ACGME BULLETIN July 1999

Accreditation Council for Graduate Medical Education

Executive Director's Column:

David C. Leach, M.D.

This column is based on several ACGME field staff visits that Dr. Leach participated in over the past months. It is the first of several articles discussing the ACGME accreditation site visit.

The principal function of the ACGME accreditation site visit is 'to clarify, to verify and to report. Every year, approximately 1,500 new program directors step to the plate, each with his or her own thoughts about what goes on during the visit. Seasoned program directors also have differing views and expectations. What actually happens during an ACGME site visit? I had experienced several site visits in my former life as a program director. Over the past months I attended three site visits as an observer, with the goal of getting a better understanding of the process. I have come away with added respect for program directors and the field representatives of the ACGME.

Most program directors have some understanding of the GME accreditation process. They know that the Residency Review Committees (RRCs) and, for the institutional review, the Institutional Review Committee (IRC), decide on the program's or institutions compliance with the ACGME's standards - peer review being central to the ACGME's accreditation function - but how do these committees make their decisions? Program Information Forms (PIFs), questions linked to Program Requirements, in some cases anonymous survey data from residents, and the field representative's report comprise the information used by the RRCs and the IRC. The site visit reports are between 15 and 30 pages long and clarify and verify the data in the PIF and other pertinent information, such as surgical case logs.

Time past and time future
What might have been and what has been
Point to one end, which is always present.
- T.S. Eliot, "Burnt Norton"

A natural question from a new program director might be: "How is this site visit report generated and what can I do to display my program in the best light?"

My response begins with "time past." Except new programs, the site visit process begins with a review of past citations - the areas where the program or sponsoring institution did not meet the standards at the previous review, with a common opening question being, "What have you done about...?" On the visits I attended these conversations lasted more than an hour - a long time for the program that is not prepared and an excellent opportunity to showcase improvements in a program that is. Good answers are to the point, focused, and accompanied by evidence that the issue has been corrected. Members of the field staff, who visit three programs a week, are savvy, have heard and seen a wide range of problems and solutions, and have an uncanny ability to ask probing questions.

The next component of the visit, still with the program director, reviews the PIF and other relevant sources of data, depending on the discipline. This process clarifies the

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information in the PIF and should go smoothly. After all, the program director has filled out the PIF and has a fair amount of control over the answers.This begins the verification process - checking for the formative and summative evaluations of the residents, residents' evaluation of the faculty, goals and objectives, curricula, patient volume and variety, affiliation agreements, and other required components of an accredited program.

The next set of interviews is with customers of the educational program - the residents - and frequently provides the richest interviews of the day. Residents interviewed are peer-selected representatives or the entire cohort for each level of training, depending on the size of the program. The field representative may ask what instructions were provided about the interview. During these interviews, unorganized, conflicting data may spill out, yet over the course of an hour convincing patterns emerge. The observer's perception is one of being close to the "reality of education" rather than to a mental model. In this session, issues mentioned have to reach consensus level before they are reported by the field representative as a statement of fact. In the absence of consensus, they are reported as the statements of a single resident or a minority of the residents. Confidentiality is the rule, although the residents are informed that if an adverse action or unfavorable decision, in the case of an institutional review, results, the site visit report may be shared with the program director. However, in no case are individual residents identified. In the programs I attended, the residents clearly were positive about their experiences. Other reports I have reviewed have documented marked disparity between the program director's and the resident's view. I suspect it is the single most common reason that an adverse action comes as a surprise to the program director. Once a program director asked me, "Why do you always believe the residents instead of me?" This occurred in a program with a pass rate on the board exam of less than 50 percent. The answer is, "Sometimes we believe them because nobody else does."

"...in the resident interviews, issues mentioned have to reach consensus level before they are reported as a statement of fact."

The data obtained from the program director and resident interviews are supplemented in the meetings the field representative has with the faculty and, in many cases, administration. They are important and add value, but appear quite orderly compared to the session with the residents. Sometimes this is followed by a tour of the facilities.

"An elaborate mechanism of appointment to the RRC identify the peers of the program director who make the judgement on a given program's compliance with published standards."

In most instances, the visit concludes with an meeting between the program director and the field representative. This 'debriefing' or 'exit' interview can be frustrating for program directors, especially if they have expectations that cannot be met. It must be remembered that the site surveyor does not make the accreditation decision. That is reserved for the RRC. An elaborate mechanism of appointment to the RRC identify the peers of the program director who then make the judgement on a given program's compliance with published standards. The site visit is but one step in this larger process, and virtually nothing definitive about outcome of the program's review can be said at the end of the day.

However, the members of the ACGME field staff are experts in their own right. Their view of GME programs is comprehensive and unique. Three days a week and, for full-time field staff, 46 weeks a year, they are in the field site visiting programs. They have seen programs in every discipline, in every setting, ranging from the best to the marginal and the worst. On occasion, a suggestion for an improvement to the program may be made in the context of this interview, but it is important to note that this is not the primary role of the field representative. It can be done in a credible and defensible fashion only when a suggestion comes to mind that could benefit the program and the individual surveyor is comfortable with making the suggestion. In addition, the field representatives are cognizant of the fact that making suggestions must not conflict with their primary role of clarifying and verifying the information provided by the program and allowing the RRC to make the judgement. At the same time, every 'exit' interview presents an opportunity to make sure that the primary objective of the site visit - the clarification and verification processes - have been accomplished, and that ambiguities or unresolved questions in the mind of the site visitor have been addressed and, if at all possible, resolved. Program directors can do this by summarizing their view of "what might have been and what has been."

To be continued........

Outcome Project Spotlight

ACGME Solicits Evaluations Methods Pilot Projects

Susan Swing, Ph.D.

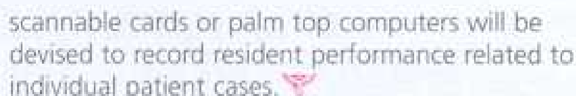
The ACGME is planning projects to develop and evaluate tools and methods for resident and residency program evaluation. This is part of our educational outcome assessment project which aims to ensure that sound information is available about residency program educational effectiveness.

We are seeking residency programs to participate as pilot project test sites. Benefits of participation will be a new assessment tool to add to your evaluation system (assuming the new tool passes the test) and summary reports prepared by the ACGME, including comparative data compiled from other pilot project participants.

To express interest in participating in a particular project or to receive updates about project development, send an email to outcomes@acgme.org and enter "pilot projects" on the subject line. In the body of the message include your specialty, title, and institution and a brief message expressing your interest.

Projects currently under consideration or in early development stages are described below.

1. Communication skills evaluation. This project will involve patients, nurses, medical students or others in a quick check-off on a 'scannable' card of observed communication skills following each of several resident-patient encounters.
2. Patient care process and outcome evaluation. This project will involve the collection and bench-marking of process and outcome data for carefully selected types of cases seen by residents.
3. Rating and tracking forms based on detailed educational objectives. Forms consisting of detailed rotation-specific objectives will be developed and evaluated for their usefulness and value in resident experience tracking; resident performance evaluation (self and others); and rotation evaluation.
4. Graduate questionnaires. A graduate questionnaire will be developed and evaluated for its usefulness in identifying areas (e.g., conditions, procedures, practice skills) where preparation during residency was inadequate, appropriate, or overemphasized given its importance for practice.
5. Methods for recording the results of chart audits and/or case discussions. A simple method utilizing scannable cards or palm top computers will be devised to record resident performance related to individual patient cases.

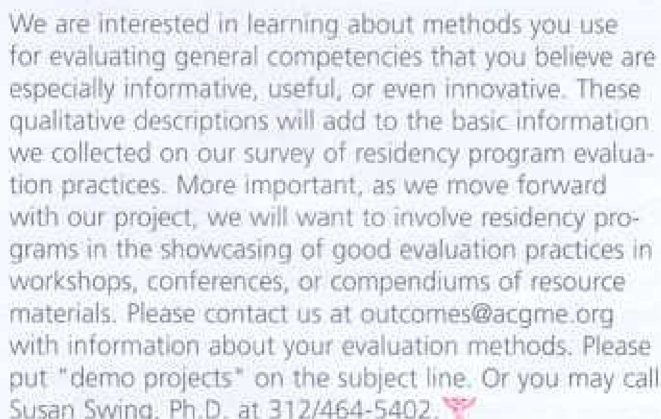


Evaluation Demonstration Projects for General Competencies

Susan Swing, Ph.D.

In February 1999, the ACGME endorsed general competencies in the areas of patient care, medical knowledge (formerly clinical science), interpersonal and communication skills, professionalism, practice-based learning and improvement, professionalism, and systems -based practice. The Residency Review Committees (RRCs) and Institutional Review Committee (IRC) will be including the competencies in their requirements during the next few years. (The current draft of the general competencies is on the ACGME World Wide Web site at http://www.acgme.org.)

"We are interested in learning about methods you use for evaluating general competencies that you believe are especially informative, useful, or even innovative."



We are interested in learning about methods you use for evaluating general competencies that you believe are especially informative, useful, or even innovative. These qualitative descriptions will add to the basic information we collected on our survey of residency program evaluation practices. More important, as we move forward with our project, we will want to involve residency programs in the showcasing of good evaluation practices in workshops, conferences, or compendiums of resource materials. Please contact us at outcomes@acgme.org with information about your evaluation methods. Please put "demo projects" on the subject line. Or you may call Susan Swing, Ph.D. at 312/464-5402.

Abrupt Closures of Residency Education Programs – What Is At Stake?

Ingrid Philibert

On Thursday, March 18, the city of Cleveland, the staff of Mt. Sinai Medical Center of Cleveland, and a group of residents and newly matched senior medical students

learned that the company that owned Mt. Sinai Medical Center of Cleveland and three other hospitals had filed for bankruptcy the previous day. Mt. Sinai Medical Center's graduate medical education programs would cease to exist after June 30, 1999. About a month later, in mid-April, residents and medical students newly accepted into Manhattan Eye Ear and Throat Hospital's programs found out that their 130-year-old institution would be sold and the residency programs would close with a little more than two months of notice.

In both cases, finances appeared to have gotten the better of resident education. The company that owns Mt. Sinai of Cleveland, Primary Health Systems Inc., an investor-owned firm, had been plagued by persistent financial problems and took advantage of the protection afforded by bankruptcy to reorganize as a not-for-profit system with less debt. The fact that teaching hospitals have higher costs meant that the new system would not operate graduate medical education (GME) programs. In an interview in April with the Cleveland "Plain Dealer," the principal of the consulting firm that managed Mount Sinai and its three sister hospitals described the bankruptcy as "a turnaround strategy," which would afford the institutions protection from creditors. Simultaneously, elimination of the teaching programs would reduce costs. Similarly, Manhattan Eye Ear and Throat Hospital appeared to have determined that, given a lack of admissions in its areas of expertise, virtually any form of enterprise would be more viable from a financial perspective than the operation of a teaching hospital. While it now appears that Manhattan Eye and Ear, initially slated for closure and conversion to another purpose, will remain open as a health care institution, the teaching programs have been disbanded.

What happens when hospitals abandon their education programs and the residents in these programs on short notice? As the cases of Mount Sinai and Manhattan Eye and Ear demonstrated recently, it leaves residents scrambling to find another hospital at which to complete their education. These residents entered GME programs expecting to complete their training, given satisfactory academic progress. However, both institutions offered virtually no advance warning of their plans, in violation of the ACGME requirements that call for notifying residents in advance of program downsizing or closure. The ACGME requirements also stipulate that, whenever possible, residents in the program should be allowed to complete their education before it is phased out, and that where this is not possible, the institution needs to assist the resident in finding another program.

Neither Mount Sinai nor Manhattan Eye and Ear complied with the ACGME requirements for programs that are downsizing or closing, most notably that current residents be given the opportunity to complete their education. From the perspective of the residents, this requirement is by far the most critical. Every abrupt closure, even when placement in another program is successfully completed, results in change - at minimum a change in program, faculty, and colleagues, and a sense of loss: "Why did my program close?" In many instances, acceptance into a new program will result in dollar, time and opportunity costs associated with relocating. In addition to the resident, this frequently involves a spouse, who may have a career and may be disadvantaged by needing to relocate with little note, as well as children who have to change child care arrangements, schools and peer groups. When financial factors force a teaching institution to close, GME programs also have to be disbanded. At the same time, changes in ownership and other external factors recently have resulted in a 'change of mission' at some institutions that will continue to operate as hospitals, but that appear to have forgotten their commitment to education and their residents.

Every abrupt closure, even when placement in another program is successfully completed, results in change – at minimum a change in program, faculty, and colleagues, and a sense of loss: "Why did my program close?' "

It is likely that, given the current financial picture, a number of teaching hospitals are contemplating downsizing of their GME enterprise. Some number of teaching institutions will also change ownership or will merge in the coming years, and in this context will reexamine their commitment to education and to operating GME programs. The provisions of the Balanced Budget Act of 1997 (BBA) are resulting in a gradual but significant reduction in the payments institutions receive for their GME programs from Medicare. The Association of American Medical Colleges (AAMC) in April released a study that estimated a cumulative loss in Medicare support resulting under The Balanced Budget Act of 1997 (BBA) of $45.8 million for a typical member hospital by 2002. It is unfortunate for residents displace by abrupt program closures that, simultaneously, another BBA provision caps the number of residents Medicare will pay

for at an institution's 1997 level. This has made it ill-advised from a financial perspective for other institutions to accept residents displaced by abrupt closures. Perhaps in part due to this cap on funded positions, as of the end of June, a number of residents displaced by the Mount Sinai and Manhattan Eye and Ear closures still lacked positions, despite the institutions' efforts and assistance from the ACGME and the RRCs in identifying and working with programs willing to accept the residents.

Over the past months, the national press has virtually abounded with articles about teaching hospitals' financial plight, including discussions of the financial situation at renowned institutions like UCSF/Stanford Health Care and the Massachusetts General Hospital. Within the teaching hospital community, there is widespread belief that the BBA provisions are significantly contributing to the bleak financial picture at these institutions, long kept afloat to some extent by their Medicare GME support. Data exist that appear to suggest that some other institutions may soon be confronting circumstances similar to those at Mount Sinai and Manhattan Eye and Ear and additional residents may be impacted by future program closures or downsizing. It will be important for these institutions, their residents, and to an extent for the character of medical education in the United States that future institutions that must downsize or close their GME programs will strive to follow the ACGME's requirements for reductions in residency education programs. Anecdotes of a few residents unable to find positions are disheartening, but pale in comparison to the specter of program closures on a larger scale and a significant number of residents being left without the opportunity to complete their professional education. Issues at stake in GME program closures on a larger scale, especially if done abruptly and with little concern for the residents involved, are the personal costs extracted from the involved residents, the foregone cost of their education up to that point, and the fact that residents without a complete course of graduate medical education entering independent practice could ultimately result in a diminishment of the quality of health care in the United States.

"A study by the AAMC estimated a cumulative loss in Medicare support resulting under the BBA of $45.8 million for a typical member hospital by 2002."

Survival Tips for New (and Some for Seasoned) Program Directors

The 'survival tips' presented here were compiled from suggestions made by the Executive Directors of the Residency Review Committees (RRCs) and the Institutional Review Committee (IRC) and selected members of the ACGME Field Staff. The intent is to offer common-sense, ready-to-implement advice to new program directors.

As soon as possible after being appointed, new program directors should inform the ACGME offices in writing of their appointment if their predecessor has not already done so. The letter should include all relevant contact information, including mailing address, voice telephone and fax numbers, and electronic mail address. The program director's current curriculum vitae (CV) should be enclosed. The letter should be addressed to the appropriate RRC Executive Director. The names and addresses of all RRC Executive Directors can be found on the ACGME World Wide Web page (http://www.acgme.org).

Next, all new program directors should visit the ACGME's Web page. In addition to general information about the ACGME and the accreditation process and the name and phone number for the RRC Executive Directors and Accreditation Administrators (this can be found both at each RRC's individual Web page or in the ACGME Information section). The Web page contains comprehensive accreditation information for each specialty. Program directors should visit the page for their specialty and review the documents, and download the Program Requirements and the Program Information Forms to allow them to familiarize themselves with these working documents. In addition, it is helpful to become familiar with the Institutional Requirements, which apply to all residency programs.

Useful Information for Program Directors

Third, new program directors, and more seasoned ones, should review and periodically re-review the ACGME accreditation information for their program. This includes:

(1) A copy of the program's most recent ACGME accreditation letter. If one is not already available in the program files, it can be obtained from the RRC team. The program director should note any comments or citations for correction; any requests for progress reports; and the tentative date for the date of your next site survey.

Program directors should contact the Executive Director of the RRC if there are sections in the letter they do not fully understand.

(2) A copy of the most recent ACGME-required internal review of the program. This document may be obtained from the institution's Designated Institutional Official or Office of Medical Education. The ACGME does not maintain a file of the documents resulting from the internal review, as they are considered 'confidential' documents, to ensure that the internal review is comprehensive and openly identifies and discusses the programs strength and weaknesses. After reviewing these documents, the program director should note any comments or requests for follow-up reports from the institution's Graduate Medical Education Committee based on the internal review.

(3) A copy of the institution's most recent ACGME Letter of Report. All program directors are entitled to receive a copy of this letter from their Designated Institutional Official or Office of Medical Education.The Letter of Report provides the results and status of the institution's current Institutional Review. Program directors should note any comments or citations in the Letter of Report that may impact upon their program and seek resolution with the institution.

(4) A copy of the institution's mission statement, vision statement, and statement of commitment to graduate medical education. This should allow the program director to become familiar with the institution's reasons for being involved in physician education and the specific institutional goals for GME.

(5) A copy of the program's history, which should be studied in detail. It is important to compile and review all recent notification letters the program has received from the RRC to ensure that previous areas of noncompliance have been corrected.

(6) Appropriate ACGME references and resource documents. In addition to the information on the ACGME Web site referenced above, this includes a copy of the "Graduate Medical Education Directory" (Green Book), which contains the ACGME program and institutional requirements, a list of ACGME-accredited GME programs and other information relevant to program directors and directors of graduate medical education. In addition, the ACGME Annual Report, the Essentials for Programs in Graduate Medical Education, and the ACGME Bulletin may provide useful information for program directors. Copies of these ACGME documents may be obtained by calling the ACGME offices.

Helpful Hints for the Site Visit

The following may be valuable to both new and established program directors. First, in ensuring the program's compliance with the requirements and in preparing for the site, it is vital that the program director know the program requirements. The Executive Director for the appropriate RRC should be contacted for clarification where the language or the intent of the requirement is not clear to the program director. Program directors may also want to consider developing a checklist to document the program's status for each of the program requirements.

In preparing for the site visit, the program director should take ownership and responsibility for the Program Information Form (PIF). While delegation of sections of the PIF to members of the teaching staff, residents and others is important and necessary, the program director him- or herself must be familiar with the entire document to facilitate a review and discussion with the site visitor. When questions arise about the PIF, many can be answered by the ACGME help desk, which can be reached via electronic mail at helpdesk@acgme.org or by calling at 312/464-5393. Questions related to the content of the PIF should be directed to the office of the Executive Director or the Accreditation Administrator of the appropriate RRC. The RRC's are responsible for developing, maintaining and periodically revising these forms.

The primary task in completing the PIF is to prepare an accurate description of the program that demonstrates compliance with the requirements. This cannot be stressed enough, because a comprehensive and detailed description of the program may not be adequate from an accreditation perspective if it fails to describe how the program meets the requirements. It is important to remember that the RRC does not review 'the program' per se, but rather a description of the program. Similarly, the ACGME field representative during the site visit reviews the description of the program that is presented in the PIF and expanded on during the site visit. The site visitor prepares his or her report on the basis of this description and the degree to which the information presented in the PIF could be verified during the visit. Some program directors may want use a mock survey to prepare for the actual site visit. If possible, this mock survey should involve staff from other programs in the institution as well as colleagues from other institutions.

On the actual site visit day, it may help to know that when the field representative meets with the Program Director, the initial discussion will focus on (1) how the

program has address the list of previous concerns (if any) identified by the RRC at the program's last review; and (2) any major changes in the program that have occurred since that last site visit. Examples of major changes include changes in program sponsorship or administration, affiliations, faculty, facilities or rotations. Being well prepared for these questions can add to the program director's confidence during the remainder of the visit.

To learn more about the accreditation process, new program directors, especially, should note the next meeting dates of their professional societies and attend all sessions that are specific to program directors in their specialty or subspecialty. ACGME staff and members of the RRC often present sessions at program directors' meetings to keep them up to date on requirements and accreditation issues within the specialty. Basic information and periodic updates on the ACGME accreditation requirements and process are also presented at an ACGME-sponsored conference entitled "Mastering the Accreditation Process," which is held at least once per year. The conference introduces program directors to the accreditation process and provides specialty-specific updates on the accreditation process.

Program directors, both new and established, are urged to use the resources of the ACGME offices. In addition to the Executive Directors and Accreditation Administrators who staff the individual RRCs and the Institutional Review Committee (IRC), the ACGME also has staff knowledgeable in computer applications, scheduling of site visit and all aspects of interface with the ACGME Field Staff, the appeals process, institutional review, how to obtain program consultants, and other useful information. Program directors should not hesitate to call the ACGME offices for help. Staff is eager to help and furnish information and advice that will assist the program director in his or her responsibilities.

Documenting the Internal Review Process During the ACGME Site Visit

Program directors and institutional officials regularly pose the question of how they should document the presence of a functional internal review process during the site visit. The following summarizes the suggested approach for documenting the existence of an internal review process in the context of both a program and an institutional site visit.

The matter of internal reviews is an important issue. The ACGME Institutional Review Committee (IRC) and the Residency Review Committees (RRCs) are is committed to ensuring that sponsoring institutions have an internal review process in place and operating. For this process to be effective, institutions and programs must believe that they will not incriminate themselves by candidly exploring the strengths and weaknesses of their programs. To ensure that programs can do this, the internal review documents must be private. This has been periodically stated in several forums, including the ACGME's "Mastering the Accreditation Process" workshop and in response to questions posed by individual program directors or institutional officials. This article is intended to provide the larger GME community with information about how to document the internal review process during the accreditation site visit, and to underscore the ACGME's commitment to ensuring the confidentiality of the internal review process.

"For the internal review process to be effective, institutions and programs must believe that they will not incriminate themselves by candidly exploring the strengths and weaknesses of their programs."

Documenting the Internal Review during the Site Visit of an Individual Residency Program

During the site visit of a residency education program, the ACGME field representative will NOT ask to see the actual report prepared following the internal review or the discussion of the internal review of the program in the minutes of the Institutional GME Committee (GMEC). The exclusive purpose of these documents is use by the program and sponsoring institution in identifying and addressing deficiencies that may impact residency education. To be useful, they must be candid documents that freely discuss the positive and negative aspects of the program.

Also, the ACGME site visitor will NOT ask to see the minutes of the GMEC for verification that individual residency programs have undergone an internal review. The minutes of the GMEC, like the report itself, might contain information that could highlight negative aspects of the program. While these negatives may be discovered through review of the Program Information Form (PIF) or the interviews conducted during the site visit, the program's own internal review should not be the source of information about program deficiencies

that will be included in the site visit report.

The ACGME field representative WILL ask to see evidence that an internal review of the program being site visited has taken place. This documentation will usually be a written synopsis of the review that discusses when it occurred, who was involved - such as faculty from other departments, residents, representatives from administration - and the process that was used. The synopsis could be the summary of the program's internal review that is developed for each program as part of the documents prepared for the ACGME institutional review. The field representative will not use this summary for any purpose other than to ascertain that an internal review of the program has taken place.

If the program director is unable to produce the type of documentation of the internal review process that is discussed in the preceding paragraph, the field representative will report this fact. He or she will not request to see information about the internal review from the full report or from the minutes of the GMEC. However, if the program opts to produce these documents as their evidence that an internal review has occurred, the site representative can look at them. The members of the ACGME field staff have been instructed that review of these documents must be limited to assuring that an internal review has occurred and that an appropriate structure and process were used. No other information that could be gleaned from the review of these institutional documents will be included in their site visit report.

Documenting the Internal Review during the Institutional Site Visit

The ACGME field representative WILL ask to see the minutes of the GMEC, with the understanding that what is discovered in these documents will not be reported to the individual RRCs. Information gathered as part of the institutional review will be used by the Institutional Review Committee only, in its determination that the institution has a functional and meaningful internal review process.

