

1999 ANNUAL REPORT

Accreditation
Council
for
Graduate
Medical
Education

ACCGME



ASSURING THE QUALITY OF MEDICAL CARE

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.



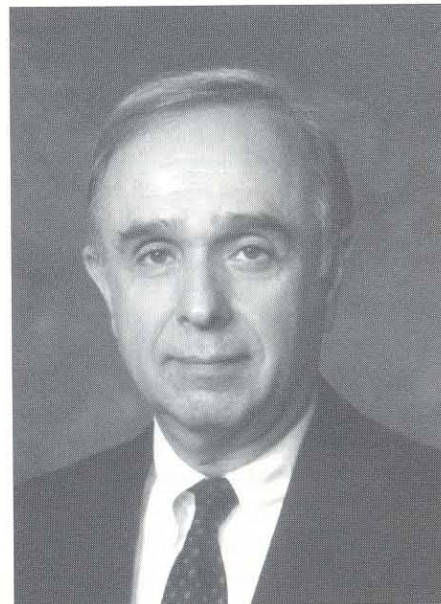
MESSAGE FROM THE CHAIR

I am pleased to submit to you my second report as Chair of the ACGME. The length of the term of service for the Chair has been extended from one year to two years to provide more continuity and more consistency over time at the Chair's level. These changes were adopted by the ACGME during the past year. This is part of an ongoing effort to try to improve the overall operations of the ACGME, making it a more efficient and effective organization. Other changes instituted this past year include the addition of a third public member, Duncan McDonald; who joins the other public members, Kay Hoffman Goodwin and Agnar Pytte on the ACGME. These public members provide a very important perspective for the ACGME which we need to consider as issues related to graduate medical education are becoming a focal point for policy makers and legislators in both the State and Federal Government. We are also exploring ways in which we can move away from our present organizational structure as an unincorporated association to a structure that more properly reflects the responsibilities and the activities of the ACGME. A proposal to change the structure to a not-for-profit corporation is presently under consideration by the ACGME and we are optimistic that this change will take effect some time this year.

The ACGME continues to improve the standards for residency education in the institutional and program requirements. We are continuing to evaluate ways in which to incorporate educational outcomes into the accreditation process. A task force of the ACGME, supported by a grant from the Robert Wood Johnson Foundation, is in the process of identifying and assessing the measurable outcomes. We anticipate that this process will be completed in this next year. The Council is also seeking ways in which the accreditation system can improve its processes and can deal with the difficult political, regulatory and financial environments. With the support of a grant

from the Commonwealth Fund, the ACGME is sponsoring a national conference on these issues in March 2000.

One major area of concern relates to the recent decision of the National Labor Relations Board. In November 1999, they overturned a long standing policy that residents are considered primarily as students and not primarily as employees. As a result of overturning this policy, dating back to the 1976 Cedars Sinai decision, we can now expect to see a great deal more union activity with regard to residents. The ACGME has taken a permissive position with regard to how house staffs should be organized. It has also worked hard to listen to the concerns of the residents by implementing procedures such as early notification about potential, significant accreditation violations. We have now completed the process of appointing a resident member to each of the Residency Review Committees and have also opened up a dialogue between the ACGME and each of the major resident organizations sponsored by one of the ACGME parent organizations. The lines of communication between the residents, the RRCs and the ACGME have never been better and will continue to improve as the ACGME addresses issues of concern to the residents. With regard to the unionization question, the ACGME is unlikely to mandate what form, if any, house staff organizations should take. The ACGME recognizes that the residents are in some senses employees of institutions and do provide significant clinical care to patients. However, the ACGME has considered that residents are primarily students and that they wish to become educated in a medical specialty. They are not primarily employed to provide patient care and not to the extent that there is a conflict between employment issues and educational issues, the educational issues must take primacy. The ultimate impact of the NLRB decisions remains to be seen. In the meanwhile, the ACGME will



continue to work with residents and resident organizations to try to address their concerns in a constructive way.

The ACGME has also been working with the American Board of Medical Specialties and other organizations on the question of what constitutes a competent physician and how can the training requirements incorporate the concept of competency. To that end, the ACGME has adopted language that incorporates the identification of competencies within the training programs. These competencies include the knowledge of clinical and basic sciences, the ability to deliver care in a compassionate and safe manner, the incorporation of quality improvement and outcome measurements, the understanding of systems in the health care delivery system, and finally, the incorporation of the concepts of professionalism and lifelong learning into the educational curriculum. These concepts have been endorsed by the ACGME and will begin to be reflected in the institutional and program requirements starting in 2001. These concepts have also been endorsed by the American Board of Medical Specialties and will be incorporated into the Board certification process as well.

There are additional ongoing efforts between the American Board of Medical Specialties and the Council of Medical Specialty Societies to link the educational processes, particularly in continuing medical education, to outcomes and competencies. The ABMS is addressing the question of how competency can be measured, both in the certification system, as well as in the maintenance of the certification system.

