

**Dr. Thomas Nasca, President and CEO Explains  
The Accrediting Council of Graduate Medical Education  
At the USDOE's NCFMEA Meeting 3/30/09**

I would like to tell you a little bit about the ACGME, and then maybe we could have a discussion on the impact of accreditation on graduate medical education.

I am going to give you an overview of the kinds of impacts we are attempting to have and talk to you a little bit about the use of accreditation structures as a lever to move the educational system in the United States, and then talk a little bit about the structure, because it is my understanding -- and if this wrong, we can skip that part -- that the alphabet soup of American organizations can sometimes be confusing to those uninitiated.

I have only one disclosure, and that is the ACGME actually does pay me, but other than that, I have no other disclosures. I don't own stock in anything to speak of, certainly anything that is worth anything, certainly nothing associated with medicine.

I think it is important to recognize that there is a legacy of graduate medical education in the United States, and we sometimes have the mistaken perspective that it was always there. It really wasn't always there, and if you go around the world, you can actually see countries in various stages of development that we have gone through over the last 60 or 70 years.

Graduate medical education in the United States has evolved into a required component of the continuum rather than an optional component of the continuum in medical education. We have evolved into production of highly trained specialists and subspecialists, and we provide the clinical workforce for the United States.

Now the ACGME is an interesting entity. It has evolved over the last 60 years. It is really the embodiment of de Tocqueville and Franklin's vision of private entities serving the public good, and it is a 501(c)(3) not-for-profit corporation. I will tell you a little bit more about that in a second.

It is really the meeting place of the thought leaders in American graduate medical education. The members of the Board of the ACGME are nominated by at least five organizations which, you

can see, are the umbrella organizations of the United States involved in either medical education, the certification of specialists, or the receiving organizations, the American Hospital Association, the American Medical Association, and the Council of Medical Specialty Societies.

Then at the Residency Review Committee level, the specific specialty level, we have three organizations that nominate individuals who volunteer to serve on those committees, the AMA, the respective Board and the respective college or academy from the specialty specific entity.

So you can see, the ACGME really is the framework for the profession coming together to do its work to create and accredit the educational programs that sustain the profession over time.

Now the ACGME has evolved from independent individual specialty review committees through a council within the AMA, in the year 2000 spun off as an independent 501(c)(3) corporation, and its mission is the advancement of the health of the citizens of the United States through enhancement in graduate medical education.

I will add parenthetically that "the citizens of the United States" was added by me just for the purposes of this presentation. It is not actually part of the mission statement. It is just "the advancement of health through enhancement of graduate medical education."

The authority of the review committees is delegated by the Board to each committee. In other words, each residency review committee has no authority to accredit on its own. It is delegated from the Board of the ACGME to each specialty committee, and the ACGME is responsible then -- that is, the ACGME Board is responsible to the public for the oversight of the work of each of these committees, and we have an extensive process that allows that to happen.

Now the Board of Directors of the ACGME are selected. There are four individuals selected from slates that are nominated by five member organizations, those five that I showed you. There are two resident members, three public members, and the Chair of the Council of Review Committee Chairs. In other words, all of the chairs of the review committees, the 28 review committees, sit together and they elect a Chair, and that Chair sits on the Board.

The Chair of the ACGME can be super-numeratedly

elected by merit from the members of the Board, and I sit on the Board as Secretary of the Board without vote by virtue of being the CEO.

Now the ACGME believes very strongly that the output of our work produces a social good, and that is that we produce individuals who provide patient care, basic and clinical research, education of the future physicians and other health care professionals, and provide community service beyond the clinical care that we provide.

We do believe very strongly that patient care is improved through education of the next generation of physicians, and that is not only patient care in the future. It is patient care in the present.

Now I am just going to try and give you some idea of the complexity of the relationships within the ACGME. Each of us, depending on our specialty, views the ACGME in this fashion. There is a specialty review committee -- in my case, for instance, internal medicine -- and there is a Board of Directors of the Accreditation Council, and there is an interchange between these two entities.

There is an Executive Committee of the Board. About 10 years ago, an Institutional Review Committee was added to the mix. So that, in addition to adjudicating the effectiveness of implementation of the standards of each specialty within an institution, the institution itself is reviewed.

We have a series of committees that interface with the review committees. The Monitoring Committee is the committee that is charged with overseeing the work of the review committees.

In other words, every five years at a minimum, and sometimes more frequently, each residency review committee must submit a report to the Monitoring Committee, and the Monitoring Committee judges their effectiveness of accreditation and their consistency, and then they render citations or deficiencies, and they render an accreditation cycle or delegated authority to accredit cycle that can be anywhere between one and five years, very much the way we accredit residency programs.

There is a Program Requirements Committee that reviews the proposed specialty specific requirements, and then for appeals when an institution is not happy with the decision that they receive, if it is an adverse decision, they can appeal it.

Obviously, there are a whole series of other committees of the Board that support the work of any not for profit 501(c)(3)

corporation.

The complexity comes, because there are 28 committees. There are not just a couple, and the relationships then are governed very strictly by policies and procedures.

The reason for that is twofold. The first is there would be chaos without policies and procedures that were rigorously applied. The second is that it is very important for every program and every program director to know the rules, and the rules are not only the standards. The rules are also how we interrelate and how we enforce those standards, the policies and procedures.

As I mentioned, there is a Council of Review Committee Chairs that is the interface between the Board and the committees, and that work of that interface is very, very important in making sure, first of all, that the Board is understanding of the challenges that these committees are facing, and these committees understand the intentions and needs of the Board.

Just one other parenthetical remark: We are adding a peer review journal. That journal will publish its first issue in September of this year, and have added a Journal Oversight Committee.

Now the Board has approved a set of values, and these values look very much like many of our institutional values, with a couple of additions.

Obviously, the values are: Professionalism, as articulated in honesty and integrity and excellence in innovation; accountability and transparency, what you would expect for an accrediting body; fairness and equity, absolutely essential, because if we cannot instill and maintain the trust of our colleagues in each one of our teaching programs that we won't have the opportunity to accredit; and then we have a stewardship responsibility.

The only source of revenue for the ACGME are accreditation fees, and so we must be good stewards of that largess. Then, obviously, engagement of the stakeholders. If you are going to lead an educational enterprise, there needs to be engagement of those who are actually accomplishing the education in order to do this well.

Now there are a whole series of accreditation goals. First and foremost is to assure the safety and excellence of patient care in the teaching setting; to create excellence in the graduate program, and we take that very seriously, and hence the move toward

outcomes and outcomes based accreditation.

Our goal is to standardize to some degree -- we would never standardize completely the clinical and educational experience and outcomes of trainees in disciplines across a jurisdiction, but we do hope, to some degree, to create some homogeneity in the output.

In order to accomplish the above, the really have to assure effective evaluation of the trainees. We have to assure that the trainees learn in humanistic and reasonable settings, obviously anything from duty hours to service versus education issues related to that bullet. Then we have to coordinate the requirements for programs with the required experiences of the trainees for certification.

So we need to make sure that we work in concert with the boards or at least understand when there are difference between our standards and boards' standards, because obviously, the goal is to produce individuals who become board certified in their specialty.

Now I probably don't need to point this out to you as an overseer of accreditors. But obviously, there is a significant difference accreditation and certification in the context of graduate medical education.

The accrediting body for programs sets accreditation standards and assesses compliance with those standards; whereas, the certifying bodies -- those are the ABMS boards in our situation -- set benchmarks for recognition of individuals, and then assess the individual's level of achievement in comparison to that benchmark.

Now -- and please, if this is information that you already know, please let me know. But there are a number of organizations that oversee the continuum of formal medical education in the United States, and you heard about five of them when it comes to the ACGME.

The AMA, the AAMC, the American Hospital Association, American Board of Medical Specialties, and Council of Medical Specialty Societies are involved in the continuum, obviously. The AMA and AAMC specifically oversee medical student education in the United States, and that is overseen by the U.S. Department of Education.

The ACGME gets its membership from these five organizations and oversees the graduate phase of medical education. Then the Federation of State Medical Licensing Boards, the National Board of Medical Examiners and the ECFMG oversee key steps in

the licensing process in the form of both the USMLE medical knowledge exams and the clinical skills examination. Then finally, recognition of the specialists is by the ABMS at the specialty board level.

