



# **Milestones Guidebook for Residents and Fellows**

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## INTRODUCTION

Welcome to the second edition of the *Milestones Guidebook for Residents and Fellows!*

This guidebook was written by the resident and fellow members of the ACGME's Milestones Development Working Groups to provide the learner perspective on what the Milestones represent and how they might be used to facilitate progress during residency/fellowship education and training. Understanding the purpose and intent behind the Milestones will help residents and fellows have a background in how and why things are structured the way they are in graduate medical education. Residents and fellows can also learn how the Milestones can be used to improve their abilities in medicine through constructive feedback and coaching. The key points to be discussed include:

- Competency-based medical education
- What the Milestones are and why are they important to you
- Assessment of residents/fellows by the program and subsequent reporting to the ACGME
- Giving and receiving feedback

## SUMMARY RECOMMENDATIONS FOR RESIDENTS AND FELLOWS

1. Be sure to review your specialty Milestones on an ongoing basis, especially at the start of each academic year, to help in your own professional development.
2. Perform a self-assessment twice a year around the same time your program's Clinical Competency Committee (CCC) meets.
3. Review and compare your self-assessment with the CCC's Milestone ratings with your program director, faculty advisor, or mentor.
4. Write an individualized learning plan at least twice a year, and discuss it with your program director, faculty advisor, or mentor.
5. Be an active participant in your regular assessment and feedback.

## COMPETENCY-BASED MEDICAL EDUCATION (CBME)

### Key Points

- CBME uses key ability areas (i.e., the Competencies) to design curriculum and assessment of programs.
- Rather than being based on a specific amount of time required to reach certification, CBME focuses on reaching a standard level of competence for medical practice.
- Content, progression, and assessment are based on the abilities an individual learner demonstrates.
- CBME creates a shared model for residents, fellows, faculty members, programs, accrediting bodies, and the public at large.
- CBME allows for better feedback, coaching, and reflection for residents and fellows to create their own action plans for improvement.

### What is CBME?

CBME has been used to educate residents and fellows, including the implementation of the Core Competencies and the Milestones.

The literature defines CBME as, “an outcomes-based approach to the design, implementation, assessment and evaluation of medical education programs, using an organizing framework of competencies” (Frank et al. 2010). A competency describes a key set of abilities required for someone to do their job. For example, all future doctors must have a basic level of knowledge and ability to provide patient care. Without these critical skills, one could not perform their job.

CBME aims for all graduating learners to achieve basic abilities in key areas to care for patients in practice. Residents, fellows, and other physicians should be able to show they have obtained these abilities. Notably, this is a different model from one where education and training are purely based on how many years you have completed (e.g., three years for internal medicine).

A comparison of Traditional versus Competency-Based Medical Education

Variable	Traditional Educational Model	CBME
Driving force for curriculum	Knowledge acquisition	Knowledge application
Driving force for process	Teacher	Learner
Path of learning	Hierarchical	Non-hierarchical
Responsibility of content	Teacher	Teacher and student
Goal of educational encounter	Knowledge and skill acquisition	Knowledge and skill application
Type of assessment tool	Single assessment measure (e.g., test)	Multiple assessment measures (e.g., direct observation)
Assessment tool	Proxy	Authentic (mimics real profession)
Setting for evaluation	Removed	In clinical and professional settings
Timing of assessment	Emphasis on summative	Emphasis on formative
Program completion	Fixed time	Variable time

Adapted from Carraccio, 2002

## **Why CBME?**

CBME is about ensuring doctors have attained an adequate level of skill or knowledge (i.e., abilities) in key areas important to the practice of medicine for a given specialty. This is critical to the safe care of patients as we ensure their future doctors can practice without the help of supervising attending physicians. CBME also aims to ensure that education and training have standard practices across institutions and programs throughout the United States.

