Beyond Must: Supporting the Evolving Role of the Designated Institutional Official

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What *Must* I Do Today?

Our daily schedules often require that we balance our professional and personal obligations. Accomplishing the tasks of the day must be done with particular efficiency to ensure timely arrival at evening events such as the family meal or an open house at school for one of our children. Barring an unpredictable graduate medical education (GME) crisis (the frequency of which practically demands that we should all build protected time for the unpredictable into our daily schedules), our role as designated institutional officials (DIOs) for 3 large teaching institutions gives us daily exposure to a series of *musts* that define the DIO's role. A normal day includes editing and signing that program information form that must be mailed the next day, reviewing the results of resident surveys posted today, preparing for the upcoming GME committee meeting, and continuously prioritizing the multiple roles and responsibilities of the DIO. The role is essentially defined by the 91 times the fateful word *must* appears in the Accreditation Council for Graduate Medical Education (ACMGE) Institutional Requirements.[1]

The importance of this 4-letter word to the GME community was underscored by Drs Batalden and Leach[2] in their editorial in the inaugural issue of the *Journal of Graduate Medical Education* in September 2009. They commented on the increasing number of times *must* appeared in the program requirements over the first 2 decades of the ACGME, and references to must are found in almost every article published in this and the 3 previous volumes of the *Journal*.

Faithful DIOs who demonstrate substantial compliance with these dictates are rewarded with positive accreditation outcomes and up to 5 years of lessened workload and anxiety. In contrast, noncompliance with the institutional musts, any of the 72 common program requirements, or the added specialty-specific requirements such as the additional 140 musts for pediatrics is memorialized in the DIO penalty box of citations recorded in Attachment 1 of the institutional review document.

The Beginnings of the DIO Role

The recorded history of the DIO began in 1998, when the ACGME created the new position and required that each institution with accredited residency or fellowship programs appoint a senior institutional leader to oversee the programs it sponsors. Most institutions had an associate dean or other senior official responsible for GME for many years before 1998, yet the inauguration of the DIO role focused a growing portion of the effort of these individuals on "institutional oversight" and the continually evolving ACGME requirements for sponsoring institutions, including the competencies and the standards limiting resident duty hours.

Must and Beyond

The eighth must in the institutional requirements defines the DIO as the person who "….in collaboration with a Graduate Medical Education Committee, must oversee all ACGME-accredited programs of the sponsoring Institution."[1] Considering that the term DIO was not introduced into the institutional requirements until 1998, one could argue that the increase in volume of musts over the preceding 20 years of accreditation created a particular need for a DIO. Ironically, although the tide of must requirements appears to be receding somewhat (although this may be camouflaged by lumping versus splitting behavior), the role of the DIO seems to be geometrically increasing and evolving way beyond the must. The recent inclusion in the institutional review document of naming a designee is another subtle recognition of the magnitude of DIO responsibilities.

Defining this expanding role of the DIO is challenging. Riesenberg et al[3] identified competencies for DIOs, including professionalism, verbal communication skills, interpersonal skills, leadership skills, and written communication skills, and suggested that resources such as templates for policies, contracts, and affiliation agreements would be useful to the position. A monograph from the June 2008 Association of American Medical Colleges Group on Resident Affairs[4] provides a comprehensive overview of leadership roles for DIOs, dividing them into 11 competencies using a 3-level Dreyfus model of competent, proficient, and expert. Although knowledge of and compliance with must remain central to many of the domains, the somewhat daunting and ever-expanding roles

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of the DIO include managing GME budgets, providing guidance on legal matters, functioning effectively in the larger medical context, working strategically in the health policy context, and being attentive to one's own professional development as well as that of GME leaders and protégés.

DIOs and the Need for GME Infrastructure

The ACGME is rightly focused on the educational outcomes of residents. At the same time, this expanding focus on outcomes creates needs for DIOs that go beyond the role and competencies described by Riesenberg and colleagues. They include enhanced institutional GME infrastructure to facilitate outcomes-focused resident education. It is intuitively appealing for educational outcome to become the responsibility and focus of institutional leaders; but it is difficult to conceive how good individual educational outcomes can be achieved if the program or institution is performing poorly.

Thus, GME outcomes are tightly linked across the multiple levels of GME within an institution, and it is difficult to envision that good educational outcomes could be achieved without a robust GME infrastructure. By default, the office of GME and the DIO must focus on educational and administrative operations to eliminate process variation that may contribute to unacceptable outcomes. The most effective way to create uniform processes is for this institutional infrastructure to include an adequate number of personnel with expertise not only in medical education but also in state law related to licensing, visa issues, and legal expertise for formulating resident contracts and agreements with participating institutions, as well labor law and other relevant areas. This expertise does not exist at the level of each individual program, and institutions with a strong focus on excellence in GME must invest in the personnel with this expertise to create the infrastructure that programs can rely on. Given the volume of data needed for robust outcomes assessment, this infrastructure must also rely heavily on information technology to enable easy data entry, storage, aggregation, and analysis at the individual, program, and institutional levels.

Once this infrastructure is created, the value of GME programs can be more easily recognized in their economic impact and also in summarizing key aspects of program and institutional performance for external reporting agencies such as the Joint Commission, the Centers for Medicare and Medicaid, and others. In their article entitled "The Direct, Indirect, and Intangible Benefits of Graduate Medical Education Programs to Their Sponsoring Institutions and Communities," Pugno et al[5] highlight such benefits.

