The Unintended Consequences of Portfolios in Graduate Medical Education
Alisa Nagler, JD, EdD, Kathryn Andolsek, MD, MPH, and Jamie S. Padmore

Abstract
Portfolios have emerged in graduate medical education despite lack of consensus on their definition, purpose, or usefulness. Portfolios can be used as a tool for residents to record their accomplishments, reflect on their experiences, and gain formative feedback. This exercise may help prepare physicians for lifelong learning as well as enhance patient care. The Accreditation Council for Graduate Medical Education has endorsed and may soon require the use of portfolios as an assessment tool to evaluate resident competence. However, using portfolios for summative evaluation purposes such as making high-stakes decisions on resident promotion or matriculation may deter resident candidness. In addition, the use of portfolios in clinical settings raises issues unique to the health care setting such as patient privacy, disclosure of clinical information, and professional liability exposure of physicians. It is not clear that peer-review statutes that sometimes protect educational materials used in teaching and evaluation of residents would also bar disclosure and/or evidentiary use of portfolio contents. Is the teaching institution, resident, or graduate vulnerable to requests and subpoenas for the portfolio contents? If so, then a resident’s documentation of insecurities, suboptimal performance, or bad outcomes would be ripe for discovery in a medical malpractice lawsuit. If embraced too quickly and without sufficient reflection on the nuances of implementation, this well-intentioned initiative may present unintended legal consequences.

By definition, portfolios are a collection of a learner’s experiences demonstrating evidence of learning, achievement, and assessment. Portfolios in medical education have been predominantly used for recording formative assessment, critical to the competence of practice-based learning and a foundation for the lifelong learning process of a physician. The learner incorporates critical experiences such as interactions with patients, clinical decision making and management plans, personal behaviors, and responses to situations. The compilation of this information allows one to reflect on actual practice and identify deficiencies requiring improvement. Self-reflection is most authentic and meaningful when the resident physician is assured the content will be used not to his or her detriment but, instead, for learning and improvement.

In addition to formative assessment, information contained in these portfolio documents can be used for summative evaluation, including academic promotion, recertification of physicians, and even program accreditation. Faculty may review resident portfolio entries and documents during annual evaluations to assess resident competence as part of promotion or graduation criteria. The Accreditation Council on Graduate Medical Education (ACGME) introduced portfolios as 1 of 13 tools in its “Toolbox Assessment Methods,” which are intended to “improve the evaluation of residents during their residency education programs.” ACGME is currently developing an electronic portfolio that will be available to residency programs and potentially used for future accreditation of programs, as well as formative and summative assessment of individual residents.

Physician educators, hospital leaders, and medical school faculty must understand the potential consequences that may result from the implementation of portfolios in the clinical setting. For purposes of this article, we limit the use of the term “peer review” to professional assessment processes conducted by one’s peers. States have peer-review statutes to protect candid peer evaluation in an attempt to encourage health care quality improvements. Each state defines, typically in their respective health occupations regulations or code, the specific parameters of what constitutes peer review. These definitions have vast variation, but they generally include reference to the review of performance of health care provided by health professionals (i.e., one’s peers). A “peer-review body” is typically limited to a

Dr. Nagler is assistant professor, Office of Graduate Medical Education, Duke University Hospital, Durham, North Carolina.

Dr. Andolsek is associate director of graduate medical education, Duke University Hospital, Durham, North Carolina.

Ms. Padmore is assistant vice president of academic affairs, MedStar Health, Columbia, Maryland.

Correspondence should be addressed to Dr. Nagler, Office of Graduate Medical Education, Duke University Hospital, Box 3951, Davison Building, Yellow Zone, Room 1086, Durham, NC 27710; telephone: (919) 681-6601; e-mail: alisa.nagler@duke.edu.

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defined committee, board, or hearing panel of the institution.

It is unclear whether the contents of a resident’s portfolio, specifically self-reflection, would be protected under these existing statutes. Documentation of suboptimal performance might be useful for individualized learning plans and professional development, but it could be detrimental to a physician’s career if used as evidence for medical malpractice lawsuits. Educationally, incorporating and documenting self-reflection in a portfolio is meritorious, but protection under existing peer-review statutes cannot be assumed. If embraced too quickly and without sufficient “reflection” on the nuances of implementation, this well-intentioned initiative may present unintended legal consequences.

If self-reflection and use of a portfolio as a learning and assessment tool are acknowledged and accepted by our profession, can existing state or federal laws be enhanced to protect physicians in order to candidly assess one’s own performance? If not, are we placing our residents and our institutions at risk under the current system?

