ACGME Update

Presentation to ARCS
Surgical Education Week
Boston, Massachusetts
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RRC—Surgery Members

- **Thomas V. Whalen, MD, Chair**
- **James C. Hebert, MD, Vice Chair/Incoming Chair**
- **Paris Butler, MD, Resident**
- **Timothy R. Billiar, MD**
- **G. Patrick Clagett, MD**
- **Ronald Dalman, MD**
- **Peter J. Fabri, MD**
- **Linda M. Harris, MD**
- **G. Whit Holcomb, MD**
- **J. Patrick O'Leary, MD**
- **Marshall Z. Schwartz, MD**
- **Charles W. Van Way III, MD, Incoming Vice Chair**
- **Marc K. Wallack, MD**
- **Frank Lewis, MD, Ex-Officio ABS**
- **Patrice Blair, MPH, Ex-Officio ACS**

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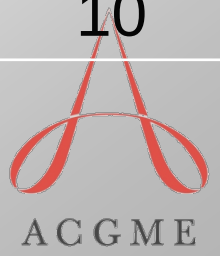
Accredited Programs

	Total Programs	Cont. Accred.	Initial Accred.	Other
Surgery	246	233	4	9
Pediatric Surgery	38	35	3	0
Critical Care	96	86	10	0
Vascular-Independent	101	94	6	1
Vascular-Integrated	26	6	20	0
Hand	1	1	0	0
TOTAL	508	455	43	10



Site Visit Results 2010

- 253 programs were surveyed
  - 68 administrative requests at meetings
  - 283 administrative interim decisions
- 387 citations issued by RRC
  - (2.09 citations per program)
- Average cycle length: 3.89 yrs.
- Common Citations
  - Education Program – Procedural Experience
  - Evaluation– Residents, Faculty, Program

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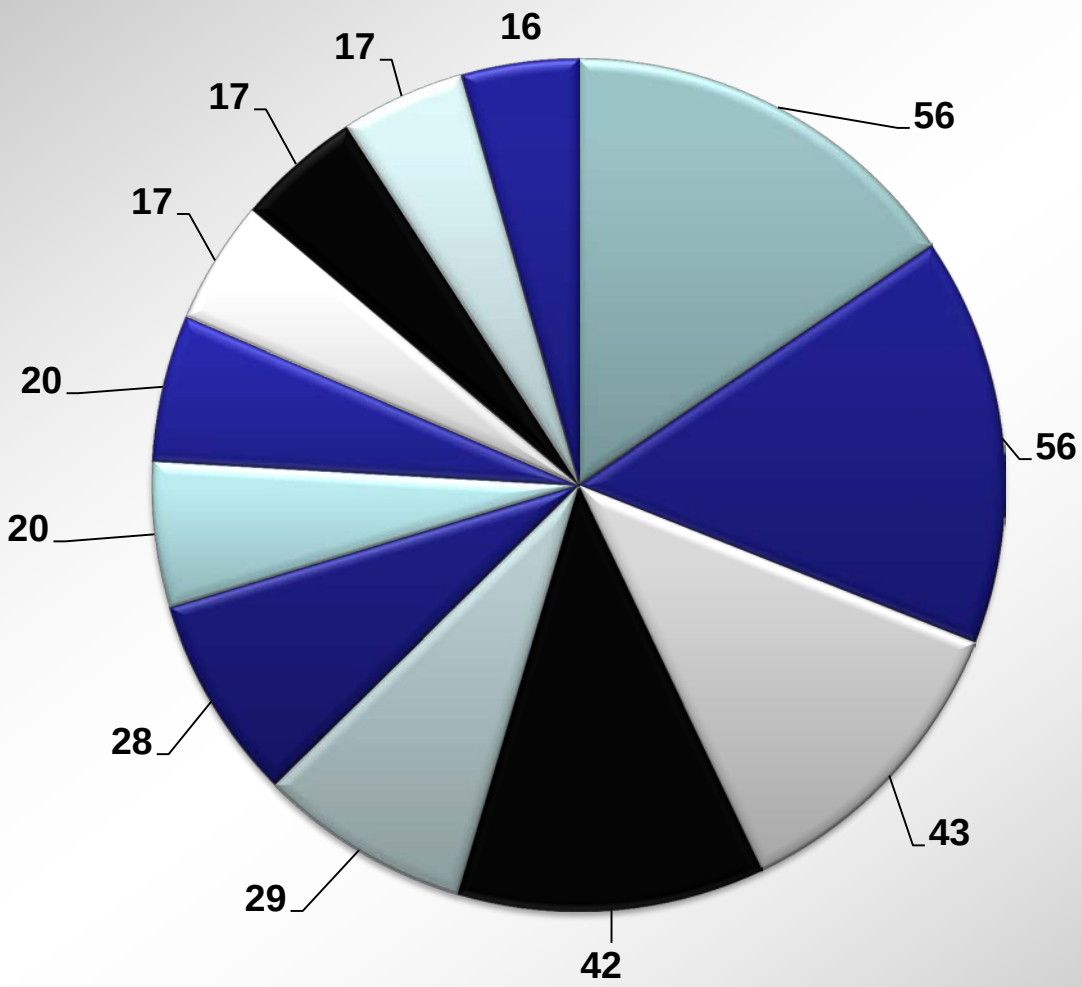
2010 Top Areas of Citation



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Resident Complement

- RRC approves by level and type
- Any changes ***must*** be approved in advance
  - “Exchanging” position types must be requested in advance
- All requests must be submitted through ADS and include DIO approval

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International Participating Sites

- International Sites permitted now permitted by RRC and ABS
  - Must apply through ADS
  - Must be electives
  - Program cycle must be =>than 4 years
  - ABMS Certified Program faculty must accompany resident to supervise
  - Unique Educational Rationale
  - Required conferences
  - No Chief rotations

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International Participating Sites (cont.)

- Access to Library
- Cases must be logged
- Physical environment must be satisfactory
- Salary, travel expenses, local licensure, insurance
  - Health insurance
  - Evacuation insurance
- PLA must be in place

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New Common Program Requirements

- Effective 7/1/2011
- Specialty Specific language for Surgery and Surgery Sub-specialties approved
- FAQs will be posted on ACGME Surgery RRC webpage

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New Common Program Requirements

- VI.D.1. - In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient's care.

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New Common Program Requirements

- I.D.5.a).(1) - Supervision of Residents: In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.

- FAQ-1

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New Common Program Requirements

INDIRECT SUPERVISION

- Patient Management Competencies
  - evaluation and management of a patient admitted to hospital
  - pre-operative evaluation and management
  - evaluation and management of post-operative patients
  - transfer of patients between hospital units or hospitals
  - discharge of patients from the hospital
  - interpretation of laboratory results

- b. Procedural Competencies
  - performance of basic venous access procedures, including establishing intravenous access
  - placement and removal of nasogastric tubes and Foley catheters
  - arterial puncture for blood gases

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New Common Program Requirements

DIRECT SUPERVISION:

- a. Patient Management Competencies
  - initial evaluation and management of patients in the urgent or emergent situation,
  - evaluation and management of post-operative complications,
  - evaluation and management of critically-ill patients, either immediately post-operatively or in the intensive care unit,
  - management of patients in cardiac or respiratory arrest (ACLS required)
- b. Procedural Competencies
  - carry-out of advanced vascular access procedures, including central venous catheterization, temporary dialysis access, and arterial cannulation
  - repair of surgical incisions of the skin and soft tissues
  - repair of skin and soft tissue lacerations
  - excision of lesions of the skin and subcutaneous tissues
  - tube thoracostomy
  - paracentesis
  - endotracheal intubation
  - bedside debridement

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New Common Program Requirements

- VI.E. - Clinical Responsibilities: The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.
- FAQ-2

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New Common Program Requirements

All members of the team should be instructed in:

- recognition of and sensitivity to the experience and competency of other team members;
- time management;
- management skills to prioritize tasks as the dynamics of a patient's needs change;
- recognizing when an individual becomes overburdened with duties that cannot be accomplished within an allotted time;
- communication, so that if all required tasks cannot be accomplished in a timely fashion, appropriate methods are established to hand off the remaining task(s) to another team member at the end of a duty period;
- signs and symptoms of fatigue not only in oneself, but in other team members;
- Compliance with work hours limits imposed at the various levels of education; and,
- Team development

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New Common Program Requirements

VI.F. - Effective surgical practices entail the involvement of members with a mix of complementary skills and attributes (physicians, nurses, and other staff). Success requires both an unwavering mutual respect for those skills and contributions, and a shared commitment to the process of patient care.

Residents must collaborate with fellow surgical residents, and especially with faculty, other physicians outside of their specialty, and non-traditional health care providers, to best formulate treatment plans for an increasingly diverse patient population.

Residents must assume personal responsibility to complete all tasks to which they are assigned (or which they voluntarily assume) in a timely fashion. These tasks must be completed in the hours assigned, or, if that is not possible, residents must learn and utilize the established methods for handing off remaining tasks to another member of the resident team so that patient care is not compromised.

Lines of authority should be defined by programs, and all residents must have a working knowledge of these expected reporting relationships to maximize quality care and patient safety.

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New Common Program Requirements

- VI.G.5.b) - Minimum Time Off between Scheduled Duty Periods: Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.
- PGY-2 and PGY-3 residents are considered to be at the intermediate level.

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New Common Program Requirements

- VI.G.5.c) - Minimum Time Off between Scheduled Duty Periods: Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular
- Residents at the PGY-4 level and beyond are considered to be in the final years of education.

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New Common Program Requirements

- VI.G.5.c).(1) - Minimum Time Off between Scheduled Duty Periods: This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

- FAQ-3

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New Common Program Requirements

- Continuity of care for patients, such as for:
  - a patient on whom a resident operated/intervened that day who needs return to the operating room (OR);
  - a patient on whom a resident operated/intervened that day who requires transfer to the Intensive Care Unit (ICU) from a lower level of care;
  - a patient on whom a resident operated/intervened that day who is in the ICU and is critically unstable;
  - a patient on whom a resident operated/intervened during that hospital admission, and who needs to return to the OR for a reason related to the procedure previously performed by resident; or,
  - a patient or patient's family with whom a resident needs to discuss limitation of treatment/DNR/DNI orders for critically-ill patient on whom the resident operated.
- a declared emergency or disaster, for which the residents are included in the disaster plan; or,
- to perform high profile, low frequency procedures necessary for competence in the field. Program would need to demonstrate marginal numbers of complex cases and resident not at minimum required number for the area

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New Common Program Requirements

- VI.G.6. - Maximum Frequency of In-House Night Float: Residents must not be scheduled for more than six consecutive nights of night float. [The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

- Residents must not be scheduled for more than six consecutive nights of night float.

- Night float rotations must not exceed two months in duration, and there can be no more than three months of night float per year. There must be at least two months between each night float rotation.

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Agenda Closing Dates

- Meeting: June 23-24, 2011
  - Agenda Closing: April 14, 2011
- Meeting: November 3-4, 2011
  - Agenda Closing: August 25, 2011
- Meeting: February 16-17, 2012
  - Agenda Closing: December 8, 2011
- Meeting: June 21-22, 2012
  - Agenda Closing: April 12, 2012

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THANK YOU

FOR ALL OF YOUR TIME AND EFFORT!!

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Questions

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