The Residency Coordinator's Handbook, Third Edition

Ruth Nawotniak, MS, C-TAGME

Your desktop companion for managing an efficient medical residency program

The Residency Coordinator's Handbook, Third Edition, is a comprehensive manual and training resource for residency program coordinators. This newly updated and expanded version provides insight into the ACGME's Next Accreditation System (NAS), the Clinical Learning Environment Review (CLER), and how to manage a medical fellowship program. New and veteran coordinators will benefit from the guidance, sample policies, and tools they can implement immediately. This book and downloadable toolkit offers residency program coordinators the education and field-tested solutions to ensure a successful and efficiently run residency program.

What's new in this edition?
All chapters have been fully and the following chapters have been added:
• A chapter on the residency coordinator's role in the Next Accreditation System
• A chapter on managing a medical fellowship program

This product will help residency program coordinators:
• Manage their everyday responsibilities
• Understand GME and GME terminology
• Manage the recruitment, orientation, and credentialing processes
• Create a work environment in compliance with ACGME requirements
• Identify the key components and structure of the NAS
• Interpret the language of the NAS
• Manage a fellowship program

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The Residency Coordinator’s Handbook
THIRD EDITION
Ruth Nawotniak, MS, C-TAGME

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She served as the deputy director for the Internal Medicine Residency Program at the University at Buffalo (SUNY) School of Medicine from 1996 to 2004, working with the program director to oversee resident curriculum, recruitment, and credentialing, as well as providing advisement to medical residents and students. She also was the University at Buffalo graduate medical education grievance administrative consultant from 2007 to 2009, managing and educating program directors and residents on the process.

Harszlak holds a PhD and an MA in communication from the University at Buffalo (SUNY), and a BS in liberal studies, magna cum laude, from Medaille College. As an adjunct assistant professor at the University at Buffalo (SUNY), she regularly teaches courses in health communication, ethics, business and professional communication, and principles and techniques of interviewing. She has also presented numerous workshops and seminars on management skills, team building, interviewing skills, resume and CV writing, intercultural communication, cultural influences in healthcare, and doctor-patient communication. Harszlak is a consultant for InspireCareers!, a career services and consulting firm.

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Jeri L. Whitten, MS, C-TAGME, is the pediatrics residency program coordinator at West Virginia University (WVU), Charleston Division/Charleston Area Medical Center. On a national level, she is a founding member of the TAGME, representing pediatrics. She served as TAGME’s vice president from 2005 to 2006, president from 2006 to 2007, and immediate past president from 2007 to
2009. She chaired the Pediatric Training Administrators Certification Council (PedTAC) from 2005 to 2010. She also chaired the steering committee to establish the coordinator section of the Association of Pediatric Program Directors and was elected to a three-year term on the coordinator’s executive council in 2001.

In March 2010, Whitten was one of five recipients of the Coordinator Excellence Award presented by the ACGME. She is currently a member of the Program Planning Group for the Coordinators’ Forum for the 2011 ACGME Meeting. In April 2009, she received the WVU School of Medicine Dean's Award for Excellence in Service to the School, being the first ever staff person to receive this award. She was the first recipient of the Carol D. Berkowitz Award for lifetime advocacy and leadership in pediatric medical education presented by the APPD in May of 2005. She was named Employee of the Year in 2003 at West Virginia University, Charleston Campus, and was a past nominee for the West Virginia Chapter, Public Relations Society Citizen of the Year Award.

Whitten chaired the William J. Maier Health Sciences Education Award Committee, was chair of the Advisory Council for Classified Employees for four years, and currently is a member of the Research Appropriations Committee at WVU Charleston/Charleston Area Medical Center. She has given more than 40 presentations at state, regional, and national meetings related to graduate medical education. She is the author of *Program Information Form Made Simple: A Guide to Completing the ACGME PIF* (HCPro, 2008).
Author’s Note

Notice of commitment to a single graduate medical education system

On February 26, 2014, immediately before publication of this book, the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA) and the American Association of Colleges of Osteopathic Medicine (AACOM) announced their commitment to a single accreditation system for graduate medical education programs in the U.S.

In the announcement, Thomas Nasca, MD, MACP, chief executive officer of the ACGME, stated: “As we move forward into the Next Accreditation System, this uniform path of preparation for practice ensures that the evaluation of and accountability for the competency of all resident physicians—MDs and DOs—will be consistent across all programs.”