As part of the attachments to the Institutional Review Document, the ACGME field representative will expect to see summaries of the internal review of each program, to enable the IRC to assess the presence of a functional internal review process. The ACGME field representative will NOT ASK to see the full documents from the internal reviews of individual residency programs. However, the institution can provide the full report of these internal reviews instead of the summaries, as is explicitly stated in the Institutional Review Document, and the field representative and IRC may review these documents if they are provided by the institution. As stated above, information from the review of these documents will be used only to determine the presence of meaningful internal review and will not be reported to the RRCs or used in any way to make determinations about individual residency education programs.

Programs that have additional questions about the internal review of individual programs should contact the Executive Director for their RRC. Questions about the documentation of internal reviews during the institutional site visit should be directed to Cynthia Taradejna, Executive Director, Institutional Review Committee, at 312-464-4685.

How Members of the ACGME Field Staff Spend their Time -

The Results of an ACGME Field Staff Time Survey

Ingrid Philibert

In May 1998, the ACGME asked its field staff to report the time they spent in preparing for and conducting program site visits and in writing and completing the site visit reports. Eight of seventeen members of the field staff participated in the survey. Information was collected via daily calendars that were completed for four weeks during which the surveyors conducted site visits of graduate medical education (GME) programs. While the information is somewhat dated, it offers an interesting glimpse of how members of the ACGME field staff spend their work hours.

During most of the weeks surveyed, each ACGME field representative visited three programs per week. Data were collected in seven categories, comprising activities related to the site visit and associated preparation and report writing, administrative functions, such as reviewing new ACGME information and communicating with the ACGME offices, and a 'miscellaneous' rubric. The categories were:

(1) reviewing Program Information Forms (PIFs) and other materials;

(2) preparing for the site visit, including planning interview schedules and logistics;

(3) time spent on-site visiting the program;

(4) time devoted to dictating and writing the site visit reports;

(5) editing, completing and transmitting site visit reports;

(6) time spent traveling;

(7) administrative activities; and

(8) miscellaneous activities.

The survey was completed by full- and part-time ACGME field representatives. At least one part-time surveyor reported data for two site visit weeks and two 'off' weeks, during which the surveyor worked on reports and contacted programs to plan upcoming visits. The data are presented in ***Table 1*** and ***Table 2***. ***Table 1*** shows selected individual survey weeks, and shows the wide range of hours spent by the field representatives in virtually every category.

For example, time spent on the actual visit at the GME program ranged from 7.5 hours for a week during which only two programs were visited to 22.75 hours for a 'heavy' week.Similarly, time spent reviewing program materials ranged from 3.25 hours to 14.75 hours, and time spent traveling varied from 7.75 hours to 24.25 hours. As a result, total hours spent by the members of the field staff during the survey week ranged from 35.75 hours to 76.25 hours. The reasons for this large variance can be found in the differences in the size and complexity of the GME programs and the length and level of detail in the requirements, all of which impact the time spent preparing for the visit, the length of the site visit, and the time to complete the report. The variance also reflects the work of the field staff, which is not completed in an orderly 40-hour work week and frequently requires far more hours in a given week devoted to visiting programs and completing reports.

Table 2 shows the overall mean for all surveyors and all weeks for which data were collected, and the individual averages for three field representatives - the site surveyors with the highest, lowest and median number of average hours over the four week survey period. Unlike the individual weeks shown in ***Table 1***, this data shows

Table 1

ACGME Field Staff Time Study

Results Reported for Individual Survey Weeks

Categories	Lowest	25th %ile	Median	75th %ile	Highest
Review of Program Materials	3.25	4.5	6.25	9.00	14.75
Preparation for Site Visit	0.00	2.00	3.75	5.00	8.75
Site Visit	7.50	12.00	13.50	15.50	22.75
Report Preparation	2.75	3.75	5.00	10.50	18.00
Report Completion	0.00	2.5	3.25	4.00	9.00
Administrative duties	0.25	1.00	2.75	3.50	5.00
Travel	7.75	10.75	12.75	17.50	24.25
Miscellaneous	0.00	0.00	0.00	1.00	4.75
Total	35.75	47.50	56.25	57.50	76.25

Table 2

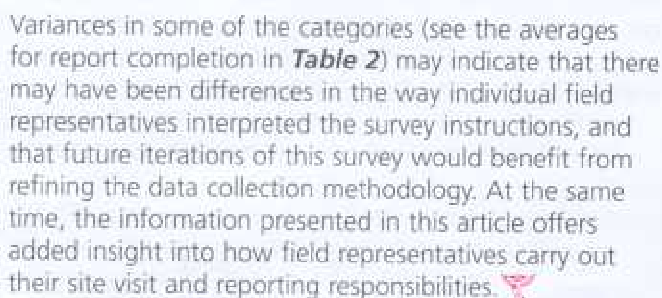
ACGME Field Staff Time Study

Average Weeks for Selected Field Representatives

Categories	Overall Mean	Lowest Average*	Median Average*	Highest Average*
Review of Program Materials	7.21	4.06	3.50	9.25
Preparation for Site Visit	3.85	0.81	6.25	3.88
Site Visit	14.12	14.06	18.63	17.13
Report Preparation	7.47	3.81	11.63	14.75
Report Completion	3.52	3.38	1.75	1.44
Administrative duties	2.47	2.13	1.38	1.38
Travel	14.28	13.38	10.63	14.56
Miscellaneous	0.85	0.00	1.00	0.00
Total	53.99	41.63	54.75	62.38