Using CBME as a framework centers the educational mission on the learner and what abilities that learner has obtained. Educational content, tools for feedback and assessment, and evaluation of programs in CBME are learner-centered and based on performance. Other evaluation systems often use Likert-type scales that rely too heavily on faculty members' frames of reference and are more subject to rater bias. CBME emphasizes using evidence-based criteria to judge ability and relies more on directly observed behaviors and performance (demonstrated competence).

CBME rests on creating a shared roadmap for growth and progression during medical education and training. Ideally, this roadmap and shared model can be used by all important members of the educational program: the learners (residents, fellows), the teachers (faculty members, program leadership), and accrediting bodies (the ACGME).

Creating public transparency about the Core Competencies and the roadmap of growth also promotes trust and clarity with patients and the public as they enter the care of residents and fellows.

## **How Has CBME Been Implemented in Medical Education? What Is it to Me?**

### *The Core Competencies*

The ACGME and the American Board of Medical Specialties developed the six Core Competencies necessary for a practicing physician:

- Patient Care and Procedural Skills
- Medical Knowledge
- Practice-based Learning and Improvement
- Interpersonal and Communication Skills
- Professionalism
- Systems-based Practice

Just like a standardized physical exam may use an anatomic approach, the Core Competencies provide a systematic framework to think about both curriculum and assessment in medical education. Each specialty was tasked with crafting specific milestones within each Competency. We will dive further into the Milestones in the next section.

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## **MILESTONES: WHAT YOU NEED TO KNOW**

### **Key Points**

#### **Milestones 2.0**

- Describe the development of specific skills, knowledge, and attitudes (i.e., abilities) organized within the six Core Competencies through the course of education in a specialty/subspecialty
- Represent a shared model for how a resident/fellow can get to the next stage towards mastery
- Created for patients, residents and fellows, faculty members, program leadership, and accrediting and specialty organizations
- Assessed through peer and health professions faculty members (including non-physicians) assessments and synthesized by the Clinical Competency Committee before submission to the ACGME
- Written by key stakeholders and revised after public comment

#### **The Milestones Are a Roadmap for Growth and Development during Residency/Fellowship**

The Milestones represent a roadmap for the development of residents and fellows as they advance in clinical skills, knowledge, and values. The Milestones are divided into the six Core Competencies of Patient Care, Medical Knowledge, Professionalism, Interpersonal and Communication Skills, Practice-based Learning and Improvement, and Systems-based Practice. Each Core Competency is divided into Subcompetencies laid out in five levels.

Each specialty has been tasked with crafting its own Milestones. Indeed, the patient care skills for an internal medicine resident will differ from those for an interventional radiology fellow. The specialty-specific Milestones guide the learning and assessment of learners in that specialty or subspecialty.

From Level 1 to Level 5, the Milestones describe a stepwise progression towards achieving mastery using the Dreyfus Model of Development as a foundation. Level 1 describes what would be expected of a novice in the specialty (a starting resident or fellow). Level 4 is a graduation target (i.e., proficiency in the Dreyfus schema), but not a requirement of the ACGME; each program or institution sets the requirements for graduation. Level 5 describes aspirational performance for a resident or fellow who is acting as a role model or coach for others.

<b>Dreyfus Stage</b>	<b>Description (Clinical reasoning example)</b>
Novice	Rule driven; analytic thinking; little ability to prioritize information
Advanced beginner	Able to sort through rules based on experience; analytic and non-analytic for some common problems
Competent	Embraces appropriate level of responsibility; dual processing of reasoning for most common problems; can see big picture; complex problems default to analytic reasoning; performance can be exhausting
Proficient	More fully developed non-analytic and dual process thinking; comfortable with evolving situations; able to extrapolate; situational discrimination; can live with ambiguity
Expert	Experience in subtle variations; distinguishes situations

**Milestones Can Help with Assessing Yourself and Growing as a Physician**

Residents and fellows should use the Milestones as they consider where they are in their educational program, to identify areas to grow, and to understand what each stage looks like. Often the Milestones describe a progression from common or basic abilities to more complex and nuanced ones.

