

*Resident Review* is published periodically by the Accreditation Council for Graduate Medical Education. Opinions stated in the newsletter do not necessarily reflect the policies of the ACGME. Comments and suggestions should be sent to Julie Jacob, manager of communications, [juliej@acgme.org](mailto:juliej@acgme.org).

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## rounds

### Residents' Council Meeting Focuses on Increasing Resident Perspective in the ACGME

For the first time since its inception, the Council of Review Committee Residents (CRCR) met at ACGME headquarters. Top ACGME staff members talked about some important issues facing the ACGME and graduate medical education. The ACGME's executive director, David C. Leach, MD, spoke of the two themes that had emerged from the ACGME June 2006 retreat – exemplary accreditation and improving the relationship between ACGME and review committees.

Along those lines, Dr. Leach stressed that ACGME is striving to become the best accrediting body in the world through consistent and fair standards, measuring what ACGME and graduate medical education values and creating an environment that exemplifies competence.

Dr. Leach noted that the retreat was an opportunity for formal professional development, and he emphasized how important the resident perspective is to the ACGME's work. Dr. Leach presented the themes that represented the resident's perspective:

- Need for more input.
- Add a medical student/applicant section to ACGME Web site.

- ACGME should be more transparent about all program information.
- Faculty must be good role models.
- What happens when things are bad – to whom does the resident turn (intimidation, sexual harassment/work harassment issues)?
- Deceleration option (flexible time for other activities during training).
- Graduate package (accomplishments, letter from ACGME, more data elements about experience).

The second theme about improving relationships between the ACGME and review committees continues to be an ongoing collaborative effort. Jeanne Heard, MD, PhD, director of accreditation committees, gave an overview of the ACGME and asked the council a number of questions about how the ACGME can improve. A few recent improvements include:

**Common Program Information Form (PIF)** – a committee has been working to prepare the Common PIF which will match the new common program requirements and include questions about the general competencies. It will replace the Competency and Assessment Form, the "CAF". The senior executive directors will meet in January to finalize the Common

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## reminders

### Upcoming Meetings

Accreditation Council for  
Graduate Medical Education  
Winter Board of  
Directors Meeting  
Chicago, Illinois  
February 12–13, 2007

ACGME Annual  
Educational Conference  
Orlando, Florida  
March 2–4, 2007

Council of Medical  
Specialty Societies  
Spring Meeting  
Chicago, Illinois  
March 16–17, 2007

Internal Medicine 2007  
San Diego, California  
April 19–21

Federation of State  
Medical Boards  
Annual Meeting  
San Francisco, California  
May 3–5, 2007

American Hospital Association  
Annual Meeting  
Washington, D.C.  
May 6–9, 2007

PIF. After the common program requirements are approved at the February Board meeting, the accreditation standards team will begin incorporating the common program requirements and Common PIF into the specialty requirements and PIFs, respectively.

**E-bulletins** – the December *ACGME E-bulletin* has been posted to the Web site. It contains important practical information for review committee teams, program directors and designated institutional officials (DIOs). It features articles about the standard letters of notification and the resident/fellow survey.

**New Features in Accreditation Data System (ADS)** – The ADS will feature program director changes and voluntary withdrawal submitted through ADS: the staff is still programming ADS to offer these two new features, which should be ready in mid-January.

In addition, with the help of two outside consultants, the ACGME is undergoing an internal review. Select review committee members, including residents, have completed the Web-based survey and participated in phone interviews. This information will be used to improve Board governance and the review committees' work.

John Nylen, chief operating and financial officer, presented information about ACGME data collection, finances, and expenses. Mr. Nylen emphasized that non-public data is not shared and none of the data is sold. He noted that case logs, at the resident's request, are sent to some specialty boards. He discussed some future projects that include a password-protected Web site for residents to verify their ACGME data, and a database with resident e-mails that would allow residents and the ACGME to communicate.

Finally, Tina Foster, MD, associate director of graduate medical education at Dartmouth Medical School, talked about the principles and underlying values of learning portfolios. The principles are:

1. Collection of evidence about competence.
2. Begun in residency in all cases (and in some cases in medical school).
3. Owned by a resident.
4. Evidence is verified during residency by site visitors (residents allow because they want to be certified).
5. Reflections on experience are private or can be shared with a mentor at discretion of resident).
6. Program directors can see elements of the portfolio that enable them to document competence as part of initial certification.
7. Designated institutional officials can see new aggregate data that demonstrates program performance and types of assessment tools used by their programs.
8. Residency review committees can see aggregate assessment data, anonymous data on individual performance.
9. Institutional Review Committee can see aggregate data.
10. Graduating resident can continue to enter data into their portfolio.

