ACGME Accreditation, Resident Unions, and the Centrality of Patient Welfare

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> *"… the ACGME cannot and will not replace resident unions, associations, or other groups where residents perceive the need arising for the presence of these organizations."*[1]

This was the concluding sentence of a 2009 commentary in response to a call[2] that the Accreditation Council for Graduate Medical Education (ACGME) might assume the role of unions for residents. In that commentary, the authors clarified the ACGME's role as an educational accreditor, its philosophical basis for accreditation functions, the primary role of residents as students, and the ACGME's mission[3] to improve health and health care of the public. In articulating these distinctions, the authors described the difference between the role of the ACGME and that of resident unions—a position we reaffirm.

The Limits of Accreditation

The ACGME, as an independent not-for-profit organization, has as its primary responsibility to oversee the preparation of the next generation of physicians to serve the public. The ACGME accomplishes this responsibility through accreditation of sponsoring institutions and their educational programs, and through provision of improvement and educational programs in support of graduate medical education. The ACGME sets standards for sponsoring institutions in both the employment and educational domains. Employment domains are limited to elements required to assure the resident's meaningful participation in the educational program. These include minimum required components of resident contracts, academic due process, insurance, vacation and leaves of absence, and core elements of the clinical learning environment (CLE). The ACGME also sets minimum educational standards in both common and specialty requirements. These include educational process and outcomes standards required to accomplish specialty-based graduate medical education.

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This framework of minimum employment elements required of the sponsoring institution, coupled with minimum structural and outcomes related–standards required for program accreditation are manifestations of the need to oversee the dichotomous roles of residents as students of the specialty and as employees of the sponsoring institution.

Wherever the needs of residents as employees overlap with their educational, safety, and well-being needs, there will be similarities between the position of ACGME and resident interests. Recent examples would include requirements related to parental and other leave policies, well-being, and 24/7 availability of counseling and support. However, the ACGME is limited by antitrust regulations in addressing certain dimensions of the resident-institution relationship, especially those related to compensation.

The ACGME, for example, requires that resident employment be governed by a contract that is available to residents during the interview process and stipulates that the sponsoring institution "must provide all residents/fellows with financial support and benefits to ensure that they are able to fulfill the responsibilities of their ACGME-accredited program(s)."[4] The ACGME requires that there be a Resident/Fellow Forum[5] to permit residents to raise questions or surface concerns with the sponsoring institution, its designated institutional official, and the Graduate Medical Education Committee. Were the ACGME to further stipulate or quantify financial support, the ACGME may be accused of anticompetitive behavior.

In circumstances where the forum or other systems fail to resolve a benefits dispute and residents complain to the ACGME, the institution may be found in violation of one or more standards. However, the ACGME is not in a position to mandate a solution to the benefits disagreement that precipitated the unearthing of the violation. In such circumstances, unionization of residents might be a solution chosen by residents to address these issues.

The Changing Clinical Learning Environment

The CLE is the cauldron from which emerge the next generation of physicians to serve the American

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public. Within this crucible, the work of medical professionals is increasingly controlled by corporate entities. The ACGME establishes educational requirements that exist in dynamic tension with other powerful forces placing productivity and other pressures on faculty as health care is commodified and financialized.

The COVID-19 pandemic, in turn, both masked and exposed rifts in the fabric of the CLE, exposing the fragility of the learning environment. Physicians placed their lives and those of their families at risk to serve the public in their time of greatest need. This honoring of the altruistic foundation of the Hippocratic Tradition was counter to some who predicted that contractual commitments were required in order to assure that physicians would "stand the line" in a pandemic.[6] Moving forward, it is reasonable to ask if they will continue to so stand, having experienced the public backlash, disinformation about immunizations, as well as the disdain and overt violence that many experienced from patients and families. Will they stand again knowing that their needs for equipment and support would be a football tossed about for political benefit? Do residents still believe that those in charge of the CLE will provide for their safety and well-being? We suspect that the responses of residents and faculty to these questions are a resounding "no" in many of our sponsoring institutions. It is not surprising, then, that we see an apparent acceleration in interest in unionization of residents following the expiration of the federal public health emergency for COVID-19.[7]

