This Year I Lied

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The goal of a graduate medical training program should be to produce safe, reliable, knowledgeable, skilled, prepared, and successful physicians. We require integrity, equality, and selflessness from ourselves and our trainees. The most important behavior required in medicine is honesty. Without honesty, we are not safe or reliable physicians; we are not trusted friends, family, colleagues, or members of the community, and we limit our own self-respect.

As a program director, I have exhorted my residents to always be honest, not just with our patients and colleagues, but also with our regulatory bodies, graduate medical education, and the Accreditation Council for Graduate Medical Education (ACGME). I believed that reporting the good and bad of a program should result in a focus on correcting the issues and the perpetuation of excellence. These regulatory and accreditation bodies have worked hard to assure that each resident in each program is well treated, well trained, and has the skills and support to succeed in their chosen field.

Unfortunately, with such oversight has come regulation and paperwork without direct benefit to the residents and citations against programs without explanation of expectations.[1] Process measurements appear to have overcome outcomes measurements. While the ACGME has been refining its resident/fellow and faculty surveys to increase its clarity and validity evidence, there is still no apparent attempt to correlate the results with the quality of the product of a program (fellowships, board pass rate, etc). The result is an overwhelming burden on the program, the program director, the teaching physicians, and the residents.

In an 80-hour work week, residents must care for an increased volume and acuity of patients, while now also performing research, quality improvement work, education of others, and extensive documentation.

Today's resident works shorter hours but works harder than I ever did. We expect our residents to put their patients before themselves, and to do this in a limited time. Staying late to care for a patient or to do an educational case is patient-centric and education-centric but may violate an ACGME policy. I repeatedly exhorted them to be honest about their hours, to include off-site required conferences, to include calls for patient care and notes completed at home. I support the goal of the 80-hour work week and agree that tracking hours is a valuable use of effort. Doing so protects my residents and patients from exhaustion, errors, and misuse. Hours violations are not frequent; we have worked hard to build a structure with shifts and physician extenders and manage attending expectations. So, in demanding accurate accounting of hours, my goal was to show our faculty and administration how hard these (unrespected, expensive) young people work and that they must have resources provided to keep work hour violations controlled.

But honesty in hours reporting results in citations. It is clear that by telling the truth on the ACGME survey, we are putting the program at risk. Our program, which has an outstanding boards pass rate and fellowship acceptance rate, has recently received multiple ACGME citations. These have come from the (undefined) "structure of our rotations" and (undefined) "environment of inquiry" survey results. Without definitions, it is impossible to determine what we should do to improve, and how these improvements will lead to the production of stronger physicians. These citations have resulted in even more hours worked by the program directors and program coordinator without any evidence of improvement in resident education or experience. Sadly, clear violations such as understaffed program coordinator support and overworked program directors did not lead to citations; such citations would have been welcomed and could have been used to provide leverage with administration for more resources. Additionally, the resource utilization for tracking ACGME requirements has increased to such an extent that the cost of training residents is rapidly approaching or has overtaken the cost of employing advanced practitioners. This will not go unnoticed by over-cap institutions that carry the financial burden of resident education. I do not doubt that reductions of residency positions will result, further increasing the disparity in numbers between graduating medical students and available training spots and worsening our impending physician shortage.

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So now, to the lie: This year, for the first time in 3 decades of answering to the ACGME as a resident, as teaching faculty, and as a program director, I lied on each and every question presented in the survey, and suggested to my colleges and residents that they also lie. I am certain that our program will continue to produce successful, skilled, well-adjusted, ethical physicians. However, the current focus on surveys and paperwork pushed me to lie in order to keep our program running. Lying to the ACGME when honesty is the cornerstone of all we do in medicine seems to be counterproductive to all the ACGME wishes to accomplish, yet it seems to be the result of process measures rather than outcomes measures. But even an improved survey does not mitigate the annual increase of new regulations and documentation requirements. I encourage the various societies of program directors to band together with a collective voice and demand accountability for requirements, which must be clearly defined and based on evidence that they improve educational outcomes. Research to determine if requirements change outcomes is necessary and should be done systematically across many residency programs (eg, FIRST^2). Accrediting and oversight bodies should be advocates in obtaining resources for GME programs, not the major driver of an overwhelming workload. Additional mandates without resources or supportive data only undermine the programs' and the ACGME's attempts to provide a fair, supportive, and honest educational environment.

References

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