So you can see that we have organizations -- those are the shaded ones -- that are involved in both individual recognition, as well as on the part of the ABMS, program specific accreditation.

Now the philosophy that I was talking about as we attempt to introduce trends into graduate medical education that bring out excellence in outcomes of our trainees is summarized in this sort of a tension that is brought about by what I am going to tell you next.

If we look at an accrediting body, it is very unusual for an accrediting body to have as a mission to drive innovation. In general, accrediting bodies function as trailing edge phenomena.

In other words, the majority of institutions or programs provide education in a certain fashion and, when they provide education in that certain fashion for long enough, if it is shown to be of benefit, that fashion of education then is incorporated into the accreditation standards, that so called trailing edge.

It is in the community. Eighty percent of programs already do it, and you get the 20 percent of programs that are not doing it to do it well by introducing a standard.

That is different than a conceptual framework of a leading edge kind of a standard. A leading edge standard is a standard that is introduced to drive the profession or the educational programs in a particular direction.

Over the course of the last 15 years, the ACGME has gradually moved from trailing edge standards to leading edge standards. What would be examples of those leading edge standards? The competencies would be a classic example, as would resident duty hours standards would be examples of leading edge standards.

Now the other important dimension here that is the same in both of these boxes is the method of assessing compliance is a substantial compliance model where the program is judged to be in substantial compliance if the vast majority of the rules are satisfied, and where deficiencies are identified, they are rectifiable or are not lethal kinds of deficiencies in the educational program.

Of late, the -- Well, let me take a step back. One of our leading edge standards that has caused considerable discussion in

the United States has been the discussion around resident duty hour standards.

The duty hour standards were introduced in 2003, and the enforcement model was a substantial compliance model with a set point very similar to the accreditation of the rest of the standards around substantial compliance model.

Now those of you who had the chance to read the Institute of Medicine report and hear the criticisms in the public of the ACGME, this is the basis of that disagreement.

The expectation of some in the society is that we be dealing with leading edge duty hour standards that have regulatory adherence as opposed to substantial compliance as the judge of compliance. Let me say that again.

There is this expectation that the duty hour standards not be treated as educational accreditation standards and judged by substantial compliance with those standards. There is the expectation that they be considered regulation and that the ACGME assess compliance by regulatory adherence -- in other words, a zero tolerance for violation model.

If you read the medical literature, you will notice that the ACGME, using a substantial compliance model, assesses that there are about eight percent of programs that have duty hours violations that cross the threshold of substantial compliance violation. In other words, they do not reach the threshold of substantial compliance.

Whereas, if you read someone like Landrigan, who has done studies with interns in pediatrics and other specialties, he assesses that deficiency at somewhere around 60-70 percent of programs, because his standard of violation in one intern saying that one time they work rated at 80 hours or stayed more than 30 hours.

So there is a dichotomy, and the IOM is driving toward this set of expectations, and hence the conflict between the ACGME and the public sector.

Now where is the ACGME trying to drive the profession? Well, I am going to give you some information that you all know, but try and give it to you graphically, quickly, so that we can frame the discussion.

That is that all of us remember that the structure of our educational programs are based on this particular model. That is graded or progressive responsibility. In other words, we start out in physical diagnosis with a very high degree of supervision and

absolutely no authority in decision making.

Then we move through the continuum of medical education with greater degrees of authority and decision making and lower degrees of supervision, ultimately ending up as an attending with no direct supervision, more distant supervision from a quality perspective, and absolute authority in decision making.

Now David Leach, my predecessor, introduced into our lexicon in medical education the Dreyfus conceptual model of the development of mastery, and with the student beginning as a novice, not knowing what they don't know, and some of us were fortunate enough progressing to mastery.

So graphically we can look at it in this fashion. We have this conceptual framework on the Y axis of starting from a novice and then moving all the way to master, and then starting in undergraduate medical education as a novice and then moving into graduate medical education, the phase that we are talking about today, somewhere as an advanced beginner to competent, and then moving to proficiency, and then in clinical practice maintaining at least proficiency, some going on to expert status, and even fewer going on to mastery. That is the conceptual framework.

What we talk about now is this graduate phase. What I would like to do is maybe peel the onion for you. You know, we have these six domains of clinical competency, probably soon to be seven with technical proficiency being a separate seventh category or competency. That will probably be approved by ABMS and ACGME over the next year.

