



Is the ACGME a Suitable Proxy for Resident Unions?

In 1999, the National Labor Relations Board (NLRB) determined that resident physicians were employees, not students. This ruling came in stark contrast with the idea supported by organizations such as the AAMC that residents were primary students, and that issues relating to residents' working conditions were the purview of the Accreditation Council for Graduate Medical Education (ACGME). Proponents of resident unions felt that the NLRB's ruling would increase the prevalence and power of resident unions, resulting in improved working environments, salaries, and benefits for union members, in addition to improving patient care. At the same time, the ACGME has focused on educational quality by advocating for residents in domains typical of resident unions or collective bargaining practices, such as benefits and working conditions. Since the ACGME's institution of work-hour limitations, Monica L. Lypton, MD, and associates ask: Now that the ACGME is also controlling work hours, in this age of ACGME institutional oversight, are resident unions still relevant?

The authors examine the extent to which conflicts exist between advocating for working conditions and addressing education issues, and, more specifically, whether there are any resident interests not covered by the current ACGME regulations. On one hand, they find that many of the ACGME institutional requirements are very similar to what one would find in a traditional union handbook of contract benefits. On the other hand, there are areas

Highlights From ACADEMIC MEDICINE

JOURNAL OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES
www.academicmedicine.org

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of the ACGME requirements that may conflict with union rights, such as regulations governing moonlighting.

Overall, say the authors, the ACGME preempts and exceeds the power that most local unions have. However, there are some drawbacks to using the ACGME as a regulatory body in this instance. The ACGME has only blunt tools, such as removal of accreditation, to deal with violations of requirements; furthermore, there is a delay in providing feedback to programs because residency review committee citations are generally compiled over several years. Because of these factors, resident unions may be in a better position than the ACGME to bring about changes more expediently. The authors conclude that for it to become a proxy for resident unions, the ACGME would need to find more precise methods for timely feedback to both residents and hospitals, as well as more powerful tools for regulatory enforcement.

Lypson ML, Hamstra SJ, Colletti L. Is the Accreditation Council for Graduate Medical Education a suitable proxy for resident unions? Acad Med 2009;84(3):296–300.

Association between Gender and Faculty Evaluations

Is there gender bias in the global evaluations of medical trainees? Previous studies have indicated that this is the case; however, these studies compared global ratings of various domains of competence. Less is known about whether the gender of the trainee and/or the attending physician is associated with the evaluation of clinical skills through direct observation by faculty. Therefore, Eric S. Holmboe, MD, and colleagues undertook a study to examine the potential interaction of the gender of faculty and residents on the evaluation of the clinical skills of medical interviewing, physical examination, and counseling.

The study involved 40 clinician–educators from 16 internal medicine residency programs, who were shown a series of nine scripted videotapes that depicted varying levels of residents' clinical performance. The researchers looked for differences in the ratings of female versus male faculty members, in relation to differences in the residents' gender.

The investigators found that there were no statistically or educationally significant differences in the rating of clinical skills that were attributable to the gender of either faculty or students in any of the three areas of medical interviewing, physical examination, or counseling. They find this result encouraging, as it suggests that gender bias in evaluation may be decreasing, particularly when specific skills are observed by faculty members. The authors call for additional research to see whether the findings of this study will translate to actual training settings.

Holmboe ES, Huot SJ, Brienza RS, Hawkins RE. The association of faculty and residents' gender on faculty evaluations of internal medicine residents in 16 residencies. Acad Med 2009;84(3):381–384.

Effect of Work Hours Reform on Workplace Ethics

Most debate about resident work hours reductions has focused on providing the safest environment for training and patient care; however, the impact of these changes on the development of residents' empathy and moral character has not been studied. The reduction in work hours raises concerns about the development of a “pass-off” mentality in patient care, in which the availability of patient care and compassion depends arbitrarily on the clock, observe Lenny Lopez, MD, MDiv, MPH, and Joel T. Katz, MD. They note that rushed physicians in the clinical encounter may be less likely to go beyond the required technical aspects of medical care, and that optimizing empathic connections with patients requires time.

Although work hours regulations are beneficial in that they reduce fatigue—and therefore, possibly, stress and burnout—they are insufficient to optimize an ethical work and training environment, say the

authors. They assert that ethical behavior can be supported by systems that make it more difficult to veer away from the ideal. Changes must be implemented to deal with the tension between self-sacrifice and self-health that exists because the provision of medical care is unpredictable in nature.

