1997 ANNUAL REPORT

Accreditation
Council
for
Graduate
Medical
Education

ACGME

The ACGME is sponsored by:

American Board of Medical Specialties
American Hospital Association
American Medical Association
Association of American Medical Colleges
Council of Medical Specialty Societies

The Accreditation Council for Graduate Medical Education is responsible for evaluating and accrediting residency programs in the United States. We are a private-sector council operating under the aegis of five medical organizations.

Most importantly we act as a catalyst, bringing together knowledgeable healthcare practitioners, educators and administrators to resolve critical issues concerning graduate medical training.

These volunteers who participate in our Residency Review Committees are key to the efficacy of our process. Through their work we directly influence the quality of graduate medical education, the quality of healthcare institutions and, ultimately, the quality of medicine in America. Because of them the ACGME is improving the pattern of medical education and the course of patient care.

MESSAGE FROM THE CHAIR

The ACGME completed a year of significant change. New bylaws were ratified, new accreditation tools were targeted for development; the founding Executive Director retired and a new one was recruited, and a reexamination of appropriate next steps was articulated by the Strategic Initiatives Committee.

A review of history will emphasize the importance of recent bylaws changes. In 1967 the individual RRCs were constituted and functioned independently, linked mainly by the staffing provided by the AMA. In 1974 the first meeting of the Liaison Committee on Graduate Medical Education (LCGME) was convened and served to provide some oversight to the RRCs. Membership of the new LCGME included our five current sponsoring organizations, which broadened the ownership of GME issues. A Coordinating Committee on Medical Education reviewed the activities of the LCGME, but because it proved to be redundant and created conflict and inefficiency, it was disbanded after a few years. The LCGME was then replaced by the ACGME which was created with new bylaws in December of 1980. Since that time the ACGME has grown in stature and independence with the guidance and support of its sponsors.

The growing confidence of the sponsoring organizations in the independent performance of the ACGME is reflected in the bylaws passed in 1997 which permit the ACGME to act, in most instances, by majority vote rather than the historic unanimous vote. This important change has measurably hastened the progress toward autonomy, and further depoliticized the accreditation process. It also makes the organization more efficient and more responsible for its actions.

These evolutionary changes in structure and function have improved the quality of the accreditation process by achieving uniformity of policies and procedures, a greater emphasis on institutional reviews, a mechanism for appeals, development of universal core program requirements and an opportunity to include the RRC Chairs in policy development.

Two other recent achievements will impact the accreditation of GME.

First is the position statement approved in September of 1997:
"The ACGME supports the increased use of outcomes assessment in the accreditation process and the development of an overarching model for outcomes assessment in accreditation that can be applied across the specialities."

This is a fundamental shift from accreditation based on the potential of programs to educate to accreditation based on evidence of their achievement. The next few years will find the organization pursuing valid and reliable measures that add value to the assessment of program competence.

The newly formed ACGME Strategic Initiatives Committee, ably chaired by Mr. William G. Gonzalez, recommended four items to be addressed by the ACGME as priority issues:

1) The impact of emerging health care delivery systems on graduate medical education;
2) General competencies that apply to all specialities;
3) Streamlining the ACGME accreditation process; and
4) Adjustments to declining resources for education.

Each of these issues is important for all specialities and their educational programs. Appropriate responses will make the ACGME more effective and efficient.

In June 1978 John Gienapp, PhD, joined what was then the LCGME. He brought to the graduate medical education community unique skills, common sense, an ability to achieve consensus among disparate parties, and a willingness to serve the larger cause while attending to

infinite detail. His background in evolutionary biology kept the organization aware of its own progress toward survival and fitness, and his background as a Lutheran minister brought practical reconciliatory skills to the table. He has been the voice of the ACGME since its inception and he will be long remembered. He has greatly strengthened the accreditation process and has enhanced the credibility of the ACGME. We offer him our sincere gratitude and our best wishes for his retirement.