If we think conceptually, say, about a three-year residency program, we would start out as an advanced beginner, but is it really that simple? It probably isn't.

It may well be that, say, in internal medicine or pediatrics that we would believe that they would start out as an advanced beginner. They sort of know how to do a complete history or physical, but they don't really know how to develop a good differential diagnosis yet and the like. So they are really not competent yet.

Over the course of the PGY1 year, we would expect that they would move to competency and then proficiency by the end of the PGY2 year, and then refine that and enhance that.

Now would we have the same expectation for systems based practice? Probably not, because if they didn't train in your institution, they don't know your systems.

So they would start off as a novice in your institution, and then assume to move very quickly in the PGY1 year to a competent level, because otherwise they wouldn't get their work done, and we have all seen interns who have been in that category, who can't really figure out how to get the work done.

Now I would ask you the question: How many of you want an advanced beginner when it comes to professionalism as an intern? You probably want a more developed set of professional behaviors than an advanced beginner for your first year house officer. So you have an expectation that they would start at a different level.

What I would posit to you is that in each one of our specialties, these are milestones. These are expectations that we have of house officers of levels of performance, and those levels of performance in key areas should be common across all programs, and this is really the outcomes project, is figuring out how do we go from this conceptual framework where we track a house officer.

They deteriorate in their performance in this case with regard to patient care capabilities, and then we rectify them with information based on where we think they should be, not based on the individual program director's gut feeling about where they should be or the program's culture about where they should be, but really on national standards or national expectations.

Then ultimately, these final milestones or expectations, as they are articulated, become the entry into the initial phase of a certification process. So we need to be sure that, as each specialty articulates these, that the Board agrees with them.

Now it is the same for surgical discipline as well. If you look at surgical skills, they may well project from advanced beginner all the way through in this envelope, but surgical training is different than nonoperative surgical training, is loaded to a great degree to the front.

Systems based practice -- again, if you haven't worked in that particular OR, you don't understand how it works, but you may have greater expectations with regard to non-operative patient care based on the structure of, for instance in this case, general surgery.

So we need to really understand the expectations. We have three specialties now that are in the process of determining these milestones. Internal medicine, pediatrics, and general surgery are in the process of defining these milestones across the six domains of clinical competency.

We hope eventually to be able to do this in all specialties so that we can rectify those deficiencies and be sure that each trainee then does enter practice or completes graduate medical education at the level of at least proficiency and be able to certify that to the public.

Now let me switch gears a little bit here. When we look internationally at prototypes of systems of accreditation and oversight of graduate medical education programs, which is different than what you look at, we see that there are three models.

The first model is the government oversight model, which is a ministry of health model, in some cases a ministry of education, but that is more frequently at the undergraduate level than it is at the post graduate level, and in most countries it is called post graduate training.

There is the self-regulation model. In other words, the profession is self-regulating, and the two models would be -- The one that predominates internationally right now is the Royal College model or the representational organizational model, where the college also accredits and also certifies in many circumstances.

Licensure in those countries may or may not be present. There are many countries where there is no such thing as formal licensure, and it is really the college activities that determine whether you are entered into the practice of medicine.

Then we have the U.S. system of professional self-regulation, and in this system there is corporate separation of accreditation and certification functions, and licensure is a third dimension. That is local, as you are well aware, and is a state governmental function, not a Federal function.

Then interestingly, in most of the world there is a non-regulatory model. In other words, in most of the world, if you counted countries, most countries would have no formal structure or oversight of post graduate training.

Now to give you some frame of reference for the U.S. system of the ACGME -- and I would add that these numbers do not include osteopathic training. That is governed by a separate body, the American Osteopathic Association.

So to look at the full portfolio of postgraduate training that is accredited, you would need to look at AOA, which is much smaller than this, but it has some number of programs and trainees.

We have 8,696 programs accredited as we speak in 692

sponsoring institutions. We have almost 3,000 teaching hospitals or institutions that participate in residency training in the United States, and we have over 111,000 residents and fellows currently enrolled in ACGME accredited residencies and fellowships.

The ACGME itself does its work with about 365 volunteers, physician volunteers, and about, right now, 162 full time administrative staff.