The joint announcement delineated several anticipated changes that will take place under this venture. Three of them have particular application to the coordinator’s job:

• The transition period for AOA application for ACGME recognition and accreditation will be from July 1, 2015 to June 30, 2020.

• Both MD and DO graduates will be able to transfer from one accredited program to another without being required to repeat education. This opens the ACGME fellowship programs to AOA program graduates whose programs are in the process of applying for or have received ACGME accreditation.

• Program management will become more efficient as the need to manage “dually accredited” or “parallel accredited” goes away.

As you are reading and utilizing this book, keep this announcement in mind as the world of graduate medical education continues to develop and redefine itself.
Chapter 1

What Is Medical Education?
Chapter 1

What Is Medical Education?

Although this book will focus on graduate medical education (GME), it is important that residency program coordinators know and understand all three components of a medical education—undergraduate medical education (UME), GME, and continuing medical education (CME). Knowing where your residents came from and where they are going after training will help you better understand the role of GME in the professional and clinical development of physicians.

For more information on the topics and organizations discussed throughout the book, their websites are listed in the Resource section at the end of each chapter.

Undergraduate Medical Education

Medical school is the first step of formal medical education in the United States. Students enter medical school after receiving their undergraduate degrees. Many college students prepare for medical school by pursuing a degree in the biological sciences, although this is not a prerequisite. Residents can enter with degrees in everything from engineering to fine arts. The medicine bug can bite at almost any time.

Philosophies of medicine

There are two main philosophies of medicine: allopathic and osteopathic. Medical students must choose whether they want to attend a medical school that teaches allopathic principles or osteopathic ones. The majority of physicians in the United States are graduates of allopathic medical schools.

Allopathic physicians treat diseases using remedies that aim to stop the effects of the symptoms of that disease.1 Osteopathic medicine takes a whole-body approach to treating a patient, looking at how diseases in one part of the body can affect other parts. Osteopathic philosophy uses both analytical and therapeutic methods to encourage patients’ bodies to heal themselves, incorporating the use of manipulation to cure diseases that are caused by misalignment of bones, ligaments, and muscles.2
Graduates of allopathic medical schools receive a doctor of medicine (MD) degree, and graduates of osteopathic schools receive a doctor of osteopathic medicine (DO) degree.

Despite these different degrees, graduates of allopathic and osteopathic medical schools receive similar education and have similar training experiences. Individuals with either degree can receive a license to practice medicine in the United States.

A third philosophy is homeopathic medicine. It is a complementary disease treatment system in which a patient is given small doses of natural substances that, in larger doses, would produce symptoms of the disease itself. Schools and colleges may offer training in homeopathy for both physicians and non-physicians, but only the American Medical College of Homeopathy (AMCH) grants a Doctor of Homeopathy degree. Arizona, Nevada, and Connecticut are the only states that offer licensing. Graduates of homeopathic schools cannot enter training in residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA).

**UME curriculum**

In both allopathic and osteopathic medical schools, the curriculum in the first two years focuses on anatomy and the basic sciences. In the third and fourth years, medical students participate in clerkship courses that introduce them to the various clinical specialties within medicine. Clerkship directors coordinate these courses, and they may work with residency programs to place their students. In some training programs, the residency program coordinator is also the clerkship coordinator.

**Medical school accreditation**

Both allopathic and osteopathic medical schools participate in an accreditation process.

Accreditation is a quality assurance process that holds institutions or programs to established standards to ensure that accredited programs maintain function, structure, and performance. The process ensures that medical education is offered in an environment that cultivates broad academic purposes and encourages reflection and improvement in both the institution and the participating programs.

The Liaison Committee for Medical Education (LCME) accredits allopathic medical schools in the United States and in Puerto Rico. The AOA Commission on Osteopathic College Accreditation (COCA) is responsible for certifying osteopathic medical schools.

**Liaison Committee for Medical Education**

The LCME accredits 137 medical schools within the borders of the United States, 17 in Canada, and four in Puerto Rico. The LCME collaborates with the Committee on Accreditation of Canadian Medical Schools (CACMS) in the accreditation process. Because of this collaboration, the U.S. Department of Education recognizes the LCME as the official accreditation authority for allopathic programs in both...
the United States and Canada. The U.S. Congress recognizes LCME as the accreditation authority, and the LCME is referred to as such in various health-related federal, state, and territorial medical licensing boards, as well as in provincial licensing boards in Canada. Additionally, medical schools must maintain LCME accreditation to receive federal grants and to participate in federal loan programs.

