Pilot Test of Family Medicine Faculty Development Fellowship Accreditation Guidelines

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**Background:** We conducted a pilot test of accreditation guidelines for family medicine faculty development fellowship programs from September 1997 to March 1999. The accreditation guidelines included 8 application categories with 27 requirements and 5 self-study criteria. The process included completion of the accreditation application and self-study and a site visit. We selected 6 sites for participation in the pilot test, and 5 sites completed all steps. The results indicated that, while fellowship faculty felt that the requirements and criteria were valid for determining quality of faculty development fellowship programs, the process was time-consuming and could be shortened. Redundancy between information supplied on the application and on the self-study was also noted. Six recommendations were included in the final report, including streamlining the accreditation process, developing guidelines for probationary status, and considering alternatives to accreditation, such as peer review.

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In 1993, Richard L. Holloway, PhD, who was then the Society of Teachers of Family Medicine (STFM) president, initiated discussions about the feasibility of accrediting faculty development fellowships in family medicine. The Accreditation Council for Graduate Medical Education (ACGME) calls the programs it accredits *residencies* and reserves the term *fellowships* for those graduate medical education programs that do not receive ACGME accreditation. There is no current accreditation for family medicine faculty development fellowship programs.

A task force of faculty development experts was convened to develop requirements, criteria, and a process for accrediting family medicine faculty development fellowship programs, issuing a task force report in April 1995 (unpublished).

Based on established practices in higher education and graduate medical education, the guidelines included 27 specific application requirements grouped into 8 categories, 5 self-study criteria that included 38 possible indicators, and a 5-step accreditation process. The accreditation requirements as they appeared in the task force report are shown in Appendix 1, and the self-study criteria and indicators are shown in Appendix 2. The process for conducting the accreditation is described in this report.

In 1995, as part of STFM's Faculty Futures Initiative, a 5-year strategic planning initiative funded by the Health Resources and Services Administration (HRSA), the STFM Board of Directors authorized the study reported in this manuscript. The study determined the viability of the accreditation guidelines and makes recommendations about their effectiveness. This paper summarizes the methods, results, and recommendations of the test.

**Accreditation Process**

The task force report describes a 5-step accreditation process. First, an applicant for fellowship accreditation completes a preliminary information form for staff analysis. This form (Appendix 1) asks the applicant to respond to questions about the fellowship requirements. If these data provide reasonable evidence that the fellowship will meet the accreditation criteria, the second step is for the applicant institution to com-

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plete a self-study. The self-study involves responding to any deficiencies noted by staff in the preliminary form and responses to the accreditation criteria (Appendix 2). In the third step, the self-report is reviewed by a team of peer consultant-evaluators. Fourth, based on the consultant-evaluators’ judgment of the likelihood that the fellowship meets the criteria, the consultant-evaluators will proceed with a site visit to validate the self-study report information. Finally, the self-study report and team report will be used by the accreditation review committee to determine accreditation status.

The study reported here determined the viability of the process and specifically focused on steps 1–4 of the accreditation process just described. No accreditation decisions were made or attempted based on the data collected during this pilot test.

Methods
Evaluation of the Accreditation Guidelines
After review of competing proposals, a contract issued by STFM was awarded to conduct this study to the first author of this paper, Christopher B. Reznich, PhD, a medical educator with 10 years of experience with family medicine faculty development programs. Dr Reznich is hereafter referred to as the principal consultant. The second author, Brian E. Mavis, PhD, referred to as the second consultant, has experience in program evaluation and was subcontracted to assist with data collection during the site visit step of the accreditation process.

Site Selection
The accreditation process was intended for 3 types of faculty development fellowship programs. The typology was based on the work of Bland et al. It should be noted that the types of faculty development programs described by Bland et al differ somewhat from the types used by HRSA in its current faculty development grants program.

Type 1 programs were those preparing participants primarily for full-time appointments at university- or community-based programs working with both students and residents. Fellows focus on teaching, patient care, and administration and are recruited locally or regionally.

Type 2 programs prepare fellows for full-time work in comprehensive institutions, universities, and sometimes community settings. Fellows, recruited nationally, emphasize research, as well as undergraduate and resident teaching, patient care, and administration.

Type 3 programs train faculty to work full-time in research-oriented universities where they conduct extensive research, teach, provide patient care, and administer programs. Fellows are recruited nationally.

During the site selection process, it was difficult to distinguish between type 1 and type 2 programs with respect to the roles for which fellows were being prepared. Fellow recruitment appeared to be a more-distinguishing characteristic and was added to better differentiate between the 2 types of fellowship programs.

Site selection began with a review of the Fellowship Directory for Family Physicians and discussions with individuals familiar with fellowship programs. An initial 6 fellowship programs were identified—2 representing each type of fellowship program—and invited to participate in the pilot test. The invited sites represented all geographical regions of the United States; all agreed to participate.

