers. However, the program actually facilitates patient-centered education by assuring residents have the core skills they will require for advanced learning in the setting of clinical care. The program stands as an example of one of many new tools that will be needed in GME to efficiently train residents in an era of reduced resident hours and increasing clinical complexity. ■

Kurt Pfeifer, MD and Susan Davids, MD, MPH are Associate Professors of Medicine and Associate Program Directors for the Internal Medicine Residency at the Medical College of Wisconsin. Michael Frank, MD is a Professor of Medicine, Program Director for the Internal Medicine Residency Program and Vice-Chair of Educational Affairs for the Department of Medicine at the Medical College of Wisconsin.

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Teaching Emotional Intelligence Skills Can Help Physicians Become Better Communicators, Improve Systems-based Practice

Julie Jacob

Emotional intelligence is a key factor in a person's career success, according to the book *Social Intelligence* by Daniel Goldman and physicians are no exception.

Teaching emotional intelligence is an important part of teaching the core competencies in residencies, especially the core competencies of interpersonal skills and communication and systems-based practice, said Bryan Martin, DO, professor of medicine at The Ohio State University and chair of the RRC for Allergy and Immunology. Dr. Martin presented a session, "Emotional Intelligence (EQ) and Graduate Medical Education: How Does EQ fit into the Paradigm of the Competencies," at the 2009 ACGME Annual Educational Conference, held March 5–8 at the Gaylord Texan Resort Hotel and Conference Center in Grapevine, TX.

Emotional intelligence has 4 components, he said: self-awareness, self-management, social awareness and social management.

Self-awareness is the ability to know one's own strengths and limitations. People who are self-aware welcome constructive criticism and feedback, he said. People are who self-aware can self-manage, he noted, which is "the ability to understand one's emotions and recognize how emotions affect performance."

A physician who is self-aware will know how to compose himself or herself before breaking bad news to a patient. "It is the ability to understand one's emotions and recognize how emotions affect performance," said Dr. Martin.

Social awareness is another piece of emotional intelligence. Dr. Martin described it as the ability to empathize with other people and see things from their perspective. People who are skilled at social management understand the culture and unspoken rules of an institution and can function harmoniously in that environment.

Emotional intelligence can be taught in several ways, said Dr. Martin, including modeling, simulation and discussion. For example, he explained, residents can look at photos of a physician breaking bad news to a patient or a surgical team interacting in the operating room and discuss what may be happening in that photo based on the people's expressions and body language.

"Residents can look at that frozen moment in time and discuss it," he said. The reflection component of the ACGME Learning Portfolio is another important tool to help residents boost their emotional intelligence. "The reflective part of the portfolio forces residents to put (down) what they are thinking. It is a self-awareness and potentially self-management, exercise." ■

Fifty Posters Featured at 2009 Marvin R. Dunn Poster Session

Fifty posters by members of the GME community were showcased at the ACGME's 2009 Marvin R. Dunn Poster Session, which took place during the ACGME March Annual Educational Conference in Grapevine, TX. The posters focused on projects that enriched the teaching and assessment of the general competencies; sought innovative ways to reduce resident hours; enhanced transitions of care; used assessment to improve programs; and changed the learning environment or redesigned education and patient care.

Of the 50 posters accepted, ACGME judges chose 10 for oral presentations during the conference, based on the quality of the abstracts. Abstracts selected included the Oregon Health and Science University's resident-driven initiative to improve patient safety and reduce errors.[1] It linked a portion of a resident retirement benefit to achievement of goals mutually agreed on by hospital administration and the residents. For 2008–2009, the goal encompassed increasing resident reports of safety incidents by 5%. This resulted in an increase in the number of incident reports by residents from 4 reports to 16 reports per month following implementation of the reporting goal. A presentation by the Medical College of Wisconsin's Urology Department discussed efforts to achieve balanced resident education under duty hour limits.[2] The program collected data on resident hours devoted to various elements of the educational program. This found that over the 4 years of urology training 4,384 resident hours were spent on performing operative procedures, 1,924 were spent in ambulatory clinics and 320 in the intensive care unit. Attaining the national average of operative procedures placed the greatest demand to resident time. The study also provided insight into the program's duty hour compliance and balance between clinical experience and didactic learning.