Imagine setting off on a hike in a park where you have never been. A map and mile markers are essential to helping you get to the end of the trail. Similarly, for any profession, knowing where you are now in your abilities and what you need to focus on next helps you along a path to mastery. The Milestones can help residents and fellows intentionally focus on each step in becoming the best physicians they can be.

The Milestones can also provide a common language to use with faculty members and program leadership. Residents/fellows can specifically ask about how they are doing in a specific competency area (e.g., patient care) or subcompetency (e.g., clinical reasoning). Having a common language and model can help the resident/fellow and the clinical coach work together.

Like a swimmer getting coached on how to push off the wall, or a pianist on intonation, having a shared understanding and language for getting better improves the learning experience.

In addition to the Milestones for each specialty/subspecialty, Supplemental Guides, written by each specialty-specific Milestones Work Group, are designed to provide additional clarity and examples.

## Milestones Were Created for Multiple Stakeholders

The Milestones were created for several critical stakeholders within health care and medical education. Ultimately, creating a shared model for growth and development for future physicians is critical to maintain transparency and engender trust with patients and the public.

Residents and fellows are the next key critical stakeholders as they are assessed on these milestones throughout their educational program.

Clarity, transparency, and standardization of common educational specialty-specific Milestones creates a more fair and equitable system for learners. *These assessments will also help program directors determine whether a resident or fellow is ready to be promoted or advanced to the next stage of their educational program.*

Milestones are also designed to assist programs in utilizing an evidence-based, learner-centered assessment model. The Milestones provide a framework approach to assessing residents and fellows. Finally, the Milestones are reported to the ACGME and assist in continued evaluation and institutional accreditation.

### The Purpose and Function of the Milestones

Constituency or Stakeholder	Purpose/Function
Residents and Fellows	<ul style="list-style-type: none"> <li>● Provide a descriptive roadmap for training</li> <li>● Increased transparency of performance requirements</li> <li>● Encourage informed self-assessment and self-directed learning</li> <li>● Facilitate better feedback to the resident or fellow</li> <li>● Guide personal action plans for improvement</li> </ul>
Residency and Fellowship Programs	<ul style="list-style-type: none"> <li>● Guide curriculum and assessment tool development</li> <li>● Provide more explicit expectations of residents and fellows</li> <li>● Provide a meaningful framework for the Clinical Competency Committee (e.g., help create shared mental model of evaluation)</li> <li>● Support better systems of assessment</li> <li>● Enhance opportunity for early identification of under-performers so as to support early intervention</li> </ul>
ACGME	<ul style="list-style-type: none"> <li>● Accreditation – enable continuous monitoring of programs and lengthening of site visit cycles</li> <li>● Public Accountability – report at an aggregated national level on competency outcomes</li> <li>● Community of practice for evaluation and research, with a focus on continuous improvement</li> </ul>

Adapted from Holmboe, 2015

## **Determination of Residents'/Fellows' Current Milestone Levels Is Performed by the Clinical Competency Committee**

More will be described regarding assessment in the next section. Beyond a shared model for resident/fellow development, the Milestones are also reported by programs to the ACGME, which provides continued monitoring and accreditation. This allows fellowship programs to view the Milestones of an individual learner reported by the prior residency program.

## **Milestones 2.0 Were Written by Key Stakeholders and Revised after Public Comment**

Representatives representing patients/the public, residents and fellows, faculty members, program directors, and specialty organizations were invited to participate in the writing of the Milestones. Each specialty group met in person multiple times to draft their Milestones. Editors at the ACGME then reviewed the working drafts to ensure consistency. The subsequent draft was then put forth to the community for public comment before ultimately being finalized for implementation by each specialty.

## **Harmonized Milestones**

An additional update to the Milestones in version 2.0 is the creation of Harmonized Milestones for the Practice-based Learning and Improvement, Systems-based Practice, Interpersonal and Communication Skills, and Professionalism Competencies. Because many of these abilities are shared and universal across subspecialties, the ACGME convened an interdisciplinary work group to create consistency throughout GME.