These are busy, interesting and exciting times for graduate medical education. There are tremendous pressures on the graduate medical system and there is considerable concern about the health of many of our major teaching hospitals. The Balanced Budget Act of 1997 played a role in some of the financial problems facing our teaching institutions and the relief legislation that has recently been passed will provide a bit of a reprieve. However, it will not address the problems on a long term basis and those issues remain to be resolved. On the whole, however, the graduate medical education system is still functioning and functioning extremely well. It will have to adapt to change like any other organizational entity, but I am very confident that the ACGME has and will continue to put into place systems that will address some of the pressures that will help to ensure the long term survival and vitality of the graduate medical education system.



Paul Friedmann, MD

Chair

*Accreditation Council for Graduate
Medical Education*



In February, 1999 the ACGME endorsed six General Competencies that it thinks all physicians should demonstrate. They are: patient care; medical knowledge; practice-based learning and improvement; interpersonal skills and communications; professionalism; and systems-based care. In September, 1999 the ACGME endorsed the minimal program requirement language that will support these competencies. The language will be incorporated no later than June, 2001. Some RRCs have already incorporated the competencies into their program requirements. The specific language can be found on www.acgme.org under outcome project. This represented an important step in the ACGME Outcome Initiative—the use of educational outcome measures to enhance the accreditation process. This initiative is based on the principle that whatever we measure we tend to improve. Measurement of educational processes and the structure of curricula, while important, looks at whether a program has the potential to educate; measurement of outcomes helps establish if it is educating.

In September, 1999 the ACGME held a planning meeting, partially supported by the Commonwealth Fund, to plan a

Symposium for March, 2000 entitled “Good Learning for Good Healthcare—Pursuing Excellence in Physician Education—Who will the Players Be?” The environment for graduate medical education has changed and has had a destabilizing influence on good GME. The goal of this conference was to analyze in detail the issues facing GME and to explore interventions to counteract destabilization and to foster excellence in GME. One of the most damaging effects of the current environment identified by the group is the gap between what is preached in GME and what happens on a daily basis. The conflicting and competing imperatives for both residents and faculty have stretched the Oslerian model of GME beyond limits and new models have yet to emerge.

One of the most interesting exercises for the group was a “Matrushka” diagram (named for the nesting Russian dolls) which displayed GME as seven interrelated systems—individual learning, one-on-one teaching between resident and preceptor, resident/preceptor and patient interactions, group learning, GME at the program level, GME at the institutional level, and GME at the national level. Each participant was asked to identify measures of “Good GME” at each level. The results have now been published in a proceedings of the meeting. One product of the planning meeting was the recommendation that the ACGME develop “RPFs” to encourage innovation and experimentation in GME. This concept will be developed further in 2000.

One goal of the ACGME is to help build knowledge about good GME and its linkages with good healthcare. The ACGME conducted a survey of core residency programs in 1999 that exposed the incredible talent and energy in the field. The dedication and effectiveness of those interested in GME is heartening. The ACGME wishes to provide a platform on which good ideas can be displayed and shared. Adaptation requires

that we quickly steal good ideas from each other and apply them in ways that make sense at home. The sponsoring organizations of ACGME together provide a forum where we can all build knowledge and improve both GME and healthcare.

The success of the ACGME is entirely dependent on the quality of volunteers serving on the ACGME, the RRCs and related committees. The talent and willingness of these volunteers continues to inspire and renew the ACGME. The times may be tough, but the talent is tougher. I would like to take this opportunity, on behalf of the ACGME, to thank all of the people who contribute to the important mission of “Good Learning for Good Healthcare”.

In 1999 the ACGME recognized Jordan Cohen, MD by granting him the John C. Gienapp Award. This award, designed to celebrate individuals who make particularly outstanding contributions to graduate medical education, was established by the ACGME and awarded for the first time last year. Dr. Cohen’s contributions have been profound and sustained. He has earned the gratitude of the ACGME and the communities our organization represents. The ACGME also recognized John C. Gienapp, Ph.D., the founding Executive Director, by granting him its Distinguished Service Award. Dr. Gienapp was an excellent steward. His gentle and thoughtful approach facilitated numerous generative conversations that shaped the development of the ACGME. We are all in his debt.

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

MILESTONES FOR 1999

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 7,731 programs accredited by the end of 1999, a full 3,650 appeared on Residency Review Committee agendas during the year, including 2,160 that were scheduled for regular accreditation status reviews. In addition, the ACGME processed 279 applications for new programs.

As a result, 47.3 percent of all programs were examined and 27.9 were subject to routine accreditation actions.

SCOPE OF RESPONSIBILITY

ACGME-accredited programs	7,731
ACGME-accredited specialties	27
ACGME-accredited training areas	77
Residents affected by ACGME accreditation	98,220

ACGME field staff conducted 1,525 surveys, including 94 institutional surveys, 737 surveys of programs in the basic disciplines, and 694 surveys of sub-specialty programs. Volunteer physician specialists conducted an additional 195 surveys.