After confirming the 6 initial programs, a type 1 site ceased operation and was replaced by another program. The other initial type 1 site was unable to complete the accreditation application and was excused from further participation, except for a follow-up telephone call to discuss difficulties encountered in attempting to complete the application. This site was not replaced. Table 1 presents some characteristics of the sites that completed the pilot test. All identifying information has been omitted to maintain the anonymity of the participating institutions and programs.

Data Collection
Data collection included several phases:

Application Phase. Each participating fellowship completed an application addressing the 8 accreditation requirement categories and their 27 associated requirements (Appendix 1). It should be noted that there were 22 specific requests for documentation noted in the application requirements. It was the documentation requests that constituted the major focus of the application process.

Participating programs were also asked to rate the level of difficulty in providing the data and documentation necessary to complete the application. In cases where the information was not readily available, an estimate of the difficulty for acquiring it was requested. A form for recording this information was included with the application materials.

Table 1
Site Characteristics

<table>
<thead>
<tr>
<th>Program Type</th>
<th># of Fellows Per Year</th>
<th>Duration of Fellowship</th>
<th>Years of Operation</th>
<th># of Graduates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>12</td>
<td>1 year</td>
<td>11</td>
<td>105</td>
</tr>
<tr>
<td>Type 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Site A</td>
<td>14–16</td>
<td>1 year part time</td>
<td>19</td>
<td>280</td>
</tr>
<tr>
<td>Site B</td>
<td>7</td>
<td>1 year part time</td>
<td>20</td>
<td>125</td>
</tr>
<tr>
<td>Type 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Site A</td>
<td>2</td>
<td>2 years full time</td>
<td>12</td>
<td>24</td>
</tr>
<tr>
<td>Site B</td>
<td>Up to 5</td>
<td>1–3 years full time</td>
<td>19</td>
<td>47</td>
</tr>
</tbody>
</table>
**Self-study Phase.** Each fellowship program conducted a self-study and documented how well its program met the accreditation criteria (Appendix 2). In addition to making a case for how their program met the accreditation self-study criteria, fellowship representatives also responded to any requests for further documentation or clarification on the basis of the initial application.

**Site-visit Phase.** The principal consultant, in preparation for site visits, reviewed self-study documents from each site. During the site visit, the principal consultant solicited opinions regarding the desirability, cost, and process of the proposed accreditation guidelines. A minimum of 5 representatives from each fellowship program were interviewed during the site visits, including the department chair, fellowship director, assistant fellowship director, fellowship staff, and recent graduates.

On 3 site visits, the principal consultant was accompanied by the second consultant to determine the extent to which 2 observers agreed in their observations. The 2 consultants visited 3 fellowship programs that represented each of the 3 program types. The consultants participated together in the interviews with fellowship and institution faculty. While there was no observer training, both consultants were guided by identical sets of questions for the site visits. An example of the interview guide is shown in Appendix 3.

Field notes and program artifacts (eg, instructional and learner evaluation materials, etc) were collected during the site visit. Each site visit was 1 business day in length.

**Data Analysis**

Data analysis varied according to the phase of data collection described in the previous section.

1. **Accreditation Application.** The principal consultant reviewed all documents for completeness. Descriptive statistics were compiled that described the percentage of information requests and the ease or difficulty of supplying the requested documentation.

2. **Self-Study.** The self-study documents were reviewed for the extent to which they addressed the 5 accreditation criteria (Appendix 2). The numbers of indicators addressed, along with numbers of pages dedicated to each criterion, were recorded for each of the reporting fellowship programs.

During the analysis of the self-study documents, it became apparent that there were instances in the self-study documents in which programs referred back to the original application documents. Data for these original application documents were collected and noted as examples of redundancy between the accreditation application and the self-study document.

3. **Site Visit.** Opinion data regarding the desirability, cost, and process of accreditation were compiled and analyzed for repeated themes. In the cases in which there were 2 consultants conducting the site visit, data were analyzed to determine the extent to which there was agreement in the observations recorded by the consultants. This happened in 1 of 2 ways. First, the observers prepared a site visit report of a type 2 site after a first visit. Field notes taken by both observers during the site visit provided the data for calculating inter-observer agreement percentages. Second, the observers prepared individual site visit reports based on their own field notes after the second and third site visits to a type 1 and type 3 site. These reports provided the data for inter-observer agreement study.

The 2 consultants’ field notes from the type 2 site visit were compared, and an item analysis was conducted. The content of the field notes was color coded, with 1 color for ideas that both sets of field notes had in common, 2 other colors for ideas that 1 consultant recorded but not the other, and a fourth color for items on which the consultants disagreed. A similar procedure was followed for the reports generated from the type 1 and type 3 site visit field notes. Percentages of agreement between the 2 consultants, percentages of documentation by 1 consultant and not the other, and percentages of disagreement between the 2 consultants were calculated. This analysis was performed by the principal consultant. There were no a priori standards for inter-observer agreement established. The goal was merely to describe levels of agreement and disagreement between the 2 observers participating in joint site visits.