*Average of four weeks of data collection for each field representative.

that the differences between the surveyors with the lowest and highest average hours worked over the survey period are not random and appear to relate to differences in time devoted to reviewing program materials (4.06 hours vs. 9.25 hours), writing of reports (3.81 hours vs. 14.75 hours), and preparing for the visit (0.81 hours vs. 3.88 hours). It is interesting to note that time devoted to travel did not show much variance across the three surveyors whose data are presented in ***Table 2***. Overall, average hours devoted to site survey activities totaled 54 hours (53.99 hours) across all respondents, and the median individual surveyor's average at 54.75 hours per week was close to the overall mean. The highest and lowest average hours for individual respondents were 41.63 hours and 62.38 hours, respectively.



Variances in some of the categories (see the averages for report completion in ***Table 2***) may indicate that there may have been differences in the way individual field representatives interpreted the survey instructions, and that future iterations of this survey would benefit from refining the data collection methodology. At the same time, the information presented in this article offers added insight into how field representatives carry out their site visit and reporting responsibilities.

ACGME Approves Several Bylaws Changes and Revisions in Program Requirements

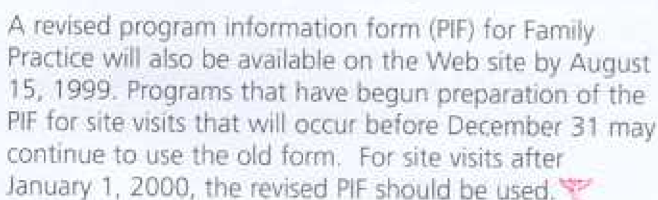
At its meeting in June, the ACGME adopted a change in the Bylaws that strengthened the requirement for appointing a resident member to each RRC. The new Bylaws state that 'one resident physician must serve as a member of each Residency Review Committee.' Exceptions to this policy may be granted only after application and approval by the ACGME.

The Council also finalized a change in the Bylaws, which had been presented for first reading in February 1999, to appoint a third public representative to the ACGME. In addition, the ACGME received for first reading proposed revisions of the ACGME Bylaws regarding the separate incorporation of the ACGME. The Council also discussed, but did not vote on, a proposed change to its system for charging for program accreditation activities, which would replace the current site visit and resident fees with an annual fee structure for all accredited programs, under a 'subscription model.'

The Council approved the revisions in the Program Requirements for Vascular Surgery and the Program Requirements for the Transitional Year. Both new sets of program requirements will become effective January 1, 2000. In addition, the ACGME approved minor revisions in the Program Requirements for Pediatrics, Medical Genetics, Obstetrics and Gynecology, and Radiation Oncology, effective August 15, 1999.

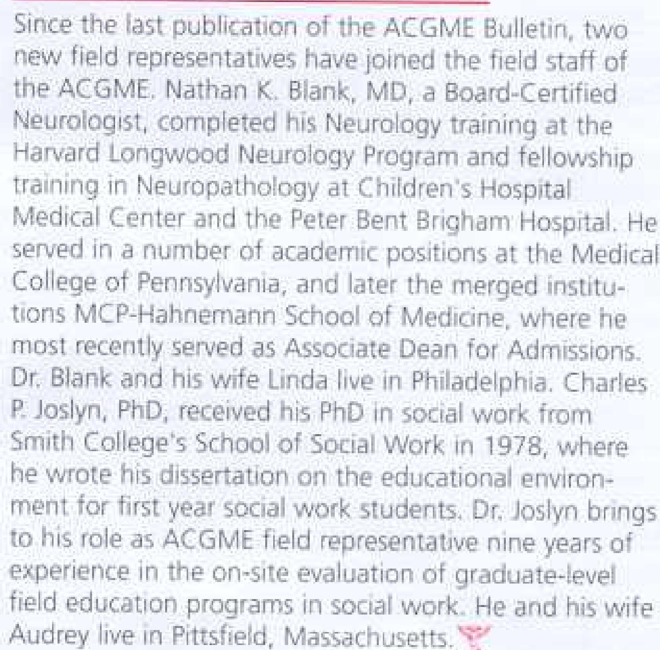
Revised Program Requirements for Pediatrics and New PIF for Family Practice to be put on the 'Web'

The recently approved revision to the Program Requirements for Pediatrics will allow an elective month in the NICU. Program directors should refer to Section V. C. 1. The revised document will be available on the ACGME's Web site (http://acgme.org) after August 15, 1999.



A revised program information form (PIF) for Family Practice will also be available on the Web site by August 15, 1999. Programs that have begun preparation of the PIF for site visits that will occur before December 31 may continue to use the old form. For site visits after January 1, 2000, the revised PIF should be used.