During regular accreditation reviews, RRCs proposed adverse evaluations for 182 programs, or 9.2 percent. Accreditation was withheld upon application in 16 cases and withdrawn in 17 cases. Sixty six programs were placed on probation, and four reductions in resident complement were mandated. Eight programs were administratively withdrawn, and 132 programs withdrew voluntarily.

The ACGME considered 10 appeals after formal hearings by specially constituted Boards of Appeals.

Another indicator of ACGME's 1999 activity is the number of people and tasks necessary to accomplish this vital process. The staff of ACGME surveyors spent approximately 530 weeks on the road. In addition, volunteer surveyors made 200 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 57 physicians to Chicago for one-day hearings.

All told, volunteer physicians and administrators contributed an estimated 40,000 hours in 1999. The ACGME staff of 76 employees supported their invaluable work.

EVALUATION ACTIVITY

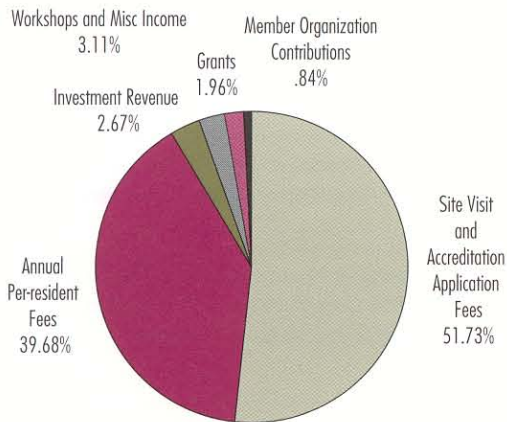
Total agenda items	3,650
Regular accreditation status reviews	2,160
Adverse actions	
Withheld	16
Withdrawn	17
Probation	66
Appeals	10
Sustained	9
Reversed	1

1999 FINANCIAL HIGHLIGHTS

The ACGME's 1999 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.

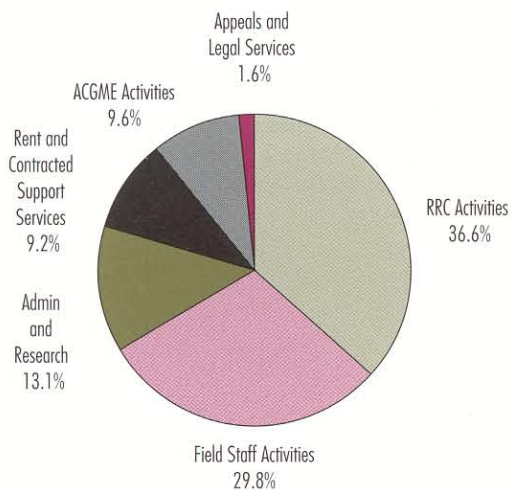
ACGME expenditures for 1999 were \$12.6 million. At year-end, cash and investments totaled \$ 9.7 million.

REVENUES



Site visit and accreditation application fees	\$ 6,159,350
Grants	\$ 233,489
Annual per-resident fees	\$ 4,724,038
Member organization contributions	\$ 100,000
Investment revenue	\$ 318,260
Workshops & Miscellaneous Income	\$ 370,586
Total	\$11,905,723

EXPENSES



Field Staff Activities	\$ 3,761,956
RRC activities	\$ 4,622,835
ACGME and general activities	\$ 1,218,265
Appeals and legal services	\$ 206,394
Administration and research	\$ 1,657,864
Rent and contracted support services	\$ 1,165,592
Total	\$12,632,906

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 also 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 Areas: • Medical Toxicology • Pediatric Emergency Medicine • 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 • Interventional Cardiology • Nephrology • Oncology • Pulmonary Disease • Pulmonary Disease & 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
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Neurological Surgery

- American Board of Neurological Surgery
 - AMA Council on Medical Education
 - American College of Surgeons
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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
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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
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Otolaryngology

Specialized Areas:
• Otolaryngology-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 Emergency 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 Areas:

- Craniofacial Surgery
- Hand Surgery

- American Board of Plastic Surgery
- AMA Council on Medical Education
- American College of Surgeons

Preventive Medicine

Specialized Area:

- Medical Toxicology

- 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:

- Abdominal Radiology
- 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

LIST OF PARTICIPANTS

Residency Review Committee Members

The ACGME's volunteers come from the membership of national medical societies and specialty boards across the country. They are the innovators, the pioneers, the respected experts. Each has a demonstrated history of involvement and commitment to excellence. With the ongoing support of these volunteers, the ACGME will continue to be a leader in assuring the quality of medicine in the United States. It is with considerable pride and gratitude that we acknowledge their contribution.

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