On completion of the site visits, a copy of the report prepared by the principal consultant was sent to the fellowship program representatives for review. Any errors of fact in the report were provided to and corrected by the principal consultant.

The results of the data analyses were reviewed by the principal consultant to determine the feasibility of the accreditation guidelines based on 4 considerations: reliability, validity, usefulness, and effectiveness. These considerations form the framework for interpreting the results of the pilot test in the discussion section of this paper.

1. **Are the Proposed Guidelines Reliable?** Of specific interest was the consistency of information gathered during the site visit. Would the process as applied by 2 observers yield the same data?

2. **Are the Proposed Guidelines Valid?** Are the proposed guidelines (requirements, criteria, and process) relevant to the types of fellowship programs that would be eligible for accreditation?
3. Are the Proposed Guidelines Useful? The ease of use of the accreditation guidelines was a practical issue of central importance, especially for a voluntary accreditation process. Cost estimates and opinion data were gathered to address the questions of relative costs and benefits of the process.

4. Are the Proposed Guidelines Effective? If effective, the accreditation guidelines provide an accreditation body with information necessary for making informed decisions. The pilot study was intended to determine whether the process would result in information that could inform the decisions of an accreditation board.

Results

The major results of the pilot test of the accreditation process are presented here according to the data collection and analysis framework presented in the Methods section.

The 5 participating sites completing the application, self-study, and site visit phases of the study included 1 type 1, 2 type 2, and 2 type 3 programs. As mentioned previously, 1 type 1 site excused itself from participation late in the study and was not replaced. Although 1 person from each institution took responsibility for completing the application and self-study, the consultants interviewed family medicine department chairs, fellowship directors, faculty and staff, and fellows during the site visits. One site allowed access to the entire current fellowship class that was in session at the time of the site visit, and 1 fellowship had no fellows available for interviews. Table 2 presents the number of site visit interviewees according to site.

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Department Chair</th>
<th>Fellowship Directors</th>
<th>Fellowship Faculty/Staff</th>
<th>Fellows</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Type 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Site A</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>Site B</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Type 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Site A</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Site B</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

Note: One department chair was also the fellowship director and was counted twice in the table.

Accreditation Application

Of the 27 accreditation requirements outlined in the application guidelines, 22 requested specific documentation related to the program. Aggregating compliance with these 22 documentation requests across 5 participating programs, the overall compliance rate was 96% for these guidelines. A total of 84% of the requests were rated by programs as easy requests to fulfill and 12% as difficult. In particular, requests for documentation for “affiliate relationships” (requirement 2.1) and “theory/practice relative emphasis” (requirement 4.5) appeared to be the most difficult. Among all programs, 90% of the requested documentation was submitted with the initial application. With follow-up by the principal consultant that requested missing documentation, we received 96% of the requested documentation.

Self-Study

The length and quality of self-study documents were widely variable. Self-study document length ranged from 1.5 to 14 pages, averaging 4.8 pages. The number of indicators referenced in the documents, a rough indicator of self-study document quality, ranged from 8 to 36, averaging 26 of 38 possible indicators per self-study. Table 3 presents the sites’ responses to the self-study in terms of the number of indicators addressed (first number), the total possible number of indicators for that criterion (second number), and the total number of pages or fraction of pages devoted to a specific criterion.

Most typically, responding fellowships provided brief half- to full-page narratives in response to each criterion, with references to the initial application and to appendices attached to the self-study report. Three of the participating fellowships responded to the self-study in this manner. Of the 2 remaining programs, 1 offered significantly longer responses to each criterion, responding to each indicator; the other offered significantly shorter responses, varying from citing an attached document to 1 response of 3 paragraphs in length.

There was some confusion in the self-studies about some of the accreditation criteria. For example, 1 part-time fellowship program felt that the indicators for criterion 3, “The fellowship is accomplishing its educational and other purposes,” were better suited to full-time fellowship programs. Another respondent remarked, “We have studied this criterion carefully, but we cannot discern what it means,” with respect to criterion indicator 5.f: “Appropriate support for resources shared with other parts of higher education.”

In preparing their self-study, 4 of the 5 responding programs made reference to the initial accreditation application. There was a total of 45 such redundancies. Examples included: “The mission of (fellowship), and its relevance to family medicine, are discussed on page 3 of the initial application,” and “Each member of the
agreed on 72% of the observations. Additionally, 12% of the observations were unique to observer 1, while 16% were unique to observer 2. The corresponding percentages for the type 1 and type 3 site visits revealed lower inter-observer agreement, based on analyses of reports written from field notes rather than the field notes themselves. For all 3 visits, the level of explicit disagreement was low (0%-2%).

Differences in observations appeared to be of 3 types. First, 1 consultant would record greater details about a specific part of a conversation, and these would be recorded as additional observations not recorded by the other consultant. An example is a listing of program evaluation methodologies captured by 1 consultant and not the other, while the other consultant made reference in general to program evaluation methodologies. Second, 1 consultant would capture details of a specific part of a conversation, while another would capture other details of the same conversation. An example is 2 listings of environmental factors affecting a fellowship program recorded by the 2 consultants, each of which contained details not included in the other. Third, 1 consultant would record an observation not included in the field notes of the other consultant. An example of this is a reference to the relationship between the fellowship program and the departmental CME program, which was recorded by 1 consultant and not the other.

Table 4
Agreement Between Observers

<table>
<thead>
<tr>
<th>Type 1, site A (n=166 total observations for 2 observers)</th>
<th>% Inter-Observable Agreement</th>
<th>% of Observer 1 Individual Observations</th>
<th>% of Observer 2 Individual Observations</th>
<th>% Disagreements Between Observers</th>
</tr>
</thead>
<tbody>
<tr>
<td>43%</td>
<td>28.5%</td>
<td>28.5%</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type 2, site A (n=170 total observations for 2 observers)</th>
<th>% Inter-Observable Agreement</th>
<th>% of Observer 1 Individual Observations</th>
<th>% of Observer 2 Individual Observations</th>
<th>% Disagreements Between Observers</th>
</tr>
</thead>
<tbody>
<tr>
<td>72%</td>
<td>12%</td>
<td>16%</td>
<td>1%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type 3, site A (n=190 total observations for 2 observers)</th>
<th>% Inter-Observable Agreement</th>
<th>% of Observer 1 Individual Observations</th>
<th>% of Observer 2 Individual Observations</th>
<th>% Disagreements Between Observers</th>
</tr>
</thead>
<tbody>
<tr>
<td>47%</td>
<td>33%</td>
<td>20%</td>
<td>2%</td>
<td></td>
</tr>
</tbody>
</table>
There were 4 points of disagreement between observers on the basis of 1 site visit, 2 points on another, and none on a third. Specific points of disagreement between the 2 observers focused on (1) alternatives to the proposed accreditation process [2 points of disagreement], (2) fellowship faculty reaction to the perceived workload the accreditation process would engender [1 point], (3) the ability of 1 fellowship program to continue should external funding cease [1 point], (4) 1 identified program strength [1 point], and (5) the awareness of the school of medicine dean of the existence of the fellowship program [1 point].

It should be noted that of the 6 total points of consultant disagreement, 3 were related directly to accreditation requirements or criteria, and 3 were related to opinions about the process itself.

Site Visit: Opinions on Accreditation
During the site visits, fellowship faculty, staff, and fellows were asked their opinions regarding the desirability, cost, and process of accreditation. Further data were obtained through a telephone conversation with the director of the excused type 1 site.

Desirability. Opinions were mixed regarding the desirability of accreditation. For example, 7 individual respondents at 5 programs noted that “accreditation will assure standards,” and 4 individual respondents at 2 programs noted that “accreditation will bring about enhanced program credibility.” Three individuals from 3 programs noted that the accreditation process they experienced promoted internal reflection. Conversely, 4 individual respondents at 2 programs expressed a fear that “accreditation would stifle innovation,” and the need to “recognize different settings and levels of fellowships” was expressed by 3 individual respondents at 2 programs.

Cost. The principal consultant suggested a possible fee range of $1,500 to $2,000 for consideration of costs for conducting accreditation. This estimate is based on an estimated consultant cost (including secretarial support, materials, correspondence, etc) of 10–15 hours of consultant work at $75 per hour and an additional $750 for costs for the site visit. Six individual respondents from 4 programs indicated that their fellowship would pay for accreditation at this fee level. Two individuals at 2 institutions thought it was premature to set cost. Two individuals from 2 programs emphasized that accreditation costs were comprised of 2 components: time and money. Individuals from all fellowship programs responsible for preparing accreditation applications and self-studies reported spending 30–60 hours to complete the 2 documents. An additional 8 hours were required for the site visit.

Process. While 2 individuals at 2 programs favored the accreditation process “as is,” 17 individual respondents from 5 institutions favored modification of the process. The most-common proposal was to collapse the application and self-study into 1 step, while maintaining the site visit. In addition, it was suggested that a preliminary short-form application could be submitted for an initial review, prior to incurring the time and cost of a full application.

Further support for collapsing the application and self-study came from reported redundancies between them. As noted above, in different sections of the self-study, 4 of the 5 responding programs made a total of 45 references back to the initial application. Two individuals from 2 programs raised the need for a probationary status, rather than only an “all or nothing” accreditation-process status. The remedy of deficiencies for fundamentally sound programs needed to be addressed as part of the process, according to the respondents.

Two individuals from 2 programs raised the issue of the identity of the accreditation body. It was thought that, given its lack of experience in program accreditation, STFM would not be appropriate as an accreditation body.

Discussion and Recommendations
In this section, we interpret the results of the study in terms of the reliability, validity, usefulness, and effectiveness of the proposed accreditation guidelines. We conclude with a series of recommendations pertaining to the guidelines and related issues.