A presentation by the Obstetrics and Gynecology residency at Resurrection Health Care/St. Joseph Hospital, Chicago, described the implementation of a critical path analysis for medication administration.[3] The initiative focused on identifying errors in prescribing, transcribing, preparing and administering medications to patients and addressed one of the Joint Commission's National Patient Safety Goals. Solutions included use of order sets for specific situations, such as induction of labor, delivering orders through the institution's tube system, avoiding phone calls and use of order stickers for stat antibiotic orders. A fourth presentation summarized the results of a study at 3 Army teaching hospitals that compared use of a task trainer to lectures for teaching ultra-sound guided central line placement to first-year residents.[4] Hands-on experience with the task trainer resulted in increased confidence and technical proficiency, producing a statistically significant improvement in overall score. Use of a lecture-based format also produced improvement, but the difference was not statistically significant over performance at baseline.

A study from Summa Health System in Akron assesses quality of care for 131 diabetic patients in an ambulatory internal medicine clinic, focusing on glycemic control and the use of quality indicators.[5] Two interventions were studied – diabetes planned visits and algorithms for medication intensification, with A1c levels as the primary outcome measure. The results showed significant improvement in A1c for patients who received 4 or more evidenced-based services compared with patients who received fewer than 4. Medication intensification resulted in a significant improvement in A1c, yet only 69% of patients who would have benefitted received intensification, with absence of timely laboratory results identified as the common barrier.

A second poster from the same institution reported on a change that reduced maximum shift length to 16 hours and used forward rotation for changes from day to night schedules, consistent with the literature on sleep and performance.[6] Residents worked an average of 56 hours per week and no resident averaged more than 80 hours per week. Self-reports for 5,755 resident duty shifts over a 4-month period showed that 2,762 shifts (47%) were longer than 12 hours and 244 shifts (4%) lasted 16 hours or more. Separate electronic tracking of shift length showed that 61.7% of scheduled 16 hour shifts resulted in residents being on duty longer than 16 hours and that an average shift length of 17:08 hours compared with a self-reported average of 16:30 hours. The findings affirmed the feasibility and sustainability of shorter shifts in an internal medicine teaching setting. Another study of the use of short shifts in the Pediatrics residency at UMDNJ–New Jersey Medical School replaced 24-hour call with a maximum shift length of 14 hours.[7] Average duty hours after the intervention totaled 66 hours per week for first-year residents, 63 hours per week for second-year residents and 60 hours per week for third-year residents. No-call rotations and a monthly weekend without service were maintained for all residents. The first-attempt pass rate for program graduates increased from 36% for the 3 years prior to the scheduling change to 61% for the 3 years since implementation and indicators for patient care quality showed no change.

"The findings affirmed the feasability and sustainability of shorter shifts in an internal medicine teaching setting."

Two presentations from Lankenau Hospital, Pennsylvania, discussed use of standardized testing in assessing competence in medical knowledge and patient care,[8] and the value of an audience response system in identifying poorly designed questions advancing medical knowledge, particularly during the first year of fellowship.[9] Learner feedback for the audience response system's effectiveness in facilitating learning was overwhelmingly positive. A study of the workflow for Otolaryngology residents at the Baylor College of Medicine used time and motion study to identify potential areas for improvement in efficiency.[10] Classification of activities showed residents spent 58% of their time on patient care, 13% on teaching and learning, 17% on activities marginally useful to meeting learning and patient care objectives and 12% on other tasks. Residents devoted more time to marginal tasks on clinic days (19%), with administrative activities a major contributor, consuming 4% of resident time.

The 2010 Marvin R. Dunn Poster Session will be held in conjunction with the 2010 ACGME Annual Educational Conference, scheduled for March 7–10 at the Gaylord Opryland Resort Hotel and Convention Center in Nashville, TN. A call for abstracts will be posted on the ACGME website in the coming months. ■

Presentations at the 2009 ACGME Educational Conference, Grapevine, TX:

[1] English C, Shaker L, Ward W, Scott D, Girard, Magnusson AR. A resident-driven quality improvement initiative to reduce errors and improve patient safety. Oregon Health and Sciences University.

[2] Mulligan M, Langenstroer P. Balanced surgical residency education. Studying clinic/surgical/educational duty hour balance. Medical College of Wisconsin.

[3] Tam T, Ipema N. Implementation of medication critical path analysis in obstetrics and gynecology. Resurrection Health Care/St. Joseph Hospital.