Residents have long been viewed by many in leadership roles of sponsoring institutions as the future lifeblood of their medical staffs.[8] They were protected, positioned to learn, and the service they provided to patients was seen as a *valuable by-product* of their rigorous preparation under the supervision of faculty who were provided the time and tools to educate. This investment by the faculty resulted from their professional responsibility to prepare the next generation, and from the benefits of having one's patients on a teaching service. Faculty reimbursement for clinical care was sufficient to subsidize the time spent supervising residents and fellows. Enlightened administrators were hesitant to disrupt this salutary cycle. This conflation of mutually supportive interests, commitments, and support is no longer present in most of our CLEs. In recent years, the transformation of the CLE under the comingled pressures of managerialism and market forces has been profound.

Productivity pressures, loss of control over structuring of clinical care and their role, and the attendant moral injury of an inability to provide excellence in patient care and education have disrupted the synergistic salutary relationships between faculty and residents and fellows. The financialization of health care[9] with its attendant introduction of the passive profit motive into the structure and operation of health care institutions and specialty practices has set off what might kindly be seen as a nonvirtuous cycle, which is now reaching into graduate medical education. The ACGME has watched residents be used as inexpensive labor, scheduled to work 80 hours each week, misusing the ACGME standard of "no more than"[10] as a target, all with little attention to their educational goals. The ACGME receives with concern complaints alleging that institutional officials, be they physicians or those from other backgrounds, threaten residents and faculty lest they report violations to the ACGME, or speak the truth in their annual surveys. Parallels to the impact of financialization at Boeing Corporation[11] on quality and safety are unavoidable, especially given the irony that the airline industry is often held up as one for American health care to emulate.

Educators have turned to the ACGME for standards to codify financial and time support for faculty in response to clinical productivity pressures in the CLE, concerned that the absence or insufficiency of a countervailing ACGME financial standard for faculty support would result in inadequate resident education. In programs that have experienced deterioration in faculty education and supervision, it is little wonder that residents have turned to unions as part of a response to these disturbing trends.

In the context of the intrusions of managerialism, commercialism, commoditization, and financialization, resident unionization might best be viewed as a symptom, a principled response to the forces manifest in their CLEs. We worry, however, that residents, in this pivotal time in their professional identity formation, will have their commitment to effacement of self-interest in service to those they promise to protect and heal be irrevocably altered by the profession's collective failure to ensure the developmental integrity of the CLE.

The Way Forward: Reinventing the Mission-Margin Equation

We believe American medicine is at an inflection point. Either it continues down the path of increasing commercialization, commoditization, and profit-based economic rationalization of health care where greed and organizational self-aggrandizement are the unstated yet guiding "virtues," or the institutions begin to transform themselves into settings where professional values undergird systems that actually put patients first.

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What needs to be accomplished to achieve this transformation? We believe that health care organizations must function at the ***"top of their license."*** Health care organizations are licensed by states to provide safe health care services to their population.[12] Functioning at the "top of their health care organization license" means that organizational resources are channeled to produce optimal clinical care for each patient, where faculty and residents (and all professionals) can optimally manifest their professional values and skills in care of patients. The purpose of a health care organization is not to make money. It is to provide excellent health care. Money is one tool among many required to accomplish that purpose. It must not be seen as an end in and of itself.

Patients are not inanimate objects brought to a repair shop for some version of a transmission swap-out. Hospitals are not commercial entities that seek to sell the goods they produce to those able to pay. Each patient requires customized care and compassion in addition to caregiver expertise. Systems should be configured to provide clinicians with the resources to reach their full potential at the bedside, in the clinic, or in the operating room, as patients achieve their health care goals. To accomplish these ends, professional values must permeate organizational structures and functions. Only then will physicians and other health care professionals have meaning in their work with patients, satisfaction in their professional circumstances as they meet the needs of their patients, and outcomes deserved by the American public for their investment in the most costly health care delivery system in the world.