Another benefit of expanded GME infrastructure through the GME office and the role of the DIO is the development of an ongoing series of meetings for program directors and coordinators that provide opportunities for networking on GME-related issues, the sharing of best practices, and the dissemination and discussion of important information. Institutions with successful GME programs have been able to create value in this GME community and thus buy in for adopting standard processes designed to eliminate the variability in process that leads to less acceptable outcomes. This is highlighted in the piece by Scott Cottrell et al,[6] "An Institutional Approach to Assist Program Directors and Coordinators with Meeting the Challenges of Graduate Medical Education," and the piece in the "ACGME News and Views Section"[7] describing the findings of the ACGME's Learning Innovation and Improvement Project.

An example of how a standardized process in GME helps program directors and coordinators meet the challenges of GME is reflected in Kathryn Andolsek's piece "Use of an Institutional Template for Annual Program Evaluation and Improvement: Benefits for Program Participation and Performance."[8] These are just a few examples of how a highly functioning GME office can achieve desirable outcomes for individual learners, programs, and institutions. Institutions must invest in the infrastructure of GME. The institutional requirements specify support for the DIO and program directors. Support for the GME office is more generic and covered in section I.B.5.c: "The Sponsoring Institution and the program must ensure sufficient salary support and resources (eg, time, space, technology, supplies) to allow for effective administration of the GME Office and all of its programs."[1] Depending on the institution, this requirement can be variably interpreted. The institutional investment can be just enough to get by or endeavor to achieve what the authors in the institutional matters section of this June issue are trying to achieve: institutional excellence.

Competencies for the Present and Future Role of the DIO

If the list of DIO "competencies" and expectations described previously is not daunting enough, institutional leaders are now faced with developing ways for physician trainees not only to survive but to thrive in a new era of medicine marked by health care reform. In its June 2009 report to Congress, the Medicare Payment Advisory Commission[9] commented that despite Medicare spending an estimated $9 billion in 2008 to support physician education and training, there is concern that health care professionals are not gaining the skills they will need to provide the kind of care that will best serve the American public. The report suggested that medical education reforms will be a key component in transforming the nation's health care delivery system from one that historically has focused on care for acute illness—at the expense of chronic condition management, coordination of care across settings, and disease prevention—to one that values patient-centered care, quality improvement, and resource conservation. The

report focuses on the development of a new set of skills for physicians in training including quality measurement and improvement, care coordination, multidisciplinary team work, cost awareness, safety consciousness, and health information technology competence.

Institutions that have been successfully incorporating this type of training into their medical education systems have been lead by DIOs able to work collaboratively with administration and across residency programs to accomplish collectively what no one program has the resources to achieve alone. Learning activities such as surgical simulation and team training exercises with nursing and other health care professionals are becoming commonplace in high-quality patient care and educational systems. Residents will need to be prepared to work in a medical world where performance matters, *value* is not a bad word, and improvement in performance requires a highly functional team.

Regardless of how one characterizes the roles of the DIO, the foundation for success with and beyond the must is built upon trust. Trust is like a delicate piece of blown glass—it is difficult and painstaking to create, can be easily shattered if not handled properly, and can never be fully restored if broken. DIOs must (that word again) have the trust of those to whom they are accountable, including program directors and coordinators, residents, GME staff, accrediting bodies, matching agencies, state medical boards, the press, and so forth. All look to the DIO for guidance and counsel in matters related to the institution's GME programs. Above all, the DIO must perform in a manner that will recapture and sustain the public's trust that the residents in the institution are being educated and supervised in an environment that promotes and ensures safe, high-quality patient care.

The ACGME and the Association of American Medical Colleges among other organizations have recognized and nurtured this expanding role. The growing audience in the DIO-track sessions at the annual ACGME educational conference and the popularity of the Group on Resident Affairs leadership course for DIOs and other institutional GME leaders are testimony to these efforts and the need to provide venues for the continuous professional development of DIOs. These educational opportunities must be complemented by accessibility to outcomes from evidenced-based, high-quality research and awareness of innovation in GME that support the DIO's efforts to identify best practices in safe patient care, optimal supervision, quality teaching, and effective mentoring. The articles in this volume of the journal, particularly those in the section on institutional matters provide invaluable information to permit the DIO to build confidence and trust among the GME stakeholders. Examples include the work by Dine et al[10] on how to make residents aware of their resource use and link this to patient outcomes, the description by Joyce and colleagues[11] of the use of the Kalamazoo Essential Elements Communication Checklist in an institutional communication curriculum, and the analysis by Guille et al[12] of the factors depressed residents perceive as barriers to obtaining mental health services.

The responsibilities of the DIO already include a lead role in promoting institutional oversight over multiple aspects of the GME programs. In the context of calls for an enhanced focus on patient safety and well-being of residents, an expansion of the DIO's role as an ombudsperson to hear and resolve the concerns of residents, faculty, and others related to aspects of the educational environment is conceivable but will require added resources for DIOs and the GME office. Optimal local practice will require access to information on institutionally focused best practices and benchmarking data not widely available to date, as well as data repositories that allow for easy data entry and manipulation to allow the tracking of an ever-increasing number of parameters about the quality and efficacy of the learning environment.

Back to the Present

We are certain that we have neglected some essential roles of the DIO position and that many DIOs have carried out local idiosyncratic but equally important responsibilities. Infrastructure, data, research, and practical models will be important in allowing DIOs to meet the multiple expectations of this complex role.

For now, we turn our attention back to what we must do today—dividing time among clinical duties, administrative requirements, scholarship, and interactions with faculty or staff recruits or even a reporter. We venture to each of these meetings with false hope that between or even during these meetings we can fit in time to review that late program information form, which we carry hidden in our briefcases. Oh well, there is always tonight for editing the program information form. Oops, tonight is the open house at school!!

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