We have been fortunate in the appointment of David C. Leach, MD, as our new Executive Director as of September 1997. Dr. Leach brings a new array of skills and experiences which promise to be of great importance for the widening array of challenges now facing Graduate Medical Education.

We will be mindful of the past but focused on the future.

Leo J. Dunn, MD
Chair
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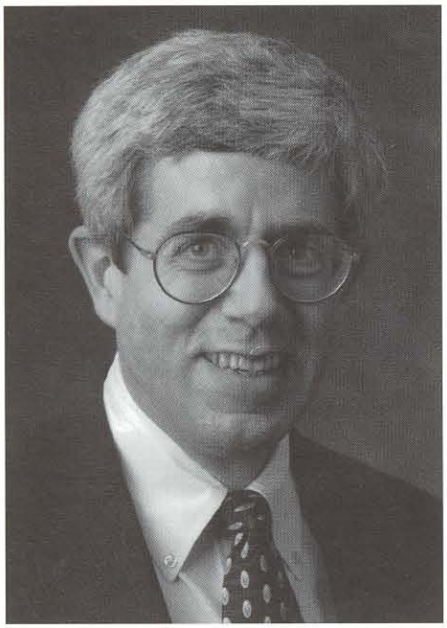


Permit me to begin by saying thank you to all of the constituents of the ACGME. The numerous congratulatory notes and comments, followed by the gracious way in which a number of you have received and oriented me will not be forgotten. Leaving the familiar world of patients and teaching to assume a new role, a role that called for new competencies on my part, was not a decision taken lightly. The opportunity to contribute with all of you in an effort to strengthen medical education proved too tempting to resist. Nonetheless, the transition was made much easier by constant and continuing discovery of the talent, principles and graciousness of the volunteers, employees, and others associated with the apparatus known as the ACGME.

Those of you who know John Gienapp know that he is not an easy act to follow. He was present at the birth of and helped shape the ACGME throughout its evolution, and many would say is synonymous with it. I could never replace him. My only courage comes from an appreciation that this thing is larger than either of us. He has been, and I will be, a servant to the larger cause, "to develop the most effective methods to evaluate graduate medical education, to promote the quality of graduate medical education, and to deal with such other matters relating to graduate medical education as are appropriate" (Bylaws, Article II, Section 1).

What does it mean to accredit something? Accreditation involves discernment and public recognition of the characteristics discerned. The derivation suggests that it means "credit to," but it sure doesn't feel that way. Right now a program director fills out a program information form (PIF), a site visit documents that what is said to happen happens, and then a council of peers reviews the data and decides whether the program meets published standards. Straightforward, if somewhat prolonged (it can take 6-18 months from PIF to notification letter), this method involves inspection, monitoring, holding to standards, and promotes defensive behaviors on the part of both the program directors and accreditors. The procedure is heavy on process and structure and rather light on outcomes. You must have six months of this and four of that, rather than graduates who prove they have learned how to do what you are allegedly teaching them.

Of the new initiatives being addressed by the ACGME few will change things more than a shift to the use of outcomes as an accreditation tool. Instead of being perceived as a barrier, accreditation will become a facilitator of innovation. Flexibility will become a value once outcomes rather than processes become the target. However, it is no small task to get from here to there. What outcomes should be measured? What measurement tools are reliable, valid and add value? How can this be done most cost effectively? In September the ACGME hosted a conference on enhancing residency education through outcomes assessment. Interest in the conference exceeded anyone's expectation. The experiences of JCAHO, the Royal College of Physicians and Surgeons of Canada, and those of several residency programs were reviewed. Problems and solutions were demonstrated. Subsequently an ACGME work group has been convened to make specific plans for operationalizing this approach across all disciplines. Dr. Susan Swing is leading this effort and has developed a plan that will unfold over the next few years.