Now if you look at the economic impact, the Medicare reimbursement for GME in the United States is about \$10 billion, which on average is \$93,000 per resident. The ACGME expense budget is \$32 million, which is less than .3 percent of total Medicare GME expenditures or about \$280 per resident per year.

Now what is the impact of accreditation in the United States? Well, we believe we have been continuously raising standards, and actually we can demonstrate that, if you look at -- track specialty standards over the years. Every specialty has raised standards and promoted excellence in many institutions that otherwise would not have been very good.

Parenthetically, I will give you an example. In the state of New Jersey in the 1980s, there was not one internal medicine program that had an American Board of Internal Medicine pass rate greater than 50 percent. Today there is not a single program in the state of New Jersey who has a Board pass rate less than 90 percent, which is five points above the national average.

The reason for that is that in 1987 the Internal Medicine Residency Review Committee put in a standard with regard to board passage rate, and lo and behold, everyone's performance improved.

So we can give you many, many examples. That is just one example of where the changes in standards resulted in improvement in outcomes, measurable outcomes.

We have introduced physician competencies into American medicine. I mean, that really came from the ACGME. We are developing the milestones of training, and we have enhanced the learning environment, including resident duty hours and resident wellbeing.

Then finally, I can tell you with confidence that the care in the United States in teaching hospitals, the outcomes of care as well as the processes of care are better than in non-teaching hospitals.

There are any number of reviews, and I will tell you, the reason these reviews were done had nothing to do with education.

The reason these reviews were done was because it costs more in teaching hospitals than non-teaching hospitals.

So there were many people interested in demonstrating that care was not better in teaching hospitals than non-teaching hospitals, but it turns out that in every situation where meta-analyses have been done and reviews have been done of studies, with one exception teaching hospitals provide better care than non-teaching hospitals, as measured by outcomes as well as process.

The one exception is in some studies looking at neonatal intensive care units in community hospitals, non-teaching community hospitals versus academic medical centers.

There are many confounding variables in those studies, and they continue to look at that, but that is the only setting where it has not been demonstrated that teaching hospitals are categorically superior.

Now I could go on and talk about the pipeline, if you want, but I will stop here and answer questions, if that is what your pleasure would be.

DR. DOCKERY: Thank you, Dr. Nasca. It might be helpful to have a few words about pipeline, because we are dealing with that through many issues. So I think we would benefit from that, if you have the time.

DR. NASCA: I always have slides. I'm a nephrologist. I have graphs, too. So now I'm in heaven.

This is a graphic that Ed Salsberg gave to me a year ago. So it is a little bit out of date, but the numbers really haven't changed very significantly.

What this shows is that back in 2002-2003 Jody Cohen called for expansion of U.S. allopathic medical school output by 30 percent, and you see the response of the community. This is first year enrollment, very similar to output numbers just with a time lag of four years.

What you see is that existing schools are projected to expand over the next decade, and with the addition of new schools, by around 2015 we are projecting around 21,000 graduates and plateauing, I think -- Jim, is it about 2022 at around 22,500 graduates. Okay? So remember that number.

This is the striking one, though, to me. If you look at allopathic expansion, by 2013 we will be at about 20,000, but remember, the curve is upward.

This is the most striking one. If you look at this number back in 1992, 10 years before this, this number was 1800, and in about 20 years it will have almost tripled. So you can see that the osteopathic output has dramatically increased.

So in 2013 it is expected we would have about 25,000 onshore graduates as opposed to 19,500 in 2002. So now remember this number, 25,100.

Now everyone, when they start to look into this, gets a sense of comfort in the fact that the total number of accredited entities accredited by the ACGME continues to increase. So you've seen a fairly significant increase in the number of residency training programs accredited by the ACGME.

This is the data from 2003 to 2008, and we went from less than 8,000 in 2003 to, in 2007-2008, about 8400; and as I just told you, we are almost at 8700. So you can see that that slope continues. Right?

Here is the problem. There has been almost no increase in residency positions. It has all been in fellowship positions. This is accredited positions -- accredited programs, pardon me.

This increase is somewhat artifactual. This, in some sense, is artifactual, because it represents the accreditation of medicine/pediatrics combined training programs that were previously not accredited, but the trainees were there.