Reliability
The highest rate of agreement between the 2 consultants was obtained from the analysis of their field notes. On the basis of field notes, the consultants agreed on approximately 72% of their observations. This suggests that only 1 consultant can supply up to 75% of the information gathered by 2 consultants. On the other hand, the fact that there were observations made by 1 consultant and not the other argues for the use of 2 consultants for a site visit. The finding that there was little disagreement between the 2 consultants provides further support for the reliability of the site visit data collection process. Given that the consultants disagreed on so few items, one must ask if it is worth the price of sending 2 consultants on a site visit to obtain 25% more information. Also unclear is whether or not the amount of information gathered by 1 consultant would be sufficient to allow an accreditation body to make an informed decision. Further study of the number of consultants needed to obtain a sufficiently rich database during the self-study phase is required.

It should again be noted that neither consultant underwent any kind of observer training prior to the site
visits. Such observer training might serve to improve the reliability of the data-gathering process.

Validity
The issue of validity as framed earlier was “Are the proposed guidelines (requirements, criteria, and process) relevant to the types of fellowship programs that would be eligible for accreditation”? The response to this question hinges on the definition of eligibility, as defined in the STFM Accreditation Task Force’s final report:

Fellowship programs, defined here as those programs designed to provide future or existing faculty with essential nonclinical skills to succeed as a full-time faculty member in academic family medicine programs, are eligible to apply for accreditation.

This definition specifically describes eligible fellowship programs as those that prepare participants for full-time faculty positions.

In our test accreditation process, the type 1 site excused from participation might not qualify for eligibility, in view of the fact that it relies heavily on part-time volunteer faculty to staff its training programs. Many programs, particularly in osteopathic medicine, which rely on part-time volunteer faculty for staffing medical student and residency training, would also be rendered ineligible for accreditation according to the current guidelines, since faculty would not be prepared for full-time positions in academic medicine. Accreditation of fellowship programs for volunteer faculty remains an unsettled issue.

The relevance of the guidelines was not questioned by any of the programs that completed the full pilot test, including the application, self-study, and site visit. Participating programs were able to comply with the majority (more than 90%) of application requirements and associated documentation, providing further evidence of the relevance of the requirements. While there was variability in the level of detail and length of responses to each criteria in the self-study documents, there was no feedback that the criteria of the self-study were in any way irrelevant.

Usefulness
The pilot study revealed that the accreditation process required streamlining to be useful to programs. Given the low staffing levels of fellowship programs, particularly for those programs relying on consultants and guest faculty, the number of hours required for a fellowship to complete the various activities of the accreditation process (30-60 hours) represented a substantial workload. This was compounded by the redundancy between the application and the self-study. Attention needs to be paid to the accreditation process to make it clear and less redundant.

Effectiveness
Our study was intended to determine whether the survey process would generate information that could inform the decisions of an accreditation board. We found that application documents offered complete pictures of the responding fellowships, but self-study documents revealed significant variability in terms of length, level of detail, and degree to which accreditation criteria were addressed. For example, 1 program submitted a 1.5 page self-study, the brevity of which limited its ability to demonstrate achievement of the accreditation criteria. However, the application and site visit for this fellowship revealed a program that clearly met the accreditation requirements and criteria. Suggestions regarding suitable length and level of detail for both the accreditation application and self-study document would be helpful in guiding applicants to make their best case for accreditation.

Recommendations
Based on the results of our study and the preceding discussion, we make the following 6 recommendations:

1. Reconsider Eligibility Criteria. In its current form, the guidelines stipulate that only those family medicine faculty development fellowship programs training fellows for full-time academic medicine positions are eligible for accreditation. This criteria would exclude the many fellowship programs that address the needs of part-time or volunteer faculty.

2. Streamline the Accreditation Process. Drawing from the comments made by several participants, accreditation procedures could be modified to include, first, a brief preliminary application submitted by the program that responds to basic accreditation requirements, enabling programs with no real chance at accreditation an opportunity to withdraw from the process prior to incurring large expenditures of time and money. Second, the primary application could be revised to combine program requirements and self-study criteria into 1 document. This would address the issue of redundancy between the application and the self-study. Third, the site visit should be maintained to verify the information obtained from the combined self-study and application. Finally, all documents would be submitted for accreditation board review and decision, with feedback from the accreditation board about program strengths and weaknesses.

3. Develop Model Applications and Self-study Reports. There was significant variation in materials submitted by participating programs, especially in response to the self-study criteria. Sample responses or a model application and guidelines for length and level of detail of responses should be developed. These would serve the interests of both the applicant institution and
the accreditation body by describing a level of program documentation and description sufficient for informed decision making. Document length should be specified. Separate examples are needed for type 1, type 2, and type 3 fellowships.

