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From the Editor

ACGME Competencies: The Curricular Challenge

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From The Editor

ACGME Competencies: The Curricular Challenge

Like many medical educators, I have had the privilege of interviewing scores of senior medical students in their quest for house officer positions in our large and competitive Internal Medicine training program at Jefferson University Hospital. Every fall for the past 14 years, I have been impressed by their youthful enthusiasm and earnestness about the pending launch of their clinical careers. I am also struck by the tone and tenor of their accompanying letters of recommendation, which gleefully point out that each applicant appears to walk on water at least every third day and regularly performs clinical miracles with his patients.

I often wistfully find myself yearning for a more rigorous outcomes-based evaluation of each applicant's skill set and evidence about the outcomes of the care they have been delivering. I have reflected on my own experience as an attending (General Medicine Attending in 1995: Observations and Reflections. Vol. 8, No. 3, September 1995), and I cringe each year having to fill out the seemingly perfunctory personal evaluations on each house officer. The evaluations are a routinized checklist, which is an inadequate reflection of the weeks I have just spent with each trainee. Perhaps a better evaluation system is lurking on the educational horizon.

In February of 1999, the Accreditation Council for Graduate Medical Education (ACGME), the key national body central to the assessment of residency programs, endorsed six new general competencies for trainees. According to the ACGME, the "identification of general competencies is the first step in a long-term effort designed to emphasize educational assessment in residency programs and in the accreditation process. During the next several years, ACGME's Residency Review and Institutional Review Committees (the RRCs) will incorporate the general competencies into their requirements" (www.acgme.org). The six endorsed general competencies include patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. Henceforth, rather than concentrating only on the assessment of a program's *potential* to educate, the future for Graduate Medical Education (GME) accreditation envisioned by the ACGME Outcomes Project emphasizes a program's *actual* accomplishments through assessment of educational outcomes.

In a nutshell, there is a quiet revolution underway in GME. I would like to explore the impetus for the creation of these new guidelines, the research evidence supporting our ability to comply with these competencies, and highlight some of our future challenges. Dr. David Leach, the executive director of the ACGME, in his recent JAMA editorial¹ made an articulate case for the need for outcomes assessment in residency education. He essentially traces current physician unhappiness, at least in part, to the deficiencies in their residency training, specifically, the lack of exposure to the science of systems thinking. In other highly publicized reports like, "Training Tomorrow's Doctors," from the Commonwealth Fund² in New York, experts have noted that, "In order to function optimally, physicians need skills such as organizational behavior and management, interdisciplinary team work, group problem solving, communication across professional boundaries, and an

understanding of how changing health care environments affect the welfare and strategic requirements of health care organizations.”

Finally, other expert observers³ have claimed that “few newly qualified physicians have the skills necessary to improve care and patient safety. These include the ability to perceive and work effectively in interdependencies, the ability to understand work as a process, skill in collecting, aggregating, analyzing, and displaying data on processes and outcomes of care, skills in designing health care processes, the ability to work in teams and in collaboration with managers and patients, and the willingness to examine honestly and learn from mistakes.” Regrettably, in my own view, I fully concur with these aforementioned indictments of medical education.

Is there research evidence that we can turn to to support the transmogrification of medical education necessary to comply with these new general competencies from the ACGME? While an exhaustive discussion of the research evidence is not appropriate for this space, I would urge readers to look at the work of several individuals and organizations. For example, Drs. Aron,³ Headrick,⁴ Weingart,⁵ and Kane⁶ have described fascinating but isolated attempts to engage trainees in varying projects with a population-based perspective. It turns out that house officer driven organizational problem solving to address prescription errors and lost laboratory data really works. Even changing the time and tone of morning report has an impact on house officer understanding of “systemness” in health care.

In my own view, I am confident that we can tackle patient care, medical knowledge, professionalism, and interpersonal and communication skills. It’s that practice-based learning and systems-based practice that turn heads for medical educators. Groups that have demonstrated leadership in systems-based practice and practice-based learning include the Partnerships for Quality Education (PQE) based at Harvard Medical School. I have previously reported on PQE (The Pew Charitable Trusts Managed Care/Academic Health Center Partnership. Vol 10, No. 2, May 1997) and would ask readers to visit their website at www.pqe.org. Dr. Gordon Moore, at Harvard Medical School, has led PQE since its inception and they have explicitly connected competencies in managing care with the need for curricular reform in medical education. Perhaps, we really can learn to comply with the ACGME through a better understanding of the tenets of managed care practice.

The Tufts Health Care Institute, also in Boston at www.tmci.org, is another national leader in this field. Their online and CD-based modules could serve as an outstanding platform for compliance with the ACGME competencies. Rosalie Phillips is their founder and guiding light. I am personally heartened by the unexpected scope and depth of the research evidence I have reviewed.

Finally, the private sector is also responding. Some of us are working closely with MedCases, a Philadelphia-based firm with an enviable track record in responding to the needs of medical educators. MedCases, with the leadership of persons like Dr. Jeffrey Levy, is also creating interactive web-based tools to help program directors respond to the ACGME. Many people are doing many good things without the “carrot and stick” of the ACGME hanging over their head. These educational leaders deserve further inquiry, support, and encouragement.

How will medical education respond in the near future to the challenges represented by the ACGME outcomes project? Clearly, by holding residency programs

responsible for achieving these six competencies, academic health centers must rededicate themselves to protecting a "learning environment." This will create tension between the service component of care and the educational component. Of course, this has been well described many times by some of our most thoughtful leaders.⁷ I see several key challenges in addition to the classic dilemma of service vs. education. Among these future challenges is the immediate need for widespread faculty development on the background and tools necessary to teach these competencies. This is especially true for practice-based learning and systems-based practice. My hunch is most well-meaning, successful medical school faculty could not currently adequately define either of these two competencies!

We need curricular tools and techniques to evaluate the impact of the new programs we might institute in response to the ACGME. In short, I believe we lack adequate evaluation techniques to measure the outcome of practice-based learning and systems-based practice. A routinized evaluation form with a Lickert Scale checklist may not capture the complexity inherent in the concepts of systems-based practice.

This past fall, our Dean, Thomas Nasca, MD, led a faculty-wide retreat including every residency program director from our university hospital to begin the arduous self-evaluation necessary to create a curriculum compatible with the ACGME competencies. Many faculty members are now fully engaged in this process affecting every specialty from medicine to dermatology. In the final analysis, despite current hand wringing, the ACGME outcome project will serve as our roadmap for the 21st century akin to the directions that bracketed the 20th century from Flexner to Ludmerer. We would be happy to share our resources on systems-based practice with our readership. Please visit our website at <http://jeffline.tju.edu/OHP/>. As usual, I am interested in your views and you can reach me at my email address david.nash@mail.tju.edu.

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