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## **ASSESSMENT FOR RESIDENTS AND FELLOWS**

### **Why Assessment Matters**

Assessment is used both for giving feedback and for making decisions about level of competence or progression to the next level of education. There are two primary types of assessment: norm-referenced and criterion-referenced.

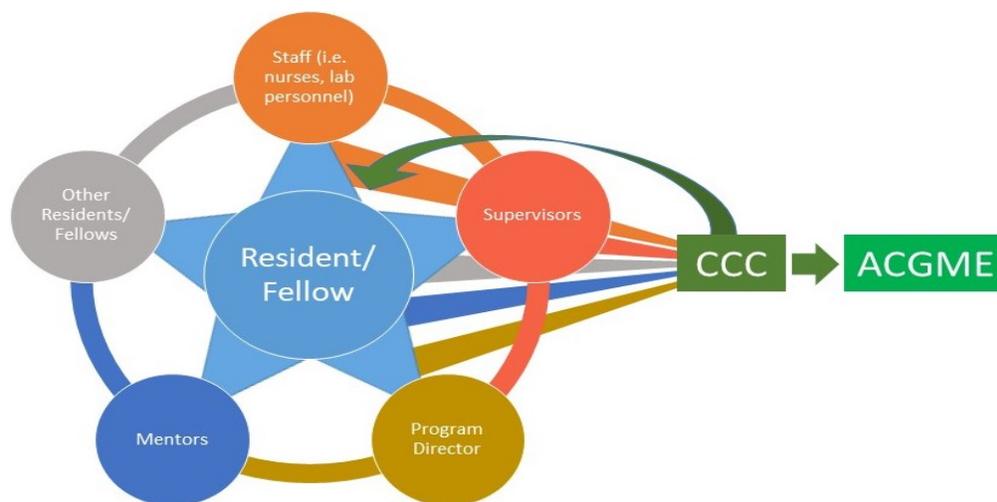
In a norm-referenced assessment, the standard compares the individual to other residents and fellows, i.e., “*Does this resident (fellow) look like other residents (fellows) at this stage of education?*” However, this has the potential to introduce bias and be variable over time.

Criterion-referenced assessment compares the individual to a specific standard or criteria, i.e., the Milestones.

Each program has a set of tools that faculty members and other health care professionals use to assess residents’ and fellows’ competence in the six Core Competencies, and each specialty has a unique set of subcompetencies under each. Ideally, every preceptor should be in a position to observe residents and fellows in the clinical setting and to rate their competence according to objective criteria for each subcompetency.

### **The Process of Milestone Assessment**

Each program has a Clinical Competency Committee (CCC) that collates and reviews all assessments for every resident or fellow in the program to produce a judgment (i.e., rating) on each milestone. The CCC must meet twice a year to discuss the ratings for each resident or fellow. At a minimum, assessment from attending physicians who supervise residents’ and fellows’ work should include direct observation of clinical encounters with patients and probing of clinical reasoning skills. It is also recommended that the CCC obtain multi-source feedback assessments (e.g., 360-degree evaluations) from all others with whom a resident or fellow may have interacted during a rotation. This provides a more complete picture of areas (competency domains, skills) that may be more difficult to assess, such as communication and professionalism skills. The Milestone assessments are then shared with the program director who reviews and reports the data to ACGME.



### **The Importance of Self-Assessment**

Self-assessment using the Milestones will enable residents/fellows to critically evaluate their abilities. Self-assessments can then be compared with the results from the CCC meetings for a more meaningful evaluation. If a particular milestone is not clear, the Supplemental Guide can provide further explanation and examples.

### **The Resident's/Fellow's Role in the Assessment Process**

Residents/fellows should take an active role in their assessment. If a resident/fellow feels that attending faculty members are not taking the time to observe their performance in each of the subcompetencies, they should ask for specific feedback to help them improve their performance. This feedback will help the resident/fellow develop their abilities in a meaningful and productive manner.