The authors feel that the medical profession should develop new standards for individual accountability within a team of providers. The rules for call systems and work hours should be flexible enough to allow for occasional situations in which residents may remain with patients beyond their allotted work time. Team practice must balance the role played by the attending physician in bridging the continuity gap with the need for residents to have increasing autonomy. The time spent in patient care should be devoted to tasks directly related to patient care and should be measured in meaningful terms, such as time spent with patients, quality of communication, patient outcomes and satisfaction, resident learning, and professional development.

Training physicians in a stressful environment, say the authors, will lead to ethical erosion, not better physicians. Rested and emotionally balanced physicians, however, can be more empathically present with their patients and colleagues.

Lopez L, Katz JT. *Perspective: Creating an ethical workplace: reverberations of resident work hours reform.* Acad Med 2009;84(3):315–319.

Reforming the First-Year Internal Medicine Residency Curriculum

Current concerns about graduate medical education in internal medicine center around the lack of coordination between training and practice environments; absence of commitment to quality, safety, and evidence-based medicine; inadequacy of ambulatory training; excessive commitment to service over education; and the declining interest in pursuing internal medicine careers. William Gustin, MD, and co-workers discuss reforms to the first year of the internal medicine program at University of California, Irvine, which incorporated educational principles,

a commitment to education over service, and a clear view of the education experience that is central to internal medicine training.

The curriculum designers first created Doctoring Skills Rotations 1 and 2 (DSR 1 and 2), two new four-week first-year rotations. Each was designed entirely around educational goals and benchmarks with patient interactions integrated to support the educational goals. Time for these rotations was carved out of inpatient rotations and overnight coverage requirements; each rotation included time for study and reflection, with the ultimate goal of attainment of core objectives rather than broad and haphazard clinical experiences.

DSR 1 has an inpatient focus, with two curricular goals: achieving and documenting competence in the core clinical skills of communication, history taking, physical diagnosis, evidence-based medicine, and medical decision making; and achieving competence in clinical bedside teaching. In DSR 2, which has an ambulatory focus, residents are taught in the context of actual patient care. Faculty members supervise only two residents at a time, allowing faculty to directly observe resident performance and provide valuable feedback. Whereas DSR 1 focuses on problem-based learning with advanced skills in medical information management and critical appraisal, DSR 2 concentrates on point-of-care resources and integration of evidence into decision making and patient communication at the point of care.

Gustin W, Batra R, Amin A, Rucker L. *Education first: reforming the first-year curriculum of the internal medicine residency.* Acad Med 2009;84(3):368–373.

Using Microsystems and QI to Improve Internal Medicine Residency Curriculum

In 2006, the Residency Review Committee of the ACGME created the Education Innovation Project (EIP), an alternative pathway to accreditation for high-performing programs, which would be based on educational and clinical outcome measures, the centrality of patient safety and quality of care, and creativity, rather than on the more

traditional process-based standards followed by most programs. Anjala V. Tess, MD, and colleagues report on the first 18 months of the Beth Israel Deaconess Internal Medicine Residency EIP.

In addition to training residents in delivering outstanding patient care, teaching colleagues and students, and conducting scholarly investigation, the EIP also attempts to train residents to become health care leaders. The EIP combines two major interventions designed to synergistically enhance residents' knowledge, skills, attitudes, and participation in health care system design and quality improvement (QI):

- ❖ A large-scale reorganization of the clinical care delivery model and inpatient medical teaching service into geographically localized clinical microsystems to effectively integrate QI and patient safety concepts into residents' daily clinical practice.
- ❖ A focused educational intervention designed to give a foundational understanding of QI and patient safety to all residents.

Under the EIP, the inpatient medical service was reconfigured to function around geographically based units, or microsystems of care, in which residents, nurses, and staff could function in integrated teams physically colocated around shared patients. In this system, the resident becomes an integral component of a patient's multidisciplinary health care team. Furthermore, residents review more than two-thirds of all cases presented at monthly departmental QI committee meetings (compared with only 10% before institution of the EIP).

Since the initiation of the EIP, residents report significant improvement in the quantity of teaching, patient load, and level of autonomy, as well as in the overall value of their inpatient general medicine rotations.

Tess AV, Yang JJ, Smith CC, Fawcett CM, Bates CK, Reynolds EE. *Combining clinical microsystems and an experiential quality improvement curriculum to improve residency education in internal medicine.* Acad Med 2009;84(3):326–334.