The Portfolio as an Assessment Tool

The ACGME Outcomes Project was initiated in 2002 to increase the emphasis on educational outcomes in the accreditation of residency programs. To adequately prepare physicians for a changing health care system, the ACGME identified six general competencies for residents. The Outcomes Project created a shift of focus in GME from acquisition of knowledge to the achievement of competence. A resulting challenge is the identification of instruments that formatively encourage the development of competencies and assess whether competence is being attained.14

The portfolio is recognized as a tool to enhance resident learning through self-reflection.5–8 Additionally, it may serve as a competence assessment instrument.9–11 Despite widespread initial adoption of portfolios in GME programs, debate remains regarding content, purpose, and usefulness. Portfolios range from a loose collection of personal reflections and individualized goals and objectives to a structured compilation of evidence dictated by a program and used for high-stakes objective decision making.

Portfolios are defined in the literature as a collection of multiple sources of information to provide evidence of learning and accomplishments.1,6,7,15 Proponents assert that portfolios provide a comprehensive picture of everyday practice and performance and afford a gauge for resident competence.6,15,16 They are intended to foster active participation in learning through self-reflection, goal setting, and identification of achievements. Critics assert the unclear value and outcomes of the portfolio and frequently cite the lack of evidence demonstrating reliability and validity as an assessment tool.17,18

The candid self-reflection component of a portfolio is thought to be critical to the development of competent physicians.7 Portfolios can promote reflection on strengths, weaknesses, and opportunities for growth.1,15 Self-reflection can have a positive impact on continuous quality improvement, reduction of medical error, and increased patient safety.5,11,19 The portfolio entry can result in identification of safety problems, candid discussions with faculty, and the assignment of finding a system-based solution.20,21 These practices are essential to physician professional development and lifelong learning. Many advocate portfolio implementation during training to set the stage for independent practice.6,15

Finally, debate remains regarding the use of the portfolio for summative assessment of individual learners. Residents may be less open in their reflections if they know the portfolio will be used to make high-stakes decisions such as academic promotion or program completion.11,15,19

Despite the lack of consensus in definition, usefulness, and outcome, the implementation continues in various forms across programs. The ACGME strongly endorses portfolio use in GME.11–13,22,23

The ACGME Learning Portfolio will serve as a repository for resident work products as well as a learning tool for residents, enabling them to track experiences, self-reflect on those experiences, share their insights, and receive real-time formative feedback.13

The ACGME’s electronic portfolio system will initially be introduced as voluntary, although proposals allude to potential future requirements. Portfolios are highlighted in ACGME’s Outcomes Project, Learning Portfolio, and Portfolio Advisory Council Report.12,13,22 The ACGME’s Web-based portfolio is currently in a beta-testing phase and is scheduled to be available (and potentially required) by 2010. Under the proposed guidelines, residency programs would transmit the contents of portfolios to the ACGME to be used for outcomes and accreditation purposes.22

The ACGME has further defined the six core competencies with 25 subcompetencies. The ACGME document, “ACGME Competencies: Suggested Best Methods for Evaluation,”23 illustrates the portfolio as a “best method” for 11 of these 25 subcompetencies, representing four of the six core competencies. Portfolios are noted as “the most desirable” evaluation tool for four subcompetencies and “the next best method” for the two remaining. Portfolios are characterized as one of the top three methods to evaluate each of the “Practice-Based Learning and Improvement” subcompetencies.12,23

Compared with other traditional assessment tools, serious questions related to the use of portfolios in the clinical setting must be raised. Do portfolios expose resident physicians and health care institutions to additional liability? Although the ACGME contends that portfolio contents will be protected information, this has not been tested by the legal system.

Statutory Protections of GME Training Material—Are They Sufficient?

Portfolios are intended to be self-initiated and owned by the resident.7,11,19 However, the sponsoring hospital or medical school will likely maintain and transmit the data to the ACGME.23 As a result, the resident, the sponsoring institution, and the ACGME may all be recognized as legitimate “keepers” of the data and, therefore, vulnerable to requests and subpoenas for this information when suits arise.