The drive for institutional profit, self-aggrandizement, or greed[13] must be supplanted by the desire to meet patient needs using the available funding sources to accomplish this goal, which we believe to be inextricably linked to the ability of institutions to function at the "top of their license." **We propose the maxim "No Margin, No Mission" be replaced by "No Mission, No Margin."** This is not to imply that attention to resources is not pivotal to the success of the health care mission. Rather, attention to resources and their proper deployment in support of the mission is necessary, but not sufficient, for organizations to deliver health care at the top of their license.

In order for institutions to function at the top of their license, physicians and other health care professionals, along with patients and administrators, will need to participate and sacrifice in this refocusing of the organization around the centrality of the patient. Administration must establish transparency and trust with the workforce to assure all funds are fairly and appropriately marshaled in support of the mission. Each of us must do our part to return our health care institutions to their core purpose.

Excellence at the bedside must reemerge as an element of system design.[14] Escalating expectations regarding clinical volume productivity must be rationally set in the context of patient needs and clinician well-being. Excessive documentation of health care provided for billing purposes, and insurance company and governmental administrative friction, must be removed to free clinicians to fulfill their professional oath.

We believe it is time for all to demand that the values undergirding individual professionalism be expressed in the design, implementation, and operation of our health care institutions.[15] In addition to professionalism of physicians, nurses, and others involved in health care delivery, it is critical that professionalism at all levels of the health care system be sustained for the good of those who are served. It is paramount that circumstances are avoided where threats to withhold services are used for individual or collective gain. Health care professionals must return to placing the needs of others before themselves and their institutions, and health care institutions must be reconfigured to place the needs of their patients first. It is time to remove cognitive dissonance-causing circumstances where putting the patient first is espoused, yet systems are designed where physicians, nurses, and others involved in health care delivery are unable to provide the care that they know actually puts the patient first.

The foundational "top of license" changes in the clinical learning environment are beyond the scope of the ACGME to regulate. The clinical context, the structures of health care delivery, and health care economics are not the purview of the educational accreditor. Yet they clearly impact the educational context and the hidden curriculum. For all these reasons, it is time that professional values be built back into our clinical care and CLEs, for the well-being of our patients and the clinicians who serve them, as well as the next generation of professionals being educated in the environment today.

Conclusion

We believe that the current discussions related to resident unionization are best seen as a symptom of the circumstances we and others describe.[16] Further, we believe that residents and practicing physicians may find attractive the leverage offered by unions to address deterioration of the clinical learning and care environment unless the professions are successful in motivating change. Unions are effective in addressing elements of employment disagreements. Nonetheless, there may be a price to be paid in return. Unions ultimately garner their leverage through the threat of withholding member services. We believe

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that the implicit threat of withholding physician clinical services for self-gain is the antithesis of our conceptualization of effacement of self-interest and risks breaching the trust between the profession and society. Ultimately, if we are unable to avert the circumstances that lead to resident unionization, that hypothesis will be tested.

Rather, we propose that, institution by institution, governance, administration, departmental and unit leadership, and each individual be refocused to make real our professional values at individual and institutional levels. We call on each institution to place patients at the center of all efforts, to surround patients with professional staff and students who are provided with the tools and circumstances required to meet the needs of their patients, and to fulfill the social contract with the public. For the benefit of today's patients, and residents who will provide the patient care of tomorrow as they carry the professional identity they form today into the future,[17] the current era of margin over mission must end. Instead, we envision a future where mission displaces margin as the primary value within our CLEs, professionalism is fostered throughout the organization, and the patient is placed at the center of all we do.

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