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## RESIDENT/FELLOW FEEDBACK

Regardless of job title and experience, we are all simultaneously educators and learners, both giving and receiving feedback on a daily basis. Thus, competence in giving and receiving feedback is crucial to the delivery and maintenance of excellent patient care (Jug, Jiang, and Bean 2019).

*Remember, feedback is an **ACTIVE** process, both for those **GIVING** the feedback and for those **RECEIVING** it.*

### Features of High-Quality Feedback

Feature	Evaluator	Learner
Timeliness	Feedback should be given at a point when the recipient would be able to implement corrective behavior or learn from the <i>specific</i> feedback.	<i>Timeliness</i> is key in order to recognize and improve weaknesses. <b>ASK</b> for feedback early to implement corrective actions.
Specificity	Feedback is most useful when it is <i>specific</i> . General feedback is not helpful for directed learning or professional development.	<b>PREPARE</b> for a feedback session. <b>REFLECT</b> honestly on yourself, and ask <b>SPECIFIC</b> questions about your performance.
Balance	Feedback should have a <i>balance</i> of both “reinforcing” and “corrective” comments, without one dominating the other. Deliver feedback with empathy in mind.	If the deliverer of feedback is giving too much reinforcing or corrective feedback, probe them with questions about what you could improve or your successes.
Recipient feedback/reflection	It is important to allow time for the recipient to process and reflect on the feedback throughout the session.	Reflect on what was told in order to create an “action plan” together with those delivering the feedback.
Action plans	Create and develop a plan during the session by setting goals for the recipient, giving timelines, and following-up!	Set goals and timelines for yourself. Check in frequently with advisors to ensure you are on the right track to meet your goals.

### 1. Types of Feedback

**Formal feedback.** Formal feedback is the most easily recognized type of feedback. It can be structured and often uses a documented formal evaluation method, such as an end-of-rotation form. Formal feedback often occurs at specified intervals (e.g., mid-rotation, end-of-rotation). This type of feedback can be thorough.

**Informal feedback.** Informal feedback should occur a couple of times throughout a rotation and often involves observations of skills and/or interactions. Generally,

this type of feedback involves a short meeting when both parties are able to focus on the conversation at hand. This feedback can be given/asked for in the moment or after a particular patient encounter.

## 2. Barriers to Feedback

- a. **Evaluator.** Common barriers include time constraints, limited understanding of the recipient’s expected competence level, discomfort that may be associated with giving negative feedback, and fear of retribution. This is important to keep in mind when giving feedback to more junior residents/fellows, peers, or faculty members/supervisors (upward feedback).

### How to Work Around This

- Set aside time to actively give feedback, preferably in a quiet, private space.
- Balance corrective feedback with reinforcing feedback, being sure not to provide too much feedback and overwhelm the receiver.
- Practice giving feedback to colleagues or other trusted individuals.
- Ask a mentor how to effectively give upward feedback.

- b. **Recipient.** Common barriers include time constraints, unknown expectations, and unease asking for feedback from particular evaluators. Recipients may also feel that they are “bothering” the evaluator by asking for feedback.

### How to Work Around This

- Be an active learner and take charge of your education.
- Ask for time for feedback.
- Self-reflect prior to the conversation and come prepared with specific questions.

## 3. How to Receive or Seek Out Feedback

- a. **Self-reflect.** Take time for critical self-reflection and identify personal weaknesses.
- b. **Develop “active” questions.**

### How to Seek Feedback

Vague - <b>AVOID!</b>	More specific	Even better	Other examples
How am I doing?	What should I do differently to improve my technique in X?  OR What can I do differently next time to improve my presentation?	How can I make this presentation more concise?	What suggestions do you have on how I can improve on X?  I have a goal of X- what do you recommend to ensure I achieve goal X?

- c. **Ask early!** Be sure to ask for feedback early and often.
- d. **Express Gratitude.** The fact that someone took their time to give you thoughtful feedback means they care about your success and patient care.

