PORTFOLIOS: AVOIDING DISASTER

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Learning Objectives:

At the end of this presentation, the learner should be able to:

- Describe the potential advantages and disadvantages of using a portfolio in Graduate Medical education (GME)
- List the key reasons that portfolios fail in GME
- Identify the different types of portfolios and the advantages and disadvantages of each type
- Describe the planning steps needed to introduce portfolios to fit individual program needs

Nearly a decade has passed since the unveiling of the Outcomes Project by the Accreditation Council for Graduate Medical Education (ACGME). As described by the ACGME, "the Outcome Project is a long-term initiative by which the ACGME is increasing emphasis on educational outcomes in the accreditation of residency education programs." Briefly put, the ACGME sought (and continues to seek) to shift the emphasis from the potential for a program to train competent physicians to the actual accomplishment of that goal. Accreditation by the ACGME increasingly rests on the ability of each program to demonstrate with outcomes data its successful production of physicians competent in the 6 core competencies. Gone are the Program Information Form (PIF) questions about numbers of books, square footage of office space, and numbers of hospital beds, and in their place are sections requiring descriptions of best practices, examples of assessment methods for the core competencies, and specific learning activities (other than lecture) during which residents develop a commitment/ competence in specific core competencies.

The paradigm shift in accreditation criteria necessarily translates into the need for better/ more elaborate/ innovative/ and unfamiliar resident assessment methods. Thankfully, the ACGME provided a toolbox of evaluation methods with rankings of their utility for each of the core competencies. Overwhelmed by the task of choosing and implementing new assessment methods, program directors with a utilitarian leaning quickly determined that portfolios and 360˚evalutions appeared to be the "darlings" of the ACGME. Portfolios are rated as the "most desirable", "next best", or a "potentially useful" method in assessing competence in Practice-Based Learning and Improvement, Professionalism, and Systems-Based Practice, perhaps the three most challenging of the competencies to assess. At the outset, portfolios appeared to be a terrific answer to the assessment dilemma.

Perceived advantages:

- Effective to assess at least three (maybe the toughest three) of the core competencies
- Can serve as both a learning tool and an assessment tool
- Promotes life-long learning and a model for demonstration of continuing competence
- Encourages self-directed learning and the development of individualized learning plans
- Functions as a repository for resident work product (presentations, projects, journal club write-ups, case reviews, quality improvement projects) and nationally vetted assessments (certifications, In Training Exam scores, etc).

Despite these perceived advantages, portfolios have met with mixed success in GME. A review of the literature reveals some of the key reasons that portfolio development and acceptance have been slow, and perhaps painful.

"Top Ten" Reasons Portfolios Fail in GME

1. Representatives of all stakeholder groups (residents, faculty, administration, support staff and information technology staff (if electronic format is to be used) are not included in the development stages.
2. Entry requirements are too structured making the resident feel that the exercise is for the administration, overly bureaucratic and not for individual learning.
3. The purpose, structure, and use of the portfolio are not clearly defined and/ or are not widely known by all stakeholders.
4. Participants (residents, faculty, staff) are given insufficient resources to efficiently work with the portfolio. This includes inadequate time or the expectation that "portfolio" time should be tacked on to the end of an already tiring day rather than carving time out from other activities.
5. A portfolio structure that is overwhelmingly bulky, cumbersome, or difficult to access causes frustration and is demoralizing. Keep it lean. Make it convenient.
6. The fear of disclosure of "bad outcomes" may diminish the honesty/ intensity of self-reflection. Self-reflection that includes bad outcomes or demonstrated need for improvement is not necessarily protected from discovery under peer review law.
7. Required entries are "separated" from the real-life learning experience of the individual resident. Thought and work should center on the actual experiences of the resident and not a fictional or artificially standardized event/ encounter.
8. The summative assessment aspect is abandoned or minimized. If portfolios are not perceived as important by either the resident or faculty, attention will be diverted from this activity toward others that have high stakes. Including summative assessment ensures that portfolio learning maintains its status alongside other assessment methods used by the program.
9. The portfolio is introduced with limited training of all end users. Repeated training is needed all users, especially residents, mentors, and assessors.
10. The portfolio, in its original structure, is completed as a finished template for completion by the resident. Anonymous surveys of all portfolio users should be conducted at least annually to understand the challenges, attitudes, successes, and needed next steps to make the system more user friendly and valuable to the learning and assessment process.