ACGME Staffing Changes



Since the last publication of the ACGME Bulletin, two new field representatives have joined the field staff of the ACGME. Nathan K. Blank, MD, a Board-Certified Neurologist, completed his Neurology training at the Harvard Longwood Neurology Program and fellowship training in Neuropathology at Children's Hospital Medical Center and the Peter Bent Brigham Hospital. He served in a number of academic positions at the Medical College of Pennsylvania, and later the merged institutions MCP-Hahnemann School of Medicine, where he most recently served as Associate Dean for Admissions. Dr. Blank and his wife Linda live in Philadelphia. Charles P. Joslyn, PhD, received his PhD in social work from Smith College's School of Social Work in 1978, where he wrote his dissertation on the educational environment for first year social work students. Dr. Joslyn brings to his role as ACGME field representative nine years of experience in the on-site evaluation of graduate-level field education programs in social work. He and his wife Audrey live in Pittsfield, Massachusetts.

ACGME and RRC Meeting Dates for 1999 and 2000

Shown below are the RRC Meeting Dates for the remainder of 1999 and the year 2000, as well as the ACGME Meeting Dates for 20001 and 20002. Please note that the meeting date for the RRC for Radiation Oncology has been changed to August 24-25, 1999, and the meeting date for the RRC for Anesthesiology has been changed to November 4-6, 1999.

1999

Date	Meeting
7/9-11	Internal Medicine
7/12	Anesthesiology
7/16-17	Thoracic Surgery
8/13-14	Physical Medicine & Rehabilitation
8/20-21	Otolaryngology
8/30-9/1	Family Practice
8/24-25	Radiation Oncology
9/10-13	Internal Medicine
9/17-18	Pathology
9/17-18	Allergy & Immunology
9/17-19	Emergency Medicine
9/24	Colon & Rectal Surgery
9/26	RRC Council Retreat
9/27-28	ACGME
9/28-29	Pediatrics
10/7-8	Preventive Medicine
10/13-16	Diagnostic Radiology
10/14-16	Obstetrics/Gynecology
10/17	Dermatology
10/20-21	Institutional Review
10/24-27	Pediatrics
10/28-29	General Surgery
10/29-30	Psychiatry
11/4-5	Neurology
11/4-6	Anesthesiology
11/8	Medical Genetics
11/10-12	Plastic Surgery
11/12	Nuclear Medicine
11/14-15	Transitional Year Review
11/18	Dermatopathology
12/2-3	Urology
12/4-5	Ophthalmology

2000

Date	Meeting
1/13-15	Orthopaedic Surgery
1/14-15	Thoracic Surgery
1/17-19	Family Practice
1/20-22	Obstetrics/Gynecology
1/28-29	Neurological Surgery
1/28-31	Internal Medicine
2/4	Otolaryngology
2/4-6	Emergency Medicine
2/14-15	ACGME
2/18-19	Physical Medicine &
2/24-25	General Surgery
3/2-3	Accreditation Process
3/7-8	Radiation Oncology
3/13	Medical Genetics
3/24-25	Allergy & Immunology
3/30-31	Preventive Medicine
3/30-4/1	Anesthesiology
3/31-4/1	Pathology
4/3-4	Neurology
4/9-12	Pediatrics
4/12-13	Institutional Review
4/14-15	Dermatology
4/14-16	Transitional Year Review
4/28	Nuclear Medicine
4/28-29	Psychiatry
5/4-5	Plastic Surgery
5/22-24	Family Practice
6/1-2	Urology
6/1-3	Obstetrics/Gynecology
6/2-5	Internal Medicine
6/16-17	Ophthalmology
6/23-24	Neurological Surgery
6/24-25	General Surgery
6/26-27	ACGME
7/14-15	Thoracic Surgery
7/14-16	Internal Medicine
8/4-5	Otolaryngology
8/18-19	Physical Medicine & Rehabilitation
9/8-11	Internal Medicine
9/11-13	Family Practice
9/12-13	Radiation Oncology
9/18	Medical Genetics
9/22-23	Allergy & Immunology
9/22-24	Emergency Medicine
9/25-26	ACGME
10/4-	Diagnostic Radiology
10/5-6	Preventive Medicine
10/6-7	Pathology
10/12-13	General Surgery
10/15-18	Pediatrics
10/18-19	Institutional Review
10/19-21	Obstetrics/Gynecology
10/20-21	Psychiatry
10/29	Dermatology
11/2-3	Plastic Surgery
11/2-4	Anesthesiology
11/10	Nuclear Medicine
11/10-11	Transitional Year Review
11/16-17	Neurology
11/30-12/1	Urology
12/8-9	Ophthalmology

2001

Date	Meeting
1/12-13	Thoracic Surgery
2/12-13	ACGME
2/22-23	General Surgery
3/23-24	Preventive Medicine
4/18-19	Institutional Review
6/11-12	ACGME
6/21-22	General Surgery
9/10-11	ACGME
10/5-6	Preventive Medicine
10/17-18	Institutional Review
10/25-26	General Surgery

2002

Date	Meeting
2/11-12	ACGME
2/21-23	General Surgery
6/10-11	ACGME
9/9-10	ACGME

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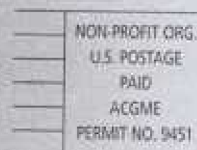

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