#### 4. How to Give Feedback

- a. **Do your research.** Ensure you understand the role of the person you are evaluating. You do not want to have specific expectations for someone who isn't yet expected to be able to do something; similarly, you do not want to miss any crucial expectations of the person you are evaluating. Take time to reflect on their performance. If you know that you are expected to evaluate someone, it may be helpful to make a physical or mental checklist of their performance over time, so that you can refer back when it is time to give feedback.
- b. **Give feedback early.** Just as you appreciate early feedback and identification of weaknesses so that you can improve, offer the same to others to allow them enough time to correct their behavior.
- c. **Set aside quiet, uninterrupted time.** No one likes to give or receive feedback in a public area. Ensure privacy and try to minimize interruptions.
- d. **Use techniques that you have admired in role models who have given you critical and useful feedback.** Perhaps you really appreciated one mentor who gave a "balance" of reinforcing and corrective honest feedback.
- e. **Provide guidance or tips when delivering negative feedback.** If you are delivering corrective feedback, ensure the person you are evaluating has time to reflect. It is often difficult for people to hear corrective feedback, and even more difficult for people to take the negative feedback and use it in a useful manner. Provide guidance, tips, or action items on how to improve or correct behavior.
- f. **Practice.** Ask a colleague to run through scenarios, including those in which the recipient disagrees or becomes defensive. If you practice remaining calm and focusing on the message, you will be confident in any feedback situation.

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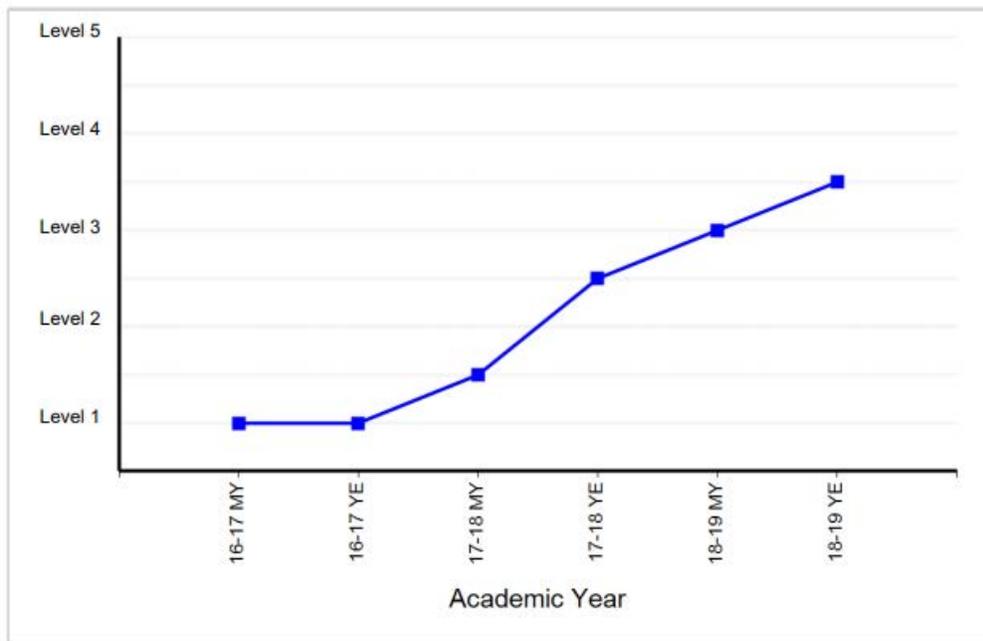
## MILESTONES REPORTS AVAILABLE IN ADS

When program directors submit Milestones evaluations twice each year, they can also download several reports on resident/fellow Milestones data. These reports may be provided to residents/fellows as a stand-alone evaluation, or in conjunction with their semi-annual evaluation. The examples below are from a third-year anesthesiology resident.

### Report 1: Individual Milestone Trends

This report includes a graph showing the individual's progression for each subcompetency. Notice how the resident begins at Level 1 and steadily progresses to Level 3.5. This is preferred over maintaining the same level status throughout residency, suggesting lack of self-improvement or growth.