4. Develop Guidelines for Probationary Status. In other accreditation processes, probationary status is an outcome available for programs with some notable weaknesses. The current guidelines make no provision for probationary status. To develop a probationary status, we would need to address issues such as (1) defining core requirements and criteria documentation, without which full accreditation cannot be awarded, (2) defining the terms of probation, including length of probationary status and the process for remediation, and (3) defining costs to the probationer to apply for full accreditation status, assuming full cost was borne for the initial review.

5. Consider Issues Related to the Accrediting Body. It was not our charge to determine a suitable accreditation body. Nevertheless, faculty from at least 2 participating programs raised the issue of the identity of possible accrediting bodies for an objective review. STFM was thought to be inappropriate for this role, given its lack of experience in the field of accreditation. It is recommended that whoever continues pursuing the issue of accreditation identify an objective accreditation institution that would enjoy the respect and trust of the fellowship programs it seeks to accredit.

6. Consider Peer Review as an Alternative to Accreditation. Participants cited a useful purpose served by the accreditation process: self-reflection resulting in potential for program improvement as a by-product of the accreditation process. By examining their programs in light of the proposed accreditation requirements and criteria, participants were able to identify areas of future improvement, as well as unique strengths.

The benefits of accreditation as an opportunity for program self-reflection offer a more-salient added value than an accreditation stamp of approval. Promotion of the reflection engendered by accreditation, by establishing a peer-review process, organized and implemented by a consortium of fellowship programs, might serve to promote program quality while minimizing the perception of accreditation as possibly stifling innovation.

Conclusions
Our study of the accreditation guidelines for family medicine faculty development fellowship programs was a real-world test of the guidelines, since it relied on just such fellowship programs to serve as test sites for application of the guidelines. The Project Team and Advisory Committee of the Faculty Futures Initiative accepted our study and recommendations at a meeting of those groups on March 30, 2000. The report recommendations are to be brought to the STFM Board of Directors for its consideration and action.

Acknowledgments: This project was supported by a contract with the Society of Teachers of Family Medicine (STFM) Faculty Futures Initiative. The results of this project were reported at the 1999 STFM Annual Spring Conference in Seattle.

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REFERENCES

Appendix 1

Accreditation Requirements

1. Mission
   • A faculty development program must have a clearly stated mission or purpose that guides all decisions.
   • The faculty development program’s purpose must address the needs of individual participants and meet the needs of the discipline with respect to the types of faculty required to staff family medicine departments and residency programs.
   • The mission must be understood and supported by program faculty and participants.

2. Governance
   • The program must be affiliated with an accredited family practice residency program or family medicine department in an accredited medical college.
   • If the fellowship is within a host organization, the host organization must provide evidence of commitment to sponsoring faculty development.
   • The program’s governance must include a steering committee that is broad based and has oversight over fellowship functions.

3. Faculty
   • The project director should commit significant time (eg, 30%–100%) to the faculty development fellowship; have experience as a faculty member and formally understand the functions of a faculty member; and have experience, training, and knowledge in education and faculty development. She/he should understand the clinical discipline (although not necessarily be a clinician), have leadership and staff development skills, have at least basic knowledge of all the content taught in the program, and have vision in guiding a faculty development program.
   • The program employs faculty who have training and experience appropriate to the level of instruction that they are asked to provide in the fellowship.
   • A sufficient number of the faculty should be full time at the institution.
   • The fellowship core faculty should have a significant role in developing and evaluating all of the fellowship’s educational programs.

4. Educational program
   • The fellowship must have a clear statement of curriculum goals, including the type of faculty roles and institutions for which graduated fellows will be prepared.
   • Project personnel should be systematic in the design and implementation of program curricula.
   • Fellowships should make provisions for maintaining clinical skills.
   • Fellowships should emphasize both theory and practice.
   • In addition to addressing traditional skills such as teaching, research, and administration, programs should address other faculty needs, such as survival skills, the academic ethic and culture, and networking.
   • Fellowships that simultaneously allow fellows to acquire degrees from other programs, such as master of public health or master of science, must clearly demonstrate that the content of these degree programs relates to the skills that they say their fellowship is providing their participants with and that clearly relate to preparing an individual for an academic role in family medicine.
   • Fellowship programs should be of appropriate length, time commitment, and continuity for the competencies addressed.
   • Fellowships must have mentors and advisors for participants.
   • The fellowship should have an established system for regularly assessing the effectiveness of its programs, faculty, and fellows and for using this information for continuous improvement.
   • The fellowship should keep a record of the placement and accomplishments of its alumni.

5. Finance
   • The fellowship must keep appropriate financial records and conduct appropriate audits. Further, financial resources, practices, records, and reports should demonstrate fiscal responsibility and stability.