**Commission on Osteopathic College Accreditation**

There are 29 colleges of osteopathic medicine in the United States accredited by COCA. The U.S. Department of Education recognizes COCA as the reliable accreditation authority for osteopathic medicine schools.

**Council on Podiatric Medical Education**

Doctors of podiatric medicine (DPM) focus on the diagnosis and treatment of disorders, diseases, and injuries of the foot and lower leg. They must complete a four-year program at a podiatric college accredited by the Council on Podiatric Medical Education (CPME). This program is similar to medical schools that prepare MDs and DOs. Most graduates go on to residency programs that last two to four years, depending on whether the person completes extensive training in specialty areas.

CPME is recognized by the U.S. Secretary of Education as the accrediting agency for professional development programs in podiatric medicine. It accredits colleges of podiatric medicine and residency and fellowship programs.

**Foreign medical schools**

Graduates of foreign medical schools—those schools outside of the United States, Canada, and Puerto Rico—can also apply for and participate in residencies and fellowships in the United States. Through its own distinct certification program, the Educational Commission for Foreign Medical Graduates (ECFMG) assesses the readiness of international medical graduates (IMG) to enter into U.S. GME training programs.

The ECFMG offers a variety of programs and services for IMGs and other members of the international medical community.

Institutions and residency programs have their own policies and procedures for accepting IMGs. Program coordinators should review their institution and program guidelines prior to the recruitment season.

**U.S. Medical Licensing Examination**

All medical students, no matter what medical school they attend, must take the U.S. Medical Licensing Examination (USMLE). This is a three-part exam required to obtain a license to practice medicine in the
United States. Students must take and pass part one during medical school as a requirement for graduation. Part two is composed of the Clinical Skills Exam and the Clinical Knowledge Exam. Many medical schools now require their students to either sit for or pass this exam before graduation. Residents cannot take part three until the candidate has completed one year of GME.

All state licensing boards require physicians to complete the three parts of the USMLE exam before the boards will grant a license to practice medicine. Each state establishes testing and procedural requirements for licensing. Some states require both DOs and MDs to take the same tests, whereas other states administer separate licensing exams.\(^5\)

### Graduate Medical Education

After medical school, students continue their education in residency programs, which train them in the specialty, or field of medicine, in which they hope to practice. Many choose to do further training in a fellowship that is a subset of their specialty or subspecialty. Whereas the purpose of UME is to provide students with a broad base of medical and scientific education, the goal of residency and fellowship programs is to prepare physicians to practice medicine independently, and without supervision in their chosen specialty or subspecialty. This period of training in residency and fellowship programs is known as GME.

The time frame in which residents must complete the USMLE can vary from state to state. Remind senior residents preparing to apply for a license to check state requirements regarding when they must complete the USMLE. If they miss the time frame, they will have to retake all three parts of the USMLE exam. Many programs require their residents to complete the USMLE3 exam in their PGY2 or PGY3 years to address this concern early.

### GME specialties

Training to establish competence in a specialized field is required to join a medical practice or to obtain hospital approval to practice in that chosen specialty.\(^6\) Although specialties are often categorized as surgical or nonsurgical, the ACGME has grouped its accredited programs into surgical, medical, and hospital-based. This book has dedicated chapters for each—surgical in Chapter 7, medical in Chapter 8, and hospital-based in Chapter 9—in which some of the variances in managing those programs will be discussed.

Graduates of osteopathic medical schools complete an approved 12-month internship before choosing a residency program in a specific clinical specialty. This 12-month internship includes experiences in internal medicine, family practice, and surgery.
Residency programs vary in duration but typically range between three to five years (e.g., surgical specialties usually take five or six years to complete, and nonsurgical specialties programs are typically three or four years in length). The acronym PGY (postgraduate year) indicates a resident’s level of training in his or her program. A first-year resident is called a PGY1, a second-year resident is PGY2, and so on.

DID YOU KNOW?

At one time, residency programs had a pyramid structure, meaning that programs accepted a high number of residents into their programs at the PGY1 level. The idea was that these physicians would be patient care service providers, and only the most competent would move on to the next level of training. Residents’ performance, ability to learn basic skills, and ability to manage the stress associated with patient care would eventually weed out those thought to be less qualified for promotion. Because many trainees were not promoted, the PGY1 residents were commonly referred to as interns. Those who moved on to PGY2 were called residents. This practice is no longer accepted. Today, accreditation agencies approve a specific number of trainees each year and at each level for all clinical specialties. The term “resident” is now used for all trainees within a training program at any PGY level. However, you will still hear the term “intern” commonly misused to refer to all PGY1 residents.

Categorical vs. preliminary residents

The ACGME uses the terms “categorical” and “preliminary” to identify the type of training commitment the program has with a resident. A categorical resident enters a training program with the intent to complete training and to graduate from the program. This applies to a PGY1 resident who just matched to a program, or an upper-level resident who transfers into the program with the intent to complete training. A preliminary resident has a one- or two-year commitment to train in the program, with no intent to complete training.

Differences in the preliminary resident designation exist as well. These apply, in particular, to the general surgery specialty. For example:

- **Designated preliminary** are residents who match into another specialty that requires residents to complete a year in general surgery as a prerequisite for their training. For example, urology requires residents to complete one year of general surgery training before entering their urology residency program, and anesthesia requires one year of prerequisite training in either surgery or internal medicine.

- **Non-designated preliminary** are residents who did not match into training programs of their choice. They generally continue to interview during the PGY1 year and try to match.
as a categorical resident the following year or find a position as a PGY2 categorical resident. This designation gives medical students who do not match into a program an opportunity to stay in the medical field and reapply to residency programs the following year.

Depending upon vacancies that occur within a training program, some training programs may also offer the preliminary resident an open PGY2 categorical position, or another preliminary year.

**Fellowships**

Physicians who wish to specialize in a subset of their clinical specialty may apply for and participate in fellowship programs. The residency program is the core or parent program, and the fellowship is categorized as a subspecialty program. Typically, trainees enter a fellowship after graduating from a residency program, and fellowships are usually one to three years in length. For example, cardiology is a subspecialty of internal medicine, so residents graduate from an internal medicine program and then complete a cardiology fellowship program.

Fellowships are either accredited or non-accredited. The ACGME approves accredited fellowships as long as it is associated with a core or parent residency program. For example, the internal medicine residency is the core or parent program for pulmonary disease fellowship programs.

There are a few exceptions to this requirement; for example, a children’s hospital may have a pediatric radiology fellowship even though it is not linked to a core diagnostic radiology program. Non-accredited fellowships do not follow the ACGME requirements and are not accredited by that agency. An example of this is minimally invasive laparoscopic fellowships.

In addition to single specialty residency and fellowship training programs, there are also combined training programs that, as the name implies, combine training in more than one specialty. Med-Peds is an example of a core residency that combines training in both internal medicine and pediatrics. An example of a fellowship program is endovascular surgical neuroradiology, which combines training in neurosurgical and catheter techniques and neuroradiology (itself a subspecialty of diagnostic radiology). Trainees in this subspecialty may have completed prerequisite residency training in diagnostic radiology, neurology, or neurological surgery.

There are also programs that emphasize medical research. One such program is the American Board of Radiology’s “Holman Pathway,” which combines residency training with extensive research. Trainees who plan to pursue a career in academic radiology medicine may elect this type of training.
DID YOU KNOW?

Although you will hear the terms “intern,” “resident,” and “fellow,” the ACGME uses the term “resident” for all GME trainees. The ACGME also refers to fellows as subspecialty residents. This can be confusing to those new to GME. You may also use the PGY designation to refer to residents and fellows. After completing a five-year core training program, fellows may be designated as PGY6, PGY7, PGY8, etc. After a three-year program, they may be considered PGY4, PGY5, PGY6, etc.

Additionally, all GME trainees, regardless of their level of training, are sometimes referred to collectively as “house staff.” This term refers to the early days of GME, when residents sometimes lived in the hospital or a nearby dormitory.

Board examinations

To practice medicine in any of the core specialties, graduates from residency programs must pass an examination administered by their specialty’s board, such as the American Board of Pediatrics or the American Board of Neurosurgery. The board exam, commonly called “the Boards,” has one or two parts depending on the specialty.

Board certification is not required to enter a fellowship program. However, physicians seeking board certification in some subspecialties may need to obtain board certification in the parent or core program. Another option for trainees entering fellowships is to pursue a specialty-specific certification process that is an added qualification signifying demonstration of skill pending completion of a focused examination.

To find out the requirements for your specialty, visit your specialty board’s website. Figure 1.1 lists each specialty board and its respective website.