#### 1. Patient Care - Patient Care 1: Pre-anesthetic Patient Evaluation, Assessment, and Preparation



## Report 2: Individual Milestone Summary

This report provides a snapshot of the individual's most recent evaluation for each subcompetency in Interpersonal and Communication Skills. While the resident effectively communicates with patients, the resident could improve these skills with other professionals.

### Interpersonal and Communication Skills

	Level 1 Not Yet Achieved	Level 1	Level 2	Level 3	Level 4	Level 5
a). Interpersonal Communication Skills 1: Communication with patients and families				●		
b). Interpersonal Communication Skills 2: Communication with other professionals			●			
c). Interpersonal Communication Skills 3: Team and leadership skills					●	

## Report 3: Individual Milestone Evaluation

This report provides the text of the level assigned for each subcompetency. When an individual's evaluation is between levels, the text for both levels are displayed with the higher level test identifying that the resident has achieved certain, but not all of the requirements. In Patient Care 7, below, the resident is between Levels 4 and 5.

7 Patient Care	Patient Care 7: Acute, chronic, and cancer-related pain consultation and management
<p><b>Dr. Name is between Level 3 and Level 4.</b></p> <p>Formulates differential diagnoses of acute and chronic pain syndromes; identifies appropriate diagnostic evaluation.</p> <p>Participates in complex procedures (e.g., thoracic ESI, medial branch blocks, radiofrequency procedures, sympathetic blocks) for alleviating acute, chronic, or cancer-related pain, under direct supervision.</p> <p>Prescribes initial therapy for pain medication, and adjusts ongoing medication regimens with indirect supervision; uses ultrasound and fluoroscopy with direct supervision.</p> <p>In addition, Dr. Name has achieved certain, but not all, elements of the competency level listed below:</p> <p>Acts as consultant for acute pain management to junior residents and other health care providers with conditional independence.</p> <p>Consults with non-anesthesiologist specialists regarding pain management as appropriate.</p> <p>Recognizes treatment failures and obtains appropriate consultations, including with a pain medicine specialist.</p>	

## SCENARIOS AND SUGGESTIONS

### 1: What to do if you are being considered for remediation

- Meet with an advisor, an associate program director, or the program director to better understand the situation.
- Before the meeting, review your written evaluations and the Milestones for your specialty.
- The Milestones can provide a common language to talk about areas for improvement and what next steps you can take.
- Create a plan on what steps you can take to reach the next level of the Milestones.
- In future clinical care, take the opportunity to identify what you would like to work on with your attending physician or supervising resident, and ask for direct observation and coaching.
- Take time to reflect on how you are doing and where you are on the Milestones. It can be helpful to reflect with your attending physician and advisors.

### 2: Striving for mastery

- The Milestones detail what an exemplary resident or fellow looks like in Level 5 of each subcompetency.
- Consider the subcompetency for which you would like to demonstrate mastery.
- Work with advisors and faculty members to make an individual plan on how you might achieve higher levels toward mastery.

In both cases, the Milestones can provide a shared model for how to advance in your education and training, offering a tool to navigate conversations and self-reflect for improvement.

## OTHER RESOURCES

The ACGME provides many resources for residents, fellows, faculty members, and program administration and leadership, and new resources are developed regularly. Visit the Milestones section of the ACGME website to review available resources and tools.

Currently available resources include:

- *Milestones Guidebook*  
The *Milestones Guidebook* was written to aid with programs' understanding of the Milestones. Included is a look back at how and why the Milestones were created, tips for implementation, and ideas for giving better feedback.
- *Clinical Competency Committee Guidebook*  
The *Clinical Competency Committee Guidebook* was designed for all stakeholders, and includes information and practical advice regarding the structure, implementation, function, and utility of a well-functioning CCC.
- *ACGME Milestones National Report*  
This annual report is a snapshot of Milestones ratings and is available each fall for the preceding academic year. It is intended to highlight both central tendencies and meaningful variation within and across specialties.