Finally, the meeting concluded with some council members volunteering to represent the ACGME when the media calls. The resident's perspective is very important to the ACGME, and the council seeks your help in improving accreditation

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## resources

### Useful Web Sites

Association of American Medical Colleges

[www.aamc.org/members/orr](http://www.aamc.org/members/orr)

American Board of Medical Specialties

[www.abms.org](http://www.abms.org)

American Medical Association Section on Residents and Fellows

[www.ama-assn.org/pub.category/12851.html](http://www.ama-assn.org/pub.category/12851.html)

Council of Medical Specialty Societies

[www.cmss.org](http://www.cmss.org)

Educational Commission on Foreign Medical Graduates

[www.ecfm.org](http://www.ecfm.org)

Federation of State Medical Boards

[www.fsmb.org](http://www.fsmb.org)

National Resident Matching Program

[www.nrmp.org](http://www.nrmp.org)

and graduate medical education. If you have issues that you would like the council to consider, please direct them to the chair, Seenu Reddy, MD, at [reddyvs@uthsca.edu](mailto:reddyvs@uthsca.edu), the vice chair, Cynthia Bodkin, MD, at [cindy\\_bodkin@yahoo.com](mailto:cindy_bodkin@yahoo.com) or ACGME staff, Marsha Miller at [mmiller@acgme.org](mailto:mmiller@acgme.org). The next CRCR meeting is February 10–11, 2007.

*Written by Marsha Miller, staff liaison to the CRCR*

### ACGME Developing Online Portfolio for Residents

As physicians go through their residency programs, they learn in many different ways: by treating patients, reading journals, talking with faculty, giving presentations, doing research. They also receive feedback from their supervisors and are periodically evaluated.

As a resident, perhaps you have wished there was a way to gather together in one place the records of all that you've learned and done, as well as the feedback and evaluations that you have received, and to reflect on what it all means and how you're growing as a physician.

Soon, there will be.

Over the next few years, the ACGME will introduce an online resident learning portfolio that will empower residents with a tool to store their residency records – including case logs, evaluations, their curriculum vitae, research articles, and presentations – in a secure, online portfolio. More importantly, it will give them a place to privately reflect on their learning and to share their reflections with their teachers, if they choose to do so. Learning activities will be grouped into the ACGME's six general competencies

(patient care, medical knowledge, practice-based learning and improvement, professionalism, interpersonal skills and communication, and systems-based practice) to help residents and program directors assess their mastery of those competencies.

Residents will own the information in their portfolios. However, they must agree to share information in the portfolio, except for their private journal reflections, with program directors and faculty so they can assess their progress. Designated institution officials, ACGME site visitors and ACGME review committees will have access to aggregate data.

An ACGME Learning Portfolio Advisory Committee met three times last year to discuss the purpose and structure of the portfolio. ACGME staff are creating a prototype portfolio that will be tested in 2007 at three to five residency programs. Based on feedback from residents and directors at those programs, the ACGME will refine the learning portfolio and test it at programs in various specialties in 2008. The final portfolio will be introduced to all programs in late 2008 or early 2009.

### ACGME Book Chronicles Chief Residents' "Journey to Authenticity"

Ask a resident how he or she became interested in medicine, and every one will tell you a different story. One will tell you that he wanted to be a doctor like his grandfather; another will say that her mother encouraged her; yet another will tell you that he entered medical school because his banking career was no longer meaningful.

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## reference

**ACGME Definitions****Clinical Supervision**

A required faculty activity involving the oversight and direction of patient care activities that are provided by residents.

**Combined Specialty Programs**

Programs recognized by two or more separate specialty boards to provide GME in a particular combined specialty. Each combined specialty program is made up of two or three programs, accredited separately by the ACGME at the same institution.

**Competencies**

Specific knowledge, skills, behaviors and attitudes and the appropriate educational experiences required of residents to complete GME programs.

Although the paths that brought these doctors to medical school vary, all these physicians shared one thing in common: their journey from an unsure intern to a confident and competent chief resident. The ACGME's executive director, David C. Leach, MD, calls this a "journey to authenticity; a journey in which physicians discover both clinical wisdom and themselves. It is a journey that no one can take for them or spare them; it is a journey that is surrounded by external drama, but which actually proceeds from the inside out."

The "journey to authenticity" of chief residents will be chronicled in a book, *Journey to Authenticity: Voices of Chief Residents*, that the ACGME is publishing this winter in honor of the Council's 25th anniversary. The book is a collection of Q&As with 20 chief residents, who reflect on their residencies. The physicians – representing a cross-section of primary care physicians, surgeons, and specialists from across the country – talk about their

reasons for becoming doctors, and how they grew both as professionals and people during their residencies. The chief residents were recommended by program directors who have received the ACGME's Parker J. Palmer Courage to Teach Award. The residents include an orthopedic surgeon serving in the Navy, a surgeon who immigrated to the United States from Belize, a family practice doctor who worked in a medical clinic in Kenya, and a former Wall Street trader who became an ophthalmologist. Their stories, and those of 16 other chief residents, are told in their own words, accompanied by photographs of them taken by Roberta Sonnino, MD, who is a pediatric surgeon and associate dean for academic and faculty affairs at Creighton University School of Medicine in Omaha, Nebraska – as well as an accomplished photographer.