Once board certified, physicians must recertify every 10 years to maintain their certifications. Recertification is referred to as maintenance of certification (MOC). It is a 4-part process over a 10-year period, incorporating the six competencies. The MOC monitors and assesses the common practice patterns of physicians, and assures the public that the physician has maintained his or her expertise in his or her medical field.
### Figure 1.1

**Specialty Boards and Their Websites**

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<tr>
<th>Specialty Board</th>
<th>Website</th>
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<tr>
<td>Allergy and immunology</td>
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<tr>
<td>Anesthesiology</td>
<td><a href="http://www.theaba.org">www.theaba.org</a></td>
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<tr>
<td>Colon and rectal surgery</td>
<td><a href="http://www.abcrs.org">www.abcrs.org</a></td>
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<tr>
<td>Dermatology</td>
<td><a href="http://www.abderm.org">www.abderm.org</a></td>
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### Accreditation of GME programs

Residency programs can be either accredited or unaccredited. Accreditation agencies include:

- **Accreditation Council for Graduate Medical Education (ACGME):** Established in 1981 as an outgrowth of the LCME, the ACGME accredits allopathic training programs. It presently accredits 9,265 training programs in 139 specialties and subspecialties. The organization sets the standards and guidelines to which residency and fellowship programs must adhere. The ACGME assesses programs’ compliance with these standards, which is discussed in further detail in Chapter 2.
• **AOA:** The AOA accredits osteopathic programs. In 1995, the AOA established the Osteopathic Postdoctoral Training Institution (OPTI) to accredit osteopathic GME programs. Currently, there are 26 colleges of osteopathic medicine and 883 accredited osteopathic training programs.9

• **Council on Dental Accreditation (CODA):** The CODA uses a peer-reviewed process for accrediting the 64 dental education programs in the United States and 1 in Puerto Rico.10

### Continuing Medical Education

CME is a self-directed process by which physicians continue their professional and clinical education and development. All certified physicians must attain CME credits to maintain their certification and their licenses. Organizations providing educational opportunities assign CME credits to formal education courses, seminars, and lectures based on the number of hours participants spend in that activity. For example, a one-hour grand rounds presentation, if approved for CME credit, would equal one CME hour of credit. A full-day seminar could be worth six hours of CME credits.

Each clinical specialty sets the number of CME credits required to recertify. Many healthcare-related facilities also require healthcare practitioners to obtain a specific number of CME credits in order to be reappointed as a member of the medical staff.

### The Accreditation Council for Continuing Medical Education

The Accreditation Council for Continuing Medical Education (ACCME) accredits entities that provide CME programs and activities. ACCME sets the educational standards for CME activities and monitors the entity’s adherence to those standards. ACCME accreditation confirms that the activities provided by an entity are based on valid content, assist physicians in maintaining or improving their practice of medicine, and are free of commercial bias. Because of this structure, the organization accredited by the ACCME, and not the ACCME itself, offers CME credits. The organization offering the CME credit determines the requirements for granting that credit. ACCME-accredited entities include:

- State medical societies
- LCME-accredited schools of medicine
- National physician membership organizations
- National medical specialty societies
Resources

On the Web

ACCME: www.accme.org
ACGME: www.acgme.org
AOA: www.osteopathic.org
CPME: www.cpme.org
ECFMG: www.ecfmg.org
Homeopathy: www.naturalhealers.com
LCME: www.lcme.org
MOC: www.abms.org

References


The Residency Coordinator's Handbook, Third Edition, is a comprehensive manual and training resource for residency program coordinators. This newly updated and expanded version provides insight into the ACGME's Next Accreditation System (NAS), the Clinical Learning Environment Review (CLER), and how to manage a medical fellowship program. New and veteran coordinators will benefit from the guidance, sample policies, and tools they can implement immediately. This book and downloadable toolkit offers residency program coordinators the education and field-tested solutions to ensure a successful and efficiently run residency program.

What's new in this edition?
All chapters have been fully and the following chapters have been added:

- A chapter on the residency coordinator's role in the Next Accreditation System
- A chapter on managing a medical fellowship program

This product will help residency program coordinators:

- Manage their everyday responsibilities
- Understand GME and GME terminology
- Manage the recruitment, orientation, and credentialing processes
- Create a work environment in compliance with ACGME requirements
- Identify the key components and structure of the NAS
- Interpret the language of the NAS
- Manage a fellowship program

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