They were just part of -- counted as part of either pediatrics or medicine in existing, accredited medicine and pediatrics programs. So this 1.5 percent increase is even artificially inflated.

Now if you take the pipeline positions -- and by pipeline -- you know, we always have to be worried about definitions. You can see the specialties that we listed here. These specialties are the specialties that we accredit that lead to initial board certification.

So for instance, you would say, well, colon and rectal surgery is a separate RRC. Yes, it is a separate RRC, but it is really a fellowship program, because you must complete five years of general surgery before you can enter a colon-rectal surgery -- what is called a residency, but it is really a fellowship.

So you need to recognize those nuances. So if you look at this as the pipeline, there is an additional phenomenon that you need to recognize in counting the numbers.

If we look at the GY-1 positions -- in other words, the first year of specialty training in each of these disciplines. So in

anesthesiology, that would be a PGY-2, right? You can see that the total number of positions in 2007-2008 was about 25,800. But the number of positions that were available to first year residents who had no previous GME experience was only 24,000.

So that defines the real pipeline for people who are coming in de novo into the GME system. It is 24,000. So what we -- if you remember that number that I showed you, in 2013 matriculating onshore students will be 25,100. Even if we have an attrition, they are not going to lose that percentage. They are not going to lose more than four or five percent.

So we are looking at around 2015 to 2017 when these lines are going to cross. In other words, if we project out, even if we projected out a 1.5 percent growth in the pipeline which, I will tell you, hospital CEO say will not happen, because they don't see any reason to expand their residency positions -- What we see is, if we project Ed Salsberg's line on there, you can see that those lines start to come together around 2013, and they cross around 2015 to 2017, not shown on the graph.

So we are heading for trouble, and I am not going to say anything more about this than that, and then entertain questions, because there are certain constraints that I have coming from the accrediting body around manpower.

DR. DOCKERY: Thank you very much, Dr. Nasca. That was a delightful and informative presentation, and we will even applaud now.

(Applause)

Are there questions from the committee? It is very timely, particularly, that you come today, because we have been charged with the responsibility of writing a report to Congress on the requirements for certain schools that have been exempt from certain criteria in advance, and trying to predict their access to accredited residency training programs.

What we have discovered is validated in your slides, and I am glad that you went ahead with the pipeline.

Dr. Hallock?

DR. HALLOCK: Maybe just for context, the 11,000 total trainees you put there, roughly 25 percent are IMGs.

DR. NASCA: Yes.

DR. HALLOCK: So that would be 25,000. Of that group, 20 percent are U.S. IMGs, which is really vital for this group. So in

training, there are probably 5,000 to 6,000 U.S. citizens, IMGs, coming out of the system that we talk about, just to give everybody that perspective.

So as Dr. Nasca showed you these numbers changing, the availability of spots for IMGs and for the U.S. IMG's begins to be a part of that pinch that he demonstrated.

DR. REGAN: Excuse me. I have a question on the slide right before that where you had the two lines. Can you go back to that?

I see you have a line, and at the very end you added in the total estimated increase in allopathic and osteopathic graduates, but the line that you first started with -- wasn't it only allopathic? So did you actually increase -- So you added -- So it is cumulative?

DR. NASCA: Yes. You can see, the number is approaching 25,000 in 2013 there. Let me go back, and I will show you where that comes from. Right there.

DR. REGAN: Okay. I knew you had separated them out, and then I didn't know if you were cumulative at the end. Okay. Thank you.

DR. DOCKERY: Other questions?

DR. MALDONADO: Are there any specialties, primary specialties, that are losing positions and accreditations overall?

DR. NASCA: Yes. Well, accredited versus occupied, because there are clearly specialties over that five-year period of time that had a downward trajectory in occupied positions, not accredited positions.

Thoracic surgery would be one of them, dramatically down. Medical genetics would be a second. A third would be down but only slightly down, is general surgery. So there a number of specialties that have a downward trajectory in occupied positions.

I didn't talk about occupancy rates of accredited positions, which is another dimension to this whole issue, because the number of vacant GME positions that are accredited in the United States has dropped dramatically over the last five year, and that is before this big influx of onshore graduates really hits the pavement.

DR. DOCKERY: What has been the success of the encouragement to the effort to grow more primary care accredited residency and training positions and to encourage people to enter primary care?