[4] Patel AA, Pavel CR, Thompson JC, Niven A, Wink J, Sim J, Calvano D. Is hands-on training with a task-trainer better than a lecture-based curriculum for improving the confidence and technical proficiency of interns learning ultrasound-guided central venous line placement? Brooke Army Medical Center, Madigan Army Medical Center and William Beaumont Army Medical Center.

[5] Torregosa H, Salem J, Clough L, Sweet D, Johnson R. Metabolic control: Finding the weakest link. Summa Health System/NEOUCOM.

[6] Sweet D, Clough L, Johnson R. Working smarter not longer – Report of a two-year experience of an internal medicine residency with creating scheduling limiting call to a maximum of 16 hours. Summa Health System, Akron.

[7] Mautone SG.Toward a new paradigm in graduate medical education: Elimination of the 24-hour call. UMDNJ-New Jersey Medical School, Department of Pediatrics.

[8] Burke JF, Gnall EM, Abramson SV, Shapiro TA, Schick PK. Use of standardized testing to objectively assess attainment of competency in medical knowledge and patient care. Lankenau Hospital and Drexel University College of Medicine, Philadelphia.

[9] Burke JF, Gnall EM, Fine S, Schick PK. Value of audience response systems in our fellowship training program and assessing medical knowledge competency. Lankenau Hospital and Drexel University College of Medicine, Philadelphia.

[10] Victores A, Roberts J, Alford B, Takashima M. Otolaryngology resident workflow. A time-motion study. Baylor College of Medicine Department of Otolaryngology and Head and Neck Surgery, Houston, TX.

ACGME/RRC Update

ACGME updates Institutional Requirements and Program Requirements in selected specialties

At its February 2009 meeting, the ACGME approved focused and minor revisions to the Program Requirements for Diagnostic Radiology, effective July 1, 2020. The Council also approved minor revisions to the Program Requirements for Allergy and Immunology, with these changes becoming effective April 7, 2009.

At the June 2009 meeting, the ACGME Board of Directors approved focused revisions to the Program Requirements for Ophthalmology and minor revisions to the Institutional Requirements. Both revisions became effective July 1, 2009.

"Focused revisions" of existing program requirements are relatively new and are used when a proposed requirement change is not minor, but is limited to a particular area and the requirements are not yet due for their mandatory 5-year review. Like other revisions, focused revisions are sent for review to the ACGME's stakeholder community. Unlike major revisions, the request for review and comment is limited to the specific area in which the "focused" change is being proposed.

"'Focused revisions' of existing program requirements are relatively new and are used when a proposed requirement change is not minor, but is limited to a particular area and the requirements are not yet due for their mandatory 5-year review."

ACGME approves 2 new directors

At its June 2009 meeting, the ACGME Board of Directors approved 2 new members. The first is Christopher C. Colenda, III, MD, who was nominated by the AAMC. Dr. Colenda is the Jean and Thomas McMullin Dean of the College of Medicine of Texas A&M Health Science Center. The second new ACGME director is Mr. Peter Rapp, the Vice President and Executive Director of Oregon Health & Science University, Portland, OR. Mr. Rapp was nominated by the American Hospital Association.

Internal Medicine group completes work on Internal Medicine Milestones, invites public comment

In May 2009, a 33-member task force (the Internal Medicine Milestone Group) convened by the ACGME and American Board of Internal Medicine completed its work to develop milestones for resident attainment of the 6 general competencies. The draft milestones that resulted from this effort provide specific behavioral descriptions for each of the ACGME's general competencies within a developmental framework. They will be incorporated into residency programs' framework for resident evaluation. It is envisioned that aggregate information on milestone attainment will be used as one data element in the accreditation process of the future.

The Internal Medicine Milestone Group invites residency program faculty, coordinators, medical team members and other stakeholders to comment on the draft milestones. To view a copy of the milestones and to provide your comments on the survey provided, visit the ACGME's web page or the summary on the ABIM web site (http://www.abim.org/milestones/public/). The site includes a link to the stakeholder survey about the internal medicine milestones.

Meet the newest members of the ACGME field staff

Over the past year, the ACGME hired and oriented 3 new accreditation field representatives. All have completed their extensive orientation and are now conducting independent program and institutional reviews. The 3 new members of the ACGME field staff come with extensive background and experience in graduate medical education, which will benefit the accreditation process and the programs they review.