The development stage for inclusion of a Portfolio in GME requires considerable time and stakeholder input. A Portfolio Committee (PC) including respected representatives from all stakeholder groups must be educated about portfolios in order to rationally approach a number of key decisions.

Key Decisions:

- Purpose of the Resident Portfolio
    - All competencies vs selected competencies
    - Includes vs. excludes self-reflection/ self-assessment (consider legal implications)
    - Portfolio as an assessment tool versus merely a repository
- Type of Portfolio (who "owns it)
    - Learning – learner selects content; may not meet competency requirements
    - Structured – learner and program have input into inclusions
    - Showcase – learner provides only examples of best work
- Structure
    - Paper vs. electronic
    - Required entries vs. creator choice

- Evaluation of Portfolio content
    - Evaluators: Mentor/ Program Director/ Portfolio Committee

    - Scoring: Subjective versus Rubric
    - Evaluation type: Formative vs. Summative (versus both)
- Expectations for Portfolio creation
    - Time commitment – when, how much time, how to count the time
    - Number of entries – minimum in each category, min/ max length
    - Breadth of entries – core competencies covered, types of entries

Just as portfolios support individualized learning for residents, they also are conducive to customization by specialty, by program and by clinical site. The more comprehensive a portfolio is to be, the more necessary it will be to "earmark" specific sections for specific clinical experiences. For instance, anesthesiology residents are required to rotate for 4 weeks in a pre-anesthesia evaluation setting. The PC may decide that the only portfolio entry that needs to be made during this clinical experience revolves around Systems-Based Practice. Faculty overseeing this rotation can become experts at helping residents determine suitable entries into the SBP section of the portfolio. By developing this expertise, faculty become invested, rather than overwhelmed or disinterested, in portfolio development. Perhaps most important is to continuously focus on structuring the portfolio to be a selective and purposeful collection of materials that demonstrate learning, and the acquisition of important skills, behaviors, experiences, and attitudes expected of a competent physician in the specialty.

Success in portfolio development will be more likely if the development includes these steps:

1. Organize a kickoff event to which all stakeholders (not just representatives) are invited. The kickoff should explain the rationale, advantages, purpose, general structure, possible uses, and resources allocated to the development of a resident portfolio system. Allow stakeholder groups to choose representatives for the PC.
2. The PC should conduct frequent meetings starting soon after the Kickoff to further define the purpose, structure, and uses of the portfolio. Once defined, these key anchors for the portfolio should be publicized to all stakeholders.
3. The PC should contact the Legal Department to investigate the ramifications of including self-reflection pieces in the portfolio. If Legal discourages such inclusion, consider asking residents to verbally share self-reflection with the mentor and to then identify learning objectives based on the self-reflection. Make it clear to all stakeholders the discoverability status of each portfolio section.
4. If the portfolio is to be comprehensive, consider assigning specific portfolio sections to specific clinical rotations, encouraging buy-in and minimizing the chances for faculty to be overwhelmed.
5. Provide examples of entries (both exemplary and deficient) to both mentors and residents. When examples are not provided, residents often feel considerable anxiety about using a portfolio.
6. Invest in training for faculty and residents. Faculty need to be able to identify opportunities for portfolio entries "in the moment" of bedside care. Residents need training to feel confident about how to identify and develop appropriate portfolio entries.
7. Provide extensive idea lists for portfolio entries eg. write up an interesting or challenging case; do a literature review on a current controversial topic and come to your own conclusion of best practices; when you are frustrated with the system, spend some time thinking what changes need to be made and jot down your thoughts; keep track of your comfort level in getting informed consent; develop a 5 minute teaching script for medical students on a topic you wish you had known more about when you were an intern, etc.
8. Consider requiring self-reflection that is shared with a mentor but not physically included in the portfolio. New learning objectives can be added to the portfolio as the result of self-reflection.
9. Develop a global rubric for summative evaluation of portfolio entries and ensure that residents understand the rubric. Such a standard for evaluation of portfolio entries provides security for residents and faculty. Combine portfolio assessment (using a rubric) with a one-on-one resident interview. The assessment of such an personal learning "record" deserves a more personalized

approach. Residents need to be given the opportunity to discuss the portfolio and the rubric results.

10. Consider a phasing in period for portfolios. Perhaps the first year of implementation, the portfolio is 70% a repository for learning that is already being documented (eg. conference attendance, journal club participation, presentations, quizzes/ exams, compliance training) and 30% "new entries" (eg. case reviews, best practice recommendations, learning plan, etc). Subsequent versions of the portfolio can shift toward a higher percentage of entries based on individual resident experience.

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