One of the reasons that I ask that question, too, is the

impact of the student debt that influences specialty choices.

DR. NASCA: Well, there are no deficiency in primary care positions in the United States. So the issue is not accredited positions. The issue in family medicine is it is applicants in internal medicine and, to a lesser extent, pediatrics. It is the specialty choice at the end. It is the sub-specialization after core residency in those disciplines.

OB/GYN is pretty stable. Hasn't gone up dramatically, hasn't gone down at all, really. It is up slightly, if you consider that a primary care discipline.

So the barrier to U.S. graduates choosing primary care is not availability of accredited residency programs.

DR. DOCKERY: And is OB/GYN the only specialty that does their own accreditation? Their special requirements are approved by the ACGME, but they have their own accreditation process.

DR. NASCA: Only for two subspecialties. I guess it's -- It is not their core residency. Their core residency --

DR. DOCKERY: Reproductive endocrinology and --

DR. NASCA: -- MFM, maternal fetal medicine, and there is discussion about that stopping.

DR. DOCKERY: Other questions? Dr. Shah.

DR. SHAH: How do the international medical graduates fit into the pipeline, because I don't think you included that one in there. Correct?

DR. NASCA: Well, by implication -- If one makes the assumption that the majority of the positions will first go to U.S. graduates, the implication is that international graduates will be crowded out.

Now that is not a given, and it is not 100 percent. So what I actually believe will happen is that somewhere around 2011-2012 we will start to see some U.S. graduates from the bottom of the class not get residency positions, because there will be very highly competitive international graduates who will be seen as more desirable than some of those graduates.

We have seen that in a microcosm on occasion in the past, but I think we will start to see that long before the lines cross.

DR. DOCKERY: Dr. Regan?

DR. REGAN: And what is the medical community doing to address this issue? They are looking forward to increasing

anymore slots?

DR. NASCA: The issue -- This is really a governmental issue. This is all driven by government funding. There has been a cap on the number of residency positions since 1997, and until that cap is lifted, you will not see -- I don't believe you will see -- and I am not controlling this. This is individual hospital decisions about whether they either start or expand residency positions.

The reason that fellowship positions continue to expand in the absence of specific funding for them is because, at an institutional level, there are benefits to having fellowships.

Most of the fellowship numbers we are seeing are in new subspecialties, clinical cardiac electrophysiology, interventional cardiology, sleep medicine, palliative care. All of these are new subspecialties that have been introduced that are on the end of the pipeline. They don't increase the diameter of the pipeline.

They provide a programmatic advantage to the institution. So they are willing to front the dollars to support these trainees; whereas, for core residency positions there is less of an economic benefit.

The other factor is that many of our primary care residencies or pipeline residencies are at or near their maximum size in each of the institutions that are currently active. They don't have the capacity to expand. So we would really be talking about putting on new institutions.

MS. LEWIS: Dr. Nasca, do you know the status of the regulation proposed by the Center for Medicare/Medicaid Services in 2007 that would eliminate the Medicare funding for GME positions in the U.S.?

DR. NASCA: Well, there have been numerous different kinds of approaches. You know, MedPAC continues to recommend continuing reductions in the indirect graduate medical education component. I think that -- and there have been at times in the past single payer models proposed -- I mean all payer models, not single payer -- all payer models proposed for graduate medical education.

As far as I can see, there has neither been a mounting charge to increase the number of positions, and there hasn't been a lot of support for doing away with graduate medical education funding. I think there would be -- It would be very difficult to do that. So they whittle at it, I think.

DR. DOCKERY: Are there other questions? Mr. La

Porte?

MR. LA PORTE: So I am a little confused about the location of the bottleneck, because I heard two things. One is that there is a cap on the number of seats and funding, and then two is that the hospitals have their own restraints.

So is the bottleneck with the hospitals or with the government funding?

DR. NASCA: I don't understand your question.

MR. LA PORTE: I heard you explain that the hospitals aren't inclined to increase the number of residency positions. I also heard that there is a limit on the number of seats -- I mean there is a limit on funding.

DR. NASCA: Yes.

MR. LA PORTE: And so I am getting confused. Let's say, for example, a hospital in Chicago wants to add more residency positions. Are they blocked from doing so because of their own constraints? Is that your point, or is it because, even if they applied, there wouldn't be funding?