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**Consortium**

An association of two or more organizations or institutions that have come together to pursue common objectives (e.g., GME).

**Designated Institutional Official (DIO)**

The individual in a sponsoring institution who has the authority and responsibility for the graduate medical education programs.

**Didactic**

A kind of systematic instruction by means of planned learning experiences, such as conferences, grand rounds, etc.

**Teaching needs to be included in definition of scholarship**

The ACGME Common Program Requirements define scholarship in Section III.B.4 as possessing the components of discovery, dissemination, and application. Complementary to this is “the regular participation of the teaching staff in clinical discussion, rounds, journal clubs, and research conferences in a manner that promotes a spirit of inquiry and scholarship; and the provision of support for resident’ participation, as appropriate, in scholarly activities.”<sup>1</sup> While most of us would agree that these activities are complementary to academic medicine as a whole, I would challenge us to redefine scholarship to have a broader meaning.

Many program directors face the increasing challenges of maintaining an accredited residency program (not to mention one with exemplary accreditation) with the multitudes of paperwork, oversight, organization, mentorship, etc. that the job entails. In addition, they have clinical and academic responsibilities that are time intensive and may or may not have adequate non-clinical time to devote to these other activities. Pressures to publish research are ever-present and come not only from the institutional level, but from the ACGME as well.

Supported by the Carnegie Foundation for the Advancement of Teaching, Ernest Boyer published *Scholarship Reconsidered* in 1990 which challenged the definition of scholarship to include four overlapping components: the scholarship of discovery, the scholarship of integration, the scholarship of application, and the scholarship of *teaching*.<sup>2</sup> Surveys conducted by Boyer and the Carnegie Foundation sought to then develop a method of quality assessment for this new definition in order to ensure academic excellence. Although Boyer passed away before seeing it through completion, the results were published in 1997 by Glassick et al. in *Scholarship Assessed*.<sup>3</sup> The following six standards for scholarship arose from this work: clear goals, adequate preparation, appropriate methods, significant results, effective presentation, and reflective critique. Numerous papers were published to follow expanding on these ideals.<sup>3-6</sup>

If we accept Boyer’s definition of scholarship and Glassick’s six standards for scholarship then we enable faculty to take a less traditional approach towards scholarly activity and encourage them to pursue teaching as a large part of that process. A similar approach to scholarship has been adopted by some institutions, with promotion and tenure committees no longer considering the number of publications to be the primary foundation for professional advancement. Wright et al found an inverse relationship between research activities and the probability of being identified as an excellent role model. At least 25% of time spent teaching had a strong independent association with being named an excellent role model. Yet these are the faculty not being recognized for having traditional scholarly activity.<sup>7</sup>

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**Duty-Hours**

All clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic assignments such as conferences. (See Common Program Requirements)

*Definitions are from the ACGME Glossary. The entire glossary is posted online at [http://www.acgme.org/acWebsite/about/ab\\_ACGMEglossary07\\_05.pdf](http://www.acgme.org/acWebsite/about/ab_ACGMEglossary07_05.pdf)*

It should then follow suit that counting the numbers of manuscripts, book chapters and abstracts that faculty members and/or program directors have published is not the only determinate of scholarly activity. Other aspects should be considered and rewarded such as curriculum development, educational outcomes-based measures, web-based learning resources, mentorship, etc. A program directors' dedication to and involvement in scholarship is clearly visible through looking at an excellent accreditation history, for one cannot exist without the other. I challenge all of us to look closely at how we define and measure scholarship and consider changing some or all of these views. As members and constituents of the ACGME we may want to stop counting publications one by one and start looking at scholarship as a whole.

*Written by Maggie Ann Jeffries, MD, CA-3 Resident, Johns Hopkins University*

<sup>1</sup>ACGME Common Program Requirements. Effective July 1, 2004

<sup>2</sup>Boyer EL. Scholarship Reconsidered: Priorities of the Professoriate. Princeton, NJ: Carnegie Foundation for the Advancement of Teaching, 1990.

<sup>3</sup>Glassick CE, Huber MR, Maeroff GI. Scholarship Assessed – Evaluation of the Professoriate. San Francisco, CA: Jossey-Bass, 1997.

<sup>4</sup>Glassick CE. Reconsidering Scholarship. J Public Health Management Practice 2000; 6: 4-9.

<sup>5</sup>Glassick CE. Boyer's expanded definitions of scholarship, the standards for assessing scholarship, and the elusiveness of the scholarship of teaching. Academic Medicine 2000; 75: 877-880.

<sup>6</sup>Fincher RE, Simpson DE, Mennin SP, Rosenfeld GC, Rothman A, McGrew MC, Hansen PA, Mazmanian PE, Turnbull JM. Scholarship in teaching: An imperative for the 21st Century. Academic Medicine 2000; 75: 887-894.

<sup>7</sup>Wright SM, Kern DE, Kolodner K, Howard DM, Brancati FL. Attributes of excellent attending-physician role models. NEJM 1998; 339: 1986-1993.