The article “Protecting Residency Programs’ Compliance Documents From
Disclosure Under State Public Records Acts by the ACGME Counsel examines disclosure under state public records acts, specifically the Freedom of Information Act (FOIA).24 Because most hospitals and medical schools, and even the ACGME, do not constitute government agencies subject to the Public Records Acts, this analysis is not applicable to most GME institutions using portfolios. Outside of the FOIA and its state counterparts, private institutions and organizations rely on legislative efforts at state and federal levels to bar disclosure and evidentiary use of peer physician evaluations. The Health Care Quality Improvement Act, Family Educational Rights and Privacy Act, and state medical review statutes attempt to address clinical quality documents and processes, which may include confidential learner evaluations. Existing state statutes protect peer-review participants from liability in an effort to promote candid assessment of professional conduct, competence, and ability. However, federal courts are not obligated to recognize state peer-review privileges, and many do not.25

In some states, educational materials used in teaching and evaluating residents may be protected by peer-review statutes. The specific material protected by these statutes, the structural requirements to protect such material, and the exceptions that apply all vary by state law. The diversity of court findings exemplifies that state peer-review statutes do not uniformly bar disclosure and evidentiary use of material used in the physician-review process. For instance, one state court found that the peer-review statute does not protect against the discovery of information generated before the peer-review process begins or after it ends.26 Another peer-review statute did not protect documents which originated outside the formal peer-review process that were available from other sources.27 One state court found that whereas practicing physician–peer evaluations are protected, evaluations of resident performance are not.28 A state court in Illinois (where ACGME is located) found that even if the facility is covered by the peer-review statute, material created by a committee not formally designated as a “peer-review committee” will not be protected.29 Many GME committees are not structured as formal peer-review committees. Thus, there is not uniformly expressed language or interpretation of state statutes that protect educational material.

The Unintended Consequences of Portfolios

In-house legal counsels have already suggested leaving (documented) reflection out of assessment because of the lack of definition concerning privacy rights associated with these documents. This, in addition to the variation in state peer-review statutes, gives rise to many potential unintended consequences. There are a number of reasons why it is not clear that a portfolio, or the contents of a portfolio, would be protected under state peer-review statutes.

1. A portfolio is intended to be “owned” by the learner, not the institution. Peer-review statutes protect institutions and products created by institutions through their respective peer-review committees. Currently, this privilege is not extended to individuals’ self-reflection. Specifically, peer-review statutes are intended to protect peers from recrimination for offering honest and critical feedback to and about one’s peers.28 Self-reflection is not peer review but self-review. Even if the portfolio were submitted to a departmental competence committee for review and assessment of the individual, then the minutes of the meeting would be protected but not the portfolio itself. For example, in the District of Columbia, it has been concluded that the actual review of activities is confidential, but the information submitted to peer-review bodies (such as basic facts about matters, medical records, and statistical trends relating to a physician) are not protected. Only the deliberations, critiques, and future planning that arise from the peer-review activity are actually protected under the current statutes.30

2. The implications of transferring this educational material to other agencies are unknown. Like all businesses, the ACGME is subject to both federal laws and governing laws for the state in which it does business. Transferring data to this Illinois business, clearly outside of the peer-review process, adds to the jurisdictional complexity and exposure of risk to multiple parties.

3. State courts have ruled that information generated outside of or after the peer-review process ends is not protected.29 However, the intent of the portfolio is that it be maintained by the resident even after the education concludes and used, even supplemented, post residency. Given these aforementioned state rulings, it is unlikely under current laws that portfolios will be protected if they follow the resident beyond the training programs as part of the lifelong learning process. Under existing law, plaintiffs’ attorneys will reasonably argue that the portability of this information compromises any previous protections realized by the institution.

Assuming there is no absolute privilege or protection of portfolio entries, the activity of self-reflecting on one’s positive and negative clinical training experiences is daunting. Why would physicians in training document their insecurities, medical errors, and bad outcomes? This content would be ripe for discovery if ever the physicians were accused of malpractice. Personal documentation of a resident’s clinical shortcomings, whether perceived or actual, creates an exposure in the event of future malpractice claims. This is especially the case if an entry reflecting suboptimal performance is never countered by a subsequent entry documenting competence and sustained performance. From an institution’s viewpoint, why would a GME program require portfolio self-reflection entries when a future plaintiff could argue that the institution was liable by allowing this admittedly underprepared physician to complete training?

Many GME institutions struggle with implementing portfolios. Eduationally, self-reflection is recognized as critical to professional growth and lifelong learning.7,31 Aspiring to remain well accredited, GME programs are anxious to "check off" their use of this strongly recommended evaluation tool. As a profession, we are accountable to many factions and interests, including our residents. Therefore, in the litigious society in which we live, programs and institutions must be cognizant of
the consequences resulting from documentation of clinical self-reflection.

**Practical Suggestions and Policy Implications**

Further examination and reflection are necessary on the potential unintended consequences of portfolios in medical education before their widespread adoption. Each institution should be familiar with relevant state statutes and case law and understand statutory requirements regarding the proper creation and operation of peer-review processes. Defining the purposes of the GME structure and processes (e.g., creation and evaluation of peer-review material for the purpose of providing educational feedback to peers and for the purpose of ensuring quality of patient care) is critical. Institutions should carefully establish and adhere to record-retention policies (paper and electronically stored data) regarding what must be maintained in resident files. When such materials are taken by residents at the conclusion of training, the institution must advise them appropriately of potential implications. Until laws are changed or implemented to protect self-reflection, institutions must be diligent to understand their existing state laws.