DR. NASCA: Depends on the hospital. Both of those can be true in one institution. One can be true in one institution and not in another.

What is clear, for instance, is -- For instance, in the Commonwealth Medical School in -- the new medical school in Northeastern Pennsylvania, they are attempting to start residency programs in support of that medical school in the multiple specialties that you need.

Unfortunately, small numbers of residents from other institutions have rotated through the participating sites. So they have an existing cap with Medicare. They have an existing number that is very low. They cannot afford to start those residency positions, because they will receive no medical education funding, incremental funding, from Medicare because of the cap.

So that institution -- it's purely money. In other institutions -- for instance, University of Chicago -- may not be able to increase its internal medicine residency because they have all of their beds covered. They have the appropriate numbers. Then in that situation, it wouldn't necessarily be cap money. It would be capacity.

DR. DOCKERY: Dr. Hallock.

DR. HALLOCK: The problem with the cap is exclusively one of limitation of funding.

DR. NASCA: Yes.

DR. HALLOCK: If a hospital chose to go over its cap, it could, if it could afford it.

DR. NASCA: Right. And that is exactly what is happening with these fellowships, because there is an economic equation that makes sense to them.

DR. DOCKERY: Dr. Crane?

DR. CRANE: Yes. I have a question for you. When we consider public and private hospitals, is there a differentiation in terms of foreign medical graduates and U.S. medical graduates that are accepted into some of those programs? Is it proportioned or do your standards prohibit that?

DR. NASCA: Our standards are neutral on the medical school of attendance. The entry criteria for any ACGME accredited program include ECFMG certification. So it is one of the -- There is no prioritization, either in our standards or in the eyes of the institutions. I think it is on an individual basis.

As regards particular types of institutions having a predominance of one origin or another of the trainee, I think that is largely institutional. It is not in any way accreditation related.

DR. CRANE: There is no regulatory requirement to --

DR. NASCA: There is no regulatory directive. We do not direct trainees in any direction, nor am I aware that anybody does.

DR. DOCKERY: Other comments or questions? Have you worked out the coordination between the institutional accreditation visit for the institutional requirements and then the program review of the residency training programs?

It is terrible when you have lived long enough that you lived through the installation of the institutional requirements and the grumbling and carrying on about they get the institutional visit and then they get the program visit, and how are those things going now?

DR. NASCA: Well, they are going grumblingly well, depending on where you are, I guess.

DR. DOCKERY: So nothing changes.

DR. NASCA: Nothing changes, and we are about to make it worse, because we are probably going to have a separate institutional review for duty hours compliance around that philosophic issue that we talked about.

DR. DOCKERY: Would you briefly just tell us what the six competencies are, so that we all can know what those are, and

you're thinking about a seventh, which you mentioned?

DR. NASCA: Medical knowledge, patient care, professionalism, communication skills and interpersonal relationships, practice-based learning and improvement, and systems-based practice.

DR. DOCKERY: Dr. Munoz, you had a question?

DR. MUNOZ: If the logjam breaks and the funding is lifted or the cap lifted, what do you think the -- or what is the estimation of the catch-up rate will be? Given that the projection of increasing both U.S. medical graduates and an increased number of foreign medical graduates, would you, even if you started now, be able to create enough slots that you wouldn't still run into the pinch?

DR. NASCA: I think that will be specialty specific. One of the things we are trying to understand is, you know, we know pretty much how fast you can create a medical school.

It takes between three or four years to go through the pre-accreditation process, depending on what time of the year you start, before you actually matriculate your first class. Then it is, obviously, three years -- or four years later then you graduate the class.

It probably takes almost as long to start a neurosurgical residency or a general surgical residency, the reason being that the infrastructure for the GME programs, especially around research and the breadth of clinical opportunities and faculty depth in all of those areas that is required is very similar to starting a medical school.

A lot of these people are small in number -- for instance, neurosurgery or some of the subspecialties in surgery -- and there is significant difficulty in doing that and significant expense.

So I would anticipate that, were we to start tomorrow to expand, we would barely be coming online about this time. So I think the clock is running.

DR. DOCKERY: Again, thank you very much, Dr. Nasca.