6. Public information
   • The fellowship should have a catalog or other official document that includes its mission statement, along with an accurate description of:
     • its educational program and any related degree possibilities
     • its learning resources
     • its admissions practices
     • its charges.
     • the academic credentials of its faculty and administrators
     • the type of faculty role for which its participants should be prepared

7. Admissions
   • Fellowships should recruit and educate faculty who plan full-time academic careers.
   • Fellowships should select only participants who are committed to (and have the time for) improving their faculty abilities.
   • Admissions policies and practices should be consistent with those of the sponsoring institution, should be formally stated, and should have records kept that document compliance.
   • The fellowship program must have a critical mass of participants. Typically, programs should be built to accommodate at least 4 fellows and enroll at least 2 fellows at a time.

8. Resources and facilities
   • The fellowship program must have the resources and facilities necessary to support its specific goals and provide clinical experience for fellows. Resources include such things as library, computers, space, and patients.
Appendix 2

Accreditation Criteria and Associated Indicators

Criterion 1: The fellowship program has clear and publicly stated purposes consistent with its mission and appropriate to an academic faculty development program in family medicine.

In determining appropriate patterns of evidence for this criterion, the evaluation committee considers evidence such as:

- long- and short-range fellowship goals
- processes, involving its constituencies, through which the fellowship evaluates its purposes
- decision-making processes that are appropriate to its stated missions and purposes
- understanding of the stated purposes by fellowship constituencies
- efforts to keep appropriate groups informed of its goals through documents such as the catalog and program brochures
- support for freedom of inquiry for faculty and students
- fellowship commitment to excellence in both the teaching provided by faculty and the learning expected of students

Criterion 2: The fellowship has effectively organized the human, financial, and physical resources necessary to accomplish its purposes.

In determining appropriate patterns of evidence for this criterion, the evaluation committee considers evidence such as:

- governance by a steering committee consisting of informed people who understand their responsibilities, function in accordance with stated policies, and have the resolve necessary to preserve the fellowship’s integrity
- effective administration through well-defined and understood organizational structures, policies, and procedures
- qualified and experienced administrative personnel who oversee fellowship activities and exercise appropriate responsibility for them
- systems of governance that provide dependable information to the fellowship’s constituencies and, as appropriate, involve them in the decision-making process
- faculty with educational credentials that testify to appropriate preparation for the courses they teach
- a sufficient number of students enrolled to meet the fellowship’s stated educational purposes
- provision of services that afford all admitted students the opportunity to succeed
- a physical plan that supports effective teaching, learning, research, and patient care
- conscientious efforts to provide students with a safe and healthy environment
- academic resources and equipment (e.g., libraries, electronic services and products, learning resource centers, laboratories and clinics, and computers) adequate to support the fellowship’s purposes
- a pattern of financial expenditures that shows the commitment to provide both the environment and the human resources necessary for effective teaching, learning, research, and patient care
- management of financial resources to maximize the fellowship’s capability to meet its purposes

Criterion 3: The fellowship is accomplishing its educational and other purposes.

In determining appropriate patterns of evidence for this criterion, the evaluation committee considers evidence such as:

- educational programs appropriate to an academic fellowship in family medicine
- assessment of appropriate student achievement in all its programs
- transcripts that accurately reflect student learning and follow commonly accepted practices
- effective teaching that characterizes its courses and academic programs
- ongoing support for professional development for faculty, staff, and administrators
- student services that effectively support the fellowship’s purposes
- staff and faculty service that contributes to the fellowship’s effectiveness

Criterion 4: The fellowship can continue to accomplish its purposes and strengthen its educational effectiveness.

In determining appropriate patterns of evidence for this criterion, the evaluation committee considers evidence such as:

- a current resource base—financial, physical, and human—that positions the fellowship for the future
- decision-making processes with tested capability of responding effectively to anticipated and unanticipated challenges in the fellowship
- structured assessment processes that are continuous, involve a variety of fellowship constituencies, and provide meaningful and useful information to the planning processes, as well as to students, faculty, and administration
- plans, as well as ongoing, effective planning processes, necessary to the fellowship’s continuance
- resources organized and allocated to support its plans for strengthening the fellowship

Criterion 5: The institution demonstrates integrity in its practices and relationships.

In determining appropriate patterns of evidence for this criterion, the evaluation committee considers evidence such as:

- policies and practices for the resolution of internal disputes within the fellowship’s constituency
- policies and practices consistent with its mission related to equity of treatment, nondiscrimination, affirmative action, and other means of enhancing access to education and the building of a diverse educational community
- fellowship publications, statements, and advertising that describe accurately and fairly the fellowship, its operations, and its programs
- relationships with other parts of higher education conducted ethically and responsibly
- appropriate support for resources shared with other parts of higher education
- oversight processes for monitoring contractual arrangements with government, industry, and other organizations
Appendix 3
Example of Site Visit Question Guide

1. Department chair
   • What is the impact of fellowship on family medicine department, examples of research activities, introduction of new teaching methods and educational technologies?
   • What would be the consequences of loss of grant funding? Given “substantial level” hard-dollar support, would the fellowship program continue? (e.g., charge tuition)
   • How would you characterize the support of the dean of the school of medicine for the fellowship? How does the dean see the fellowship fitting in with the mission of the school? How well known/supported is the program within the school?