Marguerite Hawkins, MD, MS is board certified in General Preventive Medicine and Public Health. She graduated from Eastern Virginia Medical School, Norfolk, VA and completed an internship in Obstetrics and Gynecology at the National Naval Medical Center in Bethesda. She completed residency training in General Preventive Medicine and Public Health at the University of Maryland School of Medicine. In 2005, she became the Assistant Director for the Office of Environmental Health Coordination and the Program Director for the Maryland Department of Health and Mental Hygiene's Public Health/General Preventive Medicine residency. Dr. Hawkins has been involved in professional societies, including the Board of Directors for the Association of Teachers of Preventive Medicine and as a question author for the USMLE and American Board of Preventive Medicine Examinations. She joined the ACGME as a site visitor in June of 2008.

John R. Kirkpatrick, MD is a board certified surgeon. He attended the University of Tennessee College of Medicine and completed his residency in surgery at the University of Kansas. His most recent appointment was at the Washington Hospital Center, Washington, where he was a Senior Consultant in Surgery and the Harold H. Hawfield Chair of Surgery. Prior to this, he held academic appointments at Georgetown University School of Medicine, the George Washington University, Uniformed Services University of the Health Sciences in Maryland and Wayne State University, MI. Dr. Kirkpatrick is a Fellow of the American College of Surgeons and has won numerous teaching awards and research awards from the Southwestern Pennsylvania Chapter of the American College of Surgeons. He joined the ACGME in November 2008.

Serge Martinez, MD, JD is a board certified Otolaryngologist. He attended University of Miami School of Medicine and completed his residency in Otolaryngology at National Naval Medical Center in Bethesda, MD. In 2001, Dr. Martinez received his Juris Doctorate from Western New England School of Law. He served as a Professor of Surgery and Bioethics at the University of Louisville School of Medicine and as a member of the American Academy of Otolaryngology–Head and Neck Surgery Ethics and Academy Program Advisory Committees. Prior academic positions included Associate Professor of Otolaryngology at Creighton University School of Medicine and Director of Medical/Surgical Services at Boys Town Institute for Communication Disorders in Children, the Division of Otolaryngology at the University of Louisville and Kaiser Permanente's Northeast region. Dr. Martinez is a member of the Health Law Section of the American Bar Association. He joined the ACGME in January 2009.

In Brief

United Kingdom will institute 48-hour weekly limit August 1, 2009

On August 1, 2009, the European Working Time Directive (EWTD) will result in a reduction of junior doctors' hours in the United Kingdom to 48 per week. Reports over the past month have suggested that a sizable share of UK hospitals will have problems meeting this new limit. Data collected in September 2008 indicated 1 in 3 junior doctors worked in excess of 48 hours per week, despite ongoing efforts to develop call schedules that were in compliance with the EWTD.

"Recent comments from several constituencies have suggested that the number of training hours may have decreased to an extent where it has negative effect on junior doctors' education…"

The debate in the United Kingdom highlights widespread concerns about the impact of the full implementation of the European Working Time Directive on physicians in training, particularly in a group of specialties termed "craft" specialties, which emphasize learning by direct experience with patients. This includes procedural specialties as well as Anesthesiology, Obstetrics and Gynecology, Cardiology and Interventional Radiology.[1] Recent comments from several constituencies have suggested that the number of training hours may have decreased to an extent where it has a negative effect on junior doctors' education, with concerns that physicians completing their training now have less experience, less confidence and fewer skills than earlier cohorts.[2]

A number of proposals have been made to reduce the perceived negative effect of the EWTD requirements on junior doctors. The Royal College of Surgeons has publicly stated that the restrictions may produce a generation of surgeons who have not had enough time to gain the skills of their predecessors. In early summer, the debate focused on plans by the UK Department of Health that would allow certain specialties to continue with a 52-hour weekly limit for an unspecified period. A representative from the Association of Surgeons in Training indicated that these interventions may not work and that the only solution would be to exempt surgeons from the EWTD.

[1]BMA Junior Doctors Committee. Maintaining the Quality of Training in the Craft Specialties. April 23, 2009. London, UK: British Medical Association.

[2]Devlin, K. 100 days to save surgeons' training, leaders warn. Telegraph UK, April 20, 2009.