Other efforts that the ACGME has endorsed include streamlining how we accredit, reexamining the skills future graduates will need to function in emerging delivery models and becoming more cost effective. The process must both assure society and provide direction to program directors. Increasingly graduates function in large health care systems. They must be taught how to improve patient care in such an environment. They must learn how to diagnose and treat organizational dysfunction in a manner analogous to the diagnosis and treatment of patients. Accreditation was necessary to define minimal standards. It is now encouraging continually improved standards and outcomes.

David C. Leach, MD
Executive Director, Accreditation Council for Graduate Medical Education

MILESTONES FOR 1997

The primary responsibility of the ACGME is accreditation of residency programs. One of the most important measures of annual activity, therefore, is the number of programs reviewed. Of the 7,619 programs accredited by the end of 1997, a full 3,630 appeared on Residency Review Committee agendas during the year, including 2,646 that were scheduled for regular accreditation status reviews.

As a result, 48 percent of all programs were examined and 35 percent were subject to routine accreditation actions.

SCOPE OF RESPONSIBILITY

ACGME-accredited programs	7,619
ACGME-accredited specialties	27
ACGME-accredited training areas	74
Residents affected by ACGME accreditation	99,230

ACGME field staff conducted 1,728 surveys, including 57 institutional surveys, 750 surveys of programs in the basic disciplines, and 921 surveys of sub-specialty programs. Volunteer physician specialists conducted an additional 360 surveys.

During regular accreditation reviews, RRCs proposed adverse evaluations for 171 programs, or eight percent. Accreditation was withheld upon application in 47 cases and withdrawn in 36 cases. Eighty eight programs were placed on probation, and fourteen reductions in resident complement were mandated. Six programs were administratively withdrawn, and 167 programs withdrew voluntarily.

The ACGME considered 15 appeals after formal hearings by specially constituted Boards of Appeals.

Another indicator of ACGME's 1997 activity is the number of people and tasks necessary to accomplish this vital process. The staff of ACGME surveyors spent approximately 600 weeks on the road. In addition, volunteer surveyors made 360 trips to visit programs. RRCs held 60 meetings; the Institutional Review Committee met two times; and the entire ACGME council met three times. Appeals brought 45 physicians to Chicago for one-day hearings.

All told, volunteer physicians and administrators contributed an estimated 40,000 hours in 1997. The ACGME staff of 69 employees supported their invaluable work.

EVALUATION ACTIVITY

Total agenda items	3,630
Regular accreditation status reviews	2,646
Adverse actions	
Withheld	47
Withdrawn	36
Probation	88
Appeals	
Sustained	10
Reversed	5

1997 FINANCIAL HIGHLIGHTS

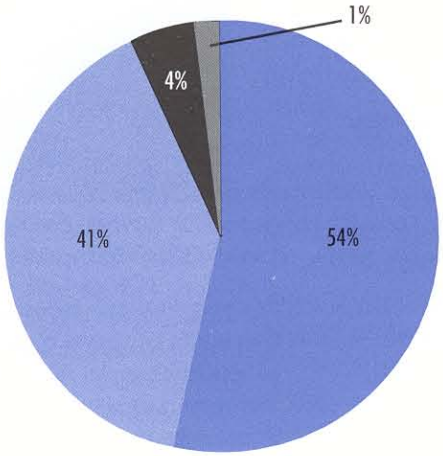
The ACGME's 1997 revenues came primarily from fees charged to programs. The largest portion of these revenues was derived from fees charged for site visits. Much of the remainder came from annual fees charged to each program based on the number of residents enrolled. Direct contributions from the five member organizations constituted approximately one percent of the ACGME's support.

ACGME expenditures for 1997 were $10.5 million. This total was slightly higher than the previous year.

At year-end, cash and investments totaled $5.9 million.

REVENUES

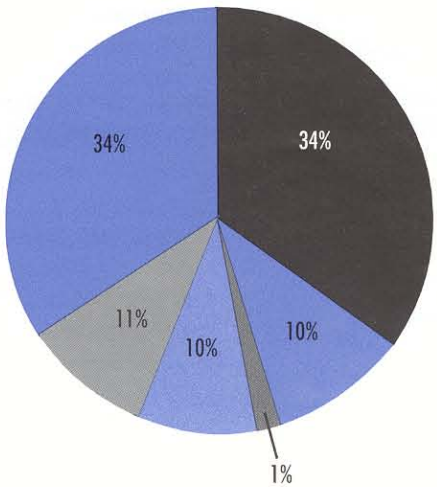
- Site visit and accreditation application fees
- Annual per-resident fees
- Member organizations contributions
- Other



Site visit and accreditation application fees	$ 5,980,670
Annual per-resident fees	$ 4,552,474
Member organization contributions	$ 100,000
Investment revenue and miscellaneous	$ 479,447
Total	**$11,112,591**

EXPENSES

- Site visits
- RRC activities
- ACGME and general activities
- Appeals and legal services
- Administration and research
- Rent and contracted support services



Site visits	$ 3,586,926
RRC activities	$ 3,611,734
ACGME and general activities	$ 1,121,794
Appeals and legal services	$ 117,021
Administration and research	$ 1,027,006
Rent and contracted support services	$ 1,047,036
Total	**$10,511,517**

RESIDENCY REVIEW COMMITTEES

Each of the 26 Residency Review Committees is sponsored by the two or three organizations listed below. The sponsoring organizations are the medical specialty boards, the American Medical Association (AMA), and in many instances an appropriate major specialty organization. Members of the Residency Review Committees, which vary in size from six to 15 persons, are appointed in equal numbers by the sponsoring organizations. In addition to the specialty area which forms the name of the committee, other specialized training areas accredited by the committee are indicated.

In addition to programs in these areas, the ACGME accredits special one-year general clinical programs called Transitional Year Programs. The ACGME also provides for an Institutional Review Committee, which evaluates sponsoring institutions for compliance with the ACGME Institutional Requirements.

Allergy and Immunology	*Specialized Area:* *Clinical and Laboratory Immunology*	• American Board of Allergy and Immunology (A Conjoint Board of the American Board of Internal Medicine and the American Board of Pediatrics) • AMA Council on Medical Education
Anesthesiology	*Specialized Areas:* *Critical Care Medicine* *Pain Management* *Pediatric Anesthesiology*	• American Board of Anesthesiology • AMA Council on Medical Education • American Society of Anesthesiologists
Colon and Rectal Surgery		• American Board of Colon and Rectal Surgery • AMA Council on Medical Education • American College of Surgeons
Dermatology	*Specialized Area:* *Dermatopathology*	• American Board of Dermatology • AMA Council on Medical Education
Emergency Medicine	*Specialized Area:* *Sports Medicine*	• American Board of Emergency Medicine • AMA Council on Medical Education • American College of Emergency Physicians
Family Practice	*Specialized Areas:* *Geriatric Medicine* *Sports Medicine*	• American Board of Family Practice • AMA Council on Medical Education • American Academy of Family Physicians
Internal Medicine	*Specialized Areas:* *Cardiovascular Disease* *Clinical Cardiac Electrophysiology* *Critical Care Medicine* *Endocrinology, Diabetes, and Metabolism* *Gastroenterology* *Geriatric Medicine* *Hematology* *Hematology and Oncology* *Infectious Disease* *Nephrology* *Oncology* *Pulmonary Disease* *Pulmonary Disease and Critical Care Medicine* *Rheumatology* *Sports Medicine*	• American Board of Internal Medicine • AMA Council on Medical Education • American College of Physicians

Medical Genetics		• American Board of Medical Genetics • AMA Council on Medical Education • American College of Medical Genetics
Neurological Surgery		• American Board of Neurological Surgery • AMA Council on Medical Education • American College of Surgeons
Neurology	*Specialized Areas:* *Child Neurology* *Clinical Neurophysiology*	• American Board of Psychiatry and Neurology • AMA Council on Medical Education • American Academy of Neurology
Nuclear Medicine		• American Board of Nuclear Medicine • AMA Council on Medical Education • Society of Nuclear Medicine
Obstetrics and Gynecology		• American Board of Obstetrics and Gynecology • AMA Council on Medical Education • American College of Obstetricians and Gynecologists
Ophthalmology		• American Board of Ophthalmology • AMA Council on Medical Education • American Academy of Ophthalmology
Orthopaedic Surgery	*Specialized Areas:* *Adult Reconstructive Orthopaedics* *Foot & Ankle Orthopaedics* *Hand Surgery* *Musculoskeletal Oncology* *Orthopaedic Sports Medicine* *Orthopaedic Surgery of the Spine* *Orthopaedic Trauma* *Pediatric Orthopaedics*	• American Board of Orthopaedic Surgery • AMA Council on Medical Education • American Academy of Orthopaedic Surgeons
Otolaryngology	*Specialized Area:* *Otology-Neurotology* *Pediatric Otolaryngology*	• American Board of Otolaryngology • AMA Council on Medical Education • American College of Surgeons
Anatomic and Clinical Pathology	*Specialized Areas:* *Blood Banking/Transfusion Medicine* *Chemical Pathology* *Cytopathology* *Dermatopathology* *Forensic Pathology* *Hematology* *Immunopathology* *Medical Microbiology* *Neuropathology* *Pediatric Pathology*	• American Board of Pathology • AMA Council on Medical Education

Pediatrics	*Specialized Areas:* *Adolescent Medicine* *Neonatal-Perinatal Medicine* *Pediatric Cardiology* *Pediatric Critical Care Medicine* *Pediatric Endocrinology* *Pediatric Gastroenterology* *Pediatric Hematology/Oncology* *Pediatric Infectious Disease* *Pediatric Nephrology* *Pediatric Pulmonology* *Pediatric Rheumatology* *Pediatric Sports Medicine*	• American Board of Pediatrics • AMA Council on Medical Education • American Academy of Pediatrics
Physical Medicine and Rehabilitation	*Specialized Area:* *Spinal Cord Injury Medicine*	• American Board of Physical Medicine and Rehabilitation • AMA Council on Medical Education • American Academy of Physical Medicine and Rehabilitation
Plastic Surgery	*Specialized Area:* *Craniofacial Surgery* *Hand Surgery*	• American Board of Plastic Surgery • AMA Council on Medical Education • American College of Surgeons
Preventive Medicine		• American Board of Preventive Medicine • AMA Council on Medical Education
Psychiatry	*Specialized Areas:* *Addiction Psychiatry* *Child and Adolescent Psychiatry* *Forensic Psychiatry* *Geriatric Psychiatry*	• American Board of Psychiatry and Neurology • AMA Council on Medical Education • American Psychiatric Association
Radiology-Diagnostic	*Specialized Areas:* *Musculoskeletal Radiology* *Neuroradiology* *Nuclear Radiology* *Pediatric Radiology* *Vascular and Interventional Radiology*	• American Board of Radiology • AMA Council on Medical Education • American College of Radiology
Radiation Oncology		• American Board of Radiology • AMA Council on Medical Education • American College of Radiology
Surgery	*Specialized Areas:* *General Vascular Surgery* *Hand Surgery* *Pediatric Surgery* *Surgical Critical Care*	• American Board of Surgery • AMA Council on Medical Education • American College of Surgeons
Thoracic Surgery		• American Board of Thoracic Surgery • AMA Council on Medical Education • American College of Surgeons
Urology	*Specialized Area:* *Pediatric Urology*	• American Board of Urology • AMA Council on Medical Education • American College of Surgeons
Transitional Year		• ACGME Standing Committee

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