Existing peer-review statutes need to be broadened to include educational materials, such as portfolios, as protected documents. Alternatively, separate legislation addressing self-reflection as a legitimate component of one’s learning and improvement processes must be written.

If a state statute expressly defined personal reflections shared with an academic (peer-review) committee, it could be protected. But, states have not done that. Policy makers should consider portfolios used in the clinical setting as protected documents, to be used by individuals and institutions to improve quality of patient care. Ideally, this should be addressed at a national level, replacing the veritable state statutes of peer-review protection. Additionally, a federal law would minimize confusion for physicians moving from state to state, or for institutions required to transmit educational material to agencies located in different jurisdictions.

The Institute of Medicine (IOM) has made recommendations to Congress to pass legislation extending peer-review protections. These protections would cover data related to patient safety and quality improvement efforts collected and analyzed by health care organizations for internal use or shared with others solely for purposes of improving safety and quality. The IOM and ACGME, as well as other interested parties, should extend these recommendations to include information shared with others for the purpose of enhancing physician education, training, and lifelong learning.

The ACGME should further explore these complex issues of clinical information (including physician self-reflection) transfer and storage, which have never been applied under Illinois law. Doing so would aid in protecting residents and institutions and enhance the authenticity of physician assessment. Candid self-reflection and suboptimal performance disclosure followed by meaningful discussions with faculty may prevent medical error and lead to quality improvement and necessary system-based change—all of which will impact the delivery of patient care.

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Teaching and Learning Moments

Food Insecurity on Three Dollars a Day

Every afternoon, the headaches and lethargy would set in. The last few hours of clinic were a struggle, like wading through deep sand. Concentration became a challenge. My daily routine became difficult—getting up was no longer stimulating, and working out, one of my favorite methods of revitalization, became a chore. It’s difficult to lead a normal life subsisting on just $3 per day.

A week earlier, during a talk on barriers to food access that was part of my family medicine clerkship, the lecturer challenged my class to eat on $21 a week, the amount allotted to the average food stamp recipient. With my basic knowledge of nutrition, I set out to the grocery store, confident that I could maintain a healthy diet on $3 per day. I made my selections—two packages of whole wheat pasta, a bag of frozen mixed vegetables, two pounds of carrots, four apples, two packs of whole wheat tortillas, and one gallon of 1% milk. I had spent my weekly allotment with a few cents to spare. At home, however, reality began to set in. I had only 18.5 servings of fruits and vegetables for the whole week, and my protein intake was going to be well below the minimum recommended level. Almost immediately, meals became nothing but a source of fuel. As I watched others eat a variety of foods, I found myself dreading mealtimes and the dissatisfaction I knew would come. Spending the weekend at my girlfriend’s parents’ house meant lugging my meager food ration with me. While I sat nudging my bland pasta, she and her family enjoyed a rich variety of flavors I could only imagine from my side of the table. During that weekend, I lost interest in what I was eating, shoveling in the tasteless mouthfuls robotically without even heating the food.

Throughout the week, I struggled to concentrate during lectures, a new experience for me. Although I kept my hourlong morning workout routine of weightlifting and aerobic training, I soon found that it was consuming too many of my now-precious calories.

I began to understand why poorer patients do not always comply with the exercise and dietary recommendations prescribed by their doctors. Many of these recommendations assume that patients have access to the appropriate resources that nutrition plans and exercise regimes require. Resources, such as access to fresh fruits and vegetables, vitamins, and the protein-rich food that provide the energy necessary to complete a strenuous exercise regimen, are not easy to come by when a patient’s diet is limited to $3 per day.

What if I—like the 28 million Americans living on food stamps—had to eat this way, not just for one week, but for a lifetime? What if I had grown up without an adequate diet? What habits might I have developed to comfort myself in ways that food no longer could? Would I be in medical school? I will never again take for granted that my patients have access to the proper resources as I ask them to exercise or watch their diets. As the week ends, I am exhausted and grateful to return to my accustomed routine.

Jordan Shapiro and Melanie Sberna

Hinojosa, PhD

Mr. Shapiro is a fourth-year student, Medical College of Wisconsin, Milwaukee, Wisconsin.

Dr. Hinojosa is assistant professor, Department of Family and Community Medicine, Medical College of Wisconsin, Milwaukee, Wisconsin; e-mail: (mhinojosa@mcw.edu).