2. Program faculty, program director
   • What has contributed to your success as a program? How have you been able to sustain it over (xx) years? How would you characterize your program strengths? Weaknesses? What is unique about your program?
   • Program evaluation: What does it take to force change in an instructional session? What is that change process?
   • How do you decide it’s time for a major curriculum revision/addition? What was the last major curriculum revision/addition, and how did it come about?
   • Given future practice environment change (increased managed care, teaching in ambulatory settings, primary care emphasis, etc.), what do you see as the future of the program? Will your model remain the same? Are you exploring options to change your model?
   • Leadership in the future: What plans do you have for the continuity of program leadership in the future? How important is it to have a clinician as director? What would be the implications if he/she were not a clinician?
   • Issues related to accreditation:
     * Do you buy into the idea of accreditation? If not, why not? If so, what do you see as the consequences of getting accredited? Of not getting accredited?
     * If you support the idea of accreditation, would you be willing to pay a fee to help defray costs (e.g., $2,000)? What would you think to be a reasonable fee, if any?
     * Issues related to process: comments on the accreditation guidelines in their current state, alternative processes

3. Fellows
   • Prior to the fellowship, what did they think the impact would be on themselves, their career? What do they think now?
   • To what extent do they feel the fellowship meets their needs? What needs were met? Not yet met?
   • Accreditation: would it make a difference in your choice of fellowship program?
   • Expectations for scholarship (publications in peer-reviewed journals and peer-reviewed conference presentations): What are your expectations for yourselves? How many would like to? How many plan to? What are your plans?

4. Facilities tour: teaching rooms, breakout rooms, computer lab, conference facilities, library resources, audiovisual resources

5. Documentation: examples of interim assignments, examples of session handouts, if I haven’t received any until then
EBM Is Dead? I Didn’t Even Know it Was Sick!

Eileen Johnson, PhD

During the most recent Society of Teachers of Family Medicine (STFM) conference (May 2000) in Orlando, Fla, several sentiments were expressed regarding the current status of evidence-based medicine (EBM). Among the most startling was the notion that EBM is dead. After much reflection, I might argue that perhaps it is not EBM itself that is dead, but our methods of teaching EBM that have expired.

To use an analogy provided by Paul Lyons, MD, EBM is like technology. One does not need to know how to program a computer to use it, although there was a time when this statement would have been considered radical. Now, programmers have created graphic-user interfaces that allow you to navigate the World Wide Web and countless software programs with little more than point and click. Of course, you must still know what you are seeking, where to look, and have enough knowledge to use the correct software for specific applications.

Similarly, there are those who feel that all clinicians must be proficient in the use of epidemiological statistics to practice EBM. To consider the possibility of practicing EBM otherwise is considered similarly radical. The mistake in this approach is trying to teach each and every clinician to be a “programmer,” when all that is really needed by the clinician is the ability to navigate and apply information appropriately. As the computer is simply a tool, useful only in the hands of informed and competent users, EBM is also a tool that aids competent and knowledgeable clinicians in making the best decisions for their individual patients.

Why all the fuss surrounding the practicing and teaching of EBM? Perhaps it is a revolt against what is seen as dogma or an insistence on practicing medicine in a circumscribed manner. Perhaps it is a denial that so much information exists and is, in fact, making its way quickly to an increasingly educated public. On the other hand, perhaps it is a backlash against the unsuccessful manner in which EBM is taught.

During a workshop at the STFM Annual Spring Conference that purported to offer a unique approach to teaching EBM, the presenter stated that every piece of research is like a work of art and should be admired for its elegance. It was the thesis of this workshop that physicians who practice EBM should be able to appreciate the data of each research study without reliance on the author’s conclusions. While it is certainly understandable that statisticians may take this approach to analyzing the literature, this is not the purpose of EBM and certainly not the goal of training physicians in the use of EBM for daily clinical practice at the point of care.

For the purposes of using EBM in clinical practice, original research must be considered as only pieces of a puzzle. Original research provides support for an overarching theory if the results and conclusions fit within a framework, but the answers to specific clinical questions will not be found in a single research study.

It is for this reason that review articles and meta-analyses, which synthesize the results of all research studies pertinent to a specific question, are so critical to the practice of EBM. Those clinicians and academicians who write evidence-based reviews and meta-analyses are the programmers of EBM. The information mastery approach has become the graphic-user interface, so to speak, while the handheld computers have become the hardware, and programs such as InfoRetriever® and Info-Pointer® have become the software of EBM. The rapid improvements in technology, coupled with the increased availability of personal computers, have resulted in vast improvements in the graphic-user interfaces and have eliminated the need for most computer users to understand text-driven and command-line programs. Similarly, appropriate use of existing hardware and software in the teaching of EBM should eliminate the need for most practitioners of EBM to understand and perform the rather complex biostatistics and epidemiological statistics.