2009 ACGME Design Conference to focus on graduate medical education and patient and family centered care

The Accreditation Council for Graduate Medical Education is still accepting registrations for its design conference entitled *Training Tomorrow's Doctors: Graduate Medical Education and Patient and Family Centered Care Design Conference*. The conference will be held September 25–26 at The Intercontinental Hotel in Rosemont, IL (near O'Hare Airport).

Since 2007, an ACGME Patient and Family Centered Care Advisory Group has explored the impact of patient and family centered care (PFCC) clinical settings on graduate medical education. The conference will feature a group of highly distinguished and influential leaders in graduate medical education and patient and family centered care. Through presentations and design sessions, these GME and PFCC leaders will share their experiences combining graduate medical education with patient and family centered care environments. The conference will offer program directors, designated institutional officials, faculty and other interested persons the opportunity to meet and work with GME and PFCC experts.

Registration information is available from the ACGME web site at: http://www.acgme.org/acWebsite/meetings/me_learnEnviron09.asp ■

What Do Patients Want from Their Caregiver? An Interview with Mark Hines

Ingrid Philibert, PhD, MBA

During a meeting of the ACGME Patient and Family Centered Care Advisory Group in 2008, Mr. Mark Hines provided a summary of one patient's expectations for patient- and family-centered care, informed by his personal experience and his work as a patient advisor at the Medical College of Georgia.

What do patients want from their caregiver?

They want their caregivers to show concern about their condition and welfare. This can be shown in many ways. The most basic expectation is that caregivers take time and explain to the patient what they are doing, even something routine like changing a dressing.

For a patient with a disability, concern means asking about his or her abilities, giving care instructions and asking whether the patient can carry them out and what kind of help he or she will need. This involves patients in the care and while it seems like it would take added time, it may make care more efficient by avoiding back and forth between the patient, the doctor and other team members.

Patients feel more involved in their care when caregivers answer questions and clarify who will handle what issue. This is especially important when their illness or the care they receive is complex and involves multiple caregivers and consultants. Patients want follow-up on tests, an explanation of the results and the reasons when something is delayed. Another way to make care more patient-centered is to anticipate patients' needs. This may mean a social worker meeting with them before discharge and assisting them in getting their needs met once outside the hospital.

If a hospital or a residency program wants to implement a patient- and family-centered approach to care where should it start?

If the effort is institution-wide, it is important to involve hospital administration, the medical director and the formal education infrastructure. However, an institutional effort is not always needed. Patient care can be made more family-centered by very simple interventions, such as attending physicians modeling these behaviors.

Most teaching settings will want a more formal plan so everyone is on the same page and understands what patient- and family-centered care is all about. Formal instruction could start during the 3rd and 4th year of medical school, with patient advisors giving an overview of patient- and family-centered care. Lectures for faculty, who may not have had instruction in this area, is an important component in teaching settings.

Are there easy ways to make teaching units more patient- and family-centered?

Educating teachers and residents is important, but it is not necessary to push a new patient- and family-centered model through the entire hospital. Patient- and family-centered rounds in the inpatient setting are a useful approach that is relatively easy to implement. The rounds use a team approach, with the attending physician, residents, nurses, social worker and patient and family members whenever possible.

During morning rounds, the team may give the patient a sense of what to expect that day, including what tests, appointments or care tasks will be done. The goal is to include the patient in discussions and in the care process. At minimum, caregivers would explain their approach, what they are doing and how these activities are important in advancing care. This helps patients with what to expect and makes them more comfortable while in the hospital.

"Patients feel more involved in their care when caregivers answer questions and clarify who will handle what issue."

What are the challenges in making care patient-centered in teaching settings?

Some of the challenges relate to how busy residents are. This may contribute to their thinking that there is enough time for patients to ask questions and be partner with them in their care. Residents may need to learn that it is possible to have effective teaching in front of the patient, without physicians discussing the care with the patient present, but without explaining their approach or involving the patient and the family.

Another challenge is providing feedback to residents on their patient-centeredness. Feedback should come from the medical team, nurses, but also from patients and families. It may be difficult for residents to accept patients' feedback, but residents can benefit from constructive criticism if they didn't make the patient feel they were part of the care process in a collaborative, patient-centered way.

Feedback to residents and other caregivers is both "educational" and helps to continuously improve the team's ability to provide patient- and family-centered care. This could be done in a scheduled meeting for the residents, other caregivers and one or more patient advisors, in which residents describe their experiences and give examples of trying to be patient- and family-centered in their care and the advisors offer feedback. ■