From the Editor: The "Tipping Point" in the ACGME Competencies in Ophthalmology

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The Accreditation Council for Graduate Medical Education (ACGME) is now several years into the national "grand experiment" of integrating six general competencies into residency training across specialties in the United States. For those of us "in the trenches" of graduate medical education, the process has been interesting and educational but it also has been frustrating, slow and not without its share of controversy. I believe that academic ophthalmology is now at a critical "tipping point" for the ACGME outcome project. As with any new initiative there have been exciting educational innovations created by small groups of daring explorers; there has also been grudging acceptance and even modest participation in the process by a cadre of "early adopters" (perhaps as high as 20%). Unfortunately, the vast majority of programs ("the middle 60%") are still waiting for their marching orders before they will commit to full implementation of the ACGME competencies and worse the last 20% of programs will likely only be brought along "kicking and screaming". I believe that we are therefore at a critical balance point between failure and success in terms of the widespread adoption of the ACGME competencies.

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Success will likely require three "top down" events: 1) The ACGME must provide specific, measurable, realistic, time limited, and prescriptive approaches to meeting the competency requirements; 2) The specialty residency review committees (RRCs) must enforce the mandate and begin to cite programs for noncompliance with the competency mandate; and 3) The specialty stakeholders (i.e., the Academy of Ophthalmology), certifying (i.e., the boards), credentialing and licensing, accreditation, and the academic leadership organizations must come together to align their organizational objectives with the ACGME mandate and to recommend and approve specific assessment tools to their individual constituencies that will be acceptable to all in the short term (i.e., transition tools in testing or development) and in the long term (e.g., longitudinal benchmarks and outcome measures).

The guiding principles for both designing and implementing the necessary tools to meet the requirements of the ACGME competency mandate have already been described for ophthalmology and by other authors in other specialties. I will summarize the key issues for moving forward below.

Formative feedback that forms the basis of summative feedback.

The goal I believe is to teach and assess at the same time and in the same encounter. Both formative (i.e., feedback that allows for learner improvement over time) and summative (i.e., the final grade) feedback mechanisms will need to be in place that provide objective assessment of competence across all six of the ACGME competency domains. The formative component ideally would occur midway during the learner's rotation or learning experience and the summative feedback would document both completion of the content and an accurate quantitative and qualitative assessment of performance at the end of the learning encounter. Ideally, the feedback process would be structured, scheduled, involve multiple (i.e.,

360 degree evaluation) evaluators (e.g., faculty, peers, patients, other professional staff) and would occur over multiple encounters (i.e., increase the sample size). In addition, the raters should undergo some type of rating training and they would also receive performance feedback themselves on their own inter-rater and intra-rater reliability. Learners and programs will be required to document progressive individual learner and programmatic improvement over time and to provide benchmarking evidence based upon aggregate data to the accreditation and certifying bodies that the resident at graduation has sufficient professional ability to practice competently and independently.

The "big four" tools.

It is my opinion, based upon my review of the literature and the progress and experiences of our sister specialties that four specific tools will likely come to be the core for all programs to start their assessment process and to come into compliance with the ACGME mandate. The four tools are: 1) examinations of medical knowledge (i.e., oral and written exams); 2) direct observation of performance in the real world (e.g., the ophthalmic clinical exam) using a structured scoring rubric; 3) global formative and summative evaluations including multi-source (i.e., 360 degree evaluation) evaluations; and 4) a learning portfolio that documents self reflection and life-long learning, practice improvements over time (e.g., chart audit) using the best available evidence (i.e., practice based learning), and systems based competency (i.e., self directed projects demonstrating an understanding and application of the system to optimize patient care).

The ACGME has recognized the importance of maintaining forward inertia during this critical "tipping point". There is emerging consensus that the following are important steps: 1) the accreditation goals including those of its participants (i.e., learners, teachers, national credentialing and certifying organizations) and the outcomes of the assessment tools themselves must be aligned; 2) Some degree of standardization and uniformity is highly desirable for the core measures but there also must be sufficient customization to allow specialties like ophthalmology to revise and improve the tools to match their specialty specific needs; and 3) Program Directors (PDs) in the "middle 60%" will need a "starter kit" for implementation that has received a "Good Housekeeping" seal of approval from the ACGME as well as a "green light" from the specialty and certifying organizations. PDs in the innovating minority ("top 20%") will require flexibility in the compliance approach and should be given rewards, incentives, permission and the opportunity to experiment. Unfortunately, PDs in the bottom 20% ("laggards") will likely require RRC citations to come into compliance.

The ACGME has already commissioned a special advisory committee to conduct a literature review of the existing assessment tools; to define criteria to evaluate the quality of the tools and the attributes of an ideal learning environment from an assessment perspective; to simplify the process through a "consumer-guide" type report of tool evaluations; and to disseminate and promote a "starter set" of core tools, implementation (best practice) guidelines and a model implementation plan.

Although I believe that we are at a "tipping point" for the ACGME competency mandate I am confident that with a continued effort and with the recognition and help of the national accreditation, certifying, and specialty organizations in ophthalmology that we can tip the balance towards success for the ACGME outcome project.