

**Frequently Asked Questions: Diagnostic Radiology**  
**Review Committee for Diagnostic Radiology**  
**ACGME**

Question	Answer
<b>General Topics</b>	
What are the procedures for requesting approval of an increase in the resident complement?	This information is provided on the Diagnostic Radiology Homepage under the heading of "Resident Complement."
If a clinical year is offered in conjunction with the residency program, does the RRC approve or review the number of positions in it?	No. The RRC approves the number of residents only for the four-year diagnostic radiology residency program. The RRC does not accredit the clinical year or approve positions for the year.
If I accept a transfer resident into the program, are there procedures that should be followed?	Yes. Prior to accepting the resident, the program director must receive written verification of the resident's previous educational experiences and a statement regarding the competency-based performance evaluation of the transferring resident.  <i>Very importantly, this same process is now required for all residents beginning training at the PGY-2 level: completion of, and performance during, the clinical year must be documented.</i>
Does a resident in a civilian program whose stipend is funded by a branch of the military (or any other funding source) count against the resident complement?	Yes. If you intend to accept a resident who has funding for his/her position through a branch of the military or from any other source, you must still request prior RRC approval for the additional position. This person will be a full-fledged resident in the program.
When I read the program requirements, some are in bold print. What does this mean?	Everything in <b>bold print</b> is an ACGME Common Program Requirement that applies to all specialties, not just radiology. The remaining requirements in <i>regular type</i> are specialty-specific to radiology. Whether in bold or regular type, programs are expected to be in compliance with all requirements.
What are the Common Program Requirements and how often are they revised?	The Common Program Requirements (CPR) address accreditation issues that must be in place in all specialties. Examples include duty hour requirements, scholarly activities, program director and faculty qualifications and responsibilities, to name a few. CPR language may not be changed; however, RRCs may add more specific requirements at the end of a Common Program Requirement section, as appropriate. The CPRs are reviewed and revised at least once every 5 years. As stated above, the CPR wording is not subject

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	to modification by individual Residency Review Committees (RRCs). The most recent revision took effect on July 1, 2007. For your information, newly revised Institutional Requirements also took effect on July 1, 2007.
What is the difference between “must” and “should?”	<i>Must</i> is a term that identifies an absolute requirement. <i>Should</i> is a term used to designate requirements so important that their absence must be justified. Such justification must be acceptable to the RRC.
How often are program requirements reviewed and/or changed?	The ACGME mandates that RRCs conduct a comprehensive review of program requirements at least once every 5 years. The RRC, however, reviews the requirements on an ongoing basis, and may choose to request ACMGE approval of changes in the interim.
The program requirements seem to be increasing y more detailed and this can make compliance more difficult. Help.	Significant changes have occurred and they require oversight and documentation. Consequently, it is essential that the program director and program coordinator be provided enough time and resources to do their jobs.
What determines the length of the resurvey cycle?	Generally speaking, the number and significance of areas of non-compliance with the program requirements identified by the RRC following a site visit is linked to the number of years between surveys. The fewer areas of non-compliance identified, the longer the cycle; range in re-review cycles extends from 1 to 5 years.
<b>PLEASE NOTE: The following Q/A’s have been formatted in the order of the Diagnostic Radiology Program Requirements, beginning with the institutional section.</b>	
<b>Institutions</b>	
What is the definition of a <i>primary</i> hospital?	A <i>primary</i> hospital is the site where the majority of the residents’ educational experiences are scheduled.
Is there a specified number of months residents are required to spend at the <i>primary</i> hospital?	Residents are no longer required to spend all but six months at the <i>primary</i> hospital. Program Directors now have significantly more latitude in arranging educationally valid rotations in participating institutions. <b>Reminder:</b> Program Directors must obtain <b>prior</b> approval from the RRC for rotations of 3 months or longer.
Are programs required to designate participating institutions as <i>integrated</i> or <i>affiliated</i> ?	The terms <i>integrated</i> and <i>affiliated</i> are no longer used. The July 1, 2008 requirements specify that the program must be based at a <i>primary</i> hospital. Rotations at other participating institutions or imaging centers may be included as part of a program’s structure, based on educational needs.
For which rotations do we now need to have a letter of agreement and	All rotations that take place outside the primary hospital, regardless of their length, require a letter of agreement. Elements to be included in these letters of agreement may be

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what must this letter include?	accessed here: <a href="http://www.acgme.org/acWebsite/about/ab_FAQAgreement.pdf">http://www.acgme.org/acWebsite/about/ab_FAQAgreement.pdf</a>
I have multiple hospitals/sites in my medical center through which my residents rotate. Do I need a letter of agreement for each?	It depends on the administrative structure of the medical center. For full details, please access here: <a href="http://www.acgme.org/acWebsite/about/ab_FAQAgreement.pdf">http://www.acgme.org/acWebsite/about/ab_FAQAgreement.pdf</a>
<b>Mergers</b>	
How do we handle a description of a merger for the RRC?	<p>Contact the Executive Director to discuss the type of merger and how to describe it for the RRC. There are various types of mergers and the specific plans may determine how the proposal should be worded and what type of action is possible by the RRC. The following are the major types that have been reported involving <i>two separately accredited programs</i>:</p> <ol style="list-style-type: none"> <li data-bbox="724 688 1898 951">1. <u>Two programs will be combined to form a new entity</u>, a combined program. The full PIF, describing the proposed combined program, will be required. The Executive Director will tell you whether a site visit will be required prior to RRC review of the proposal. A <u>request for voluntary withdrawal of accreditation</u>, and the date of closure, will be needed from each of the currently accredited programs and should be co-signed by the CEO of its sponsoring entity. The newly constituted combined program will be issued a new ACGME identification number, and if accredited, will be accredited on a provisional basis.</li> <li data-bbox="724 987 1898 1317">2. One program (#1) will absorb the other program (#2) and will usually include rotations to the latter. Program #1 will submit the proposal, explaining the extent of the change in curriculum and resident complement. Program #2 will submit a request for voluntary withdrawal of accreditation with the date by which current residents will complete their training in that program. This must be co-signed by the CEO of that program's sponsoring entity. The Executive Director of the RRC will tell you whether the changes necessitate a site visit prior to RRC review of the proposal. Unless the changes are so extensive that the RRC considers the finished product to be virtually a new program, program (#1) will retain its current ACGME identification number and accreditation status.</li> </ol>
How do we change the sponsoring institution?	A letter that is signed by the CEO's of both the existing sponsor and the proposed sponsoring entity should be submitted. (Two separate letters may be submitted.) The existing sponsor should agree explicitly to the change in sponsorship. The proposed

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	<p>sponsor should agree to assume the responsibilities of a sponsoring institution that are outlined in the ACGME Institutional Requirements. The letter should contain a statement on the impact the change will have upon the structure and curriculum of the residency. If the change is approved, the program name and listing will be changed as appropriate.</p> <p>A request to change the program's sponsorship or related questions should be addressed to Ingrid Philibert, MHA, MBA, Director, Department of Field Activities.</p>
<b>Program Director</b>	
<p>What academic credentials should a program director have?</p>	<p>Programs and department chairs are given significant latitude in appointing Program Directors. A Program Director must be board certified by the American Board of Radiology (ABR). If not board certified, other qualifications must be approved by the RRC. The Program Director's primary qualification should be a dedication to resident education.</p>
<p>Must the program director be a full-time faculty member?</p>	<p>Yes</p>
<p>What are the responsibilities of a program director? Please NOTE: The responsibilities listed are not all-inclusive. For a full listing, you may access the Common Program Requirements.</p>	<p>The following are the responsibilities of the Program Director:</p> <ul style="list-style-type: none"> <li>• Program Directors are required to spend at least the equivalent of one day a week managing the residency program.</li> <li>• Program Directors should be thoroughly conversant with all current Program requirements to ensure compliance with ACGME standards.</li> <li>• Program Directors should ensure that the internal review occurs on a timely basis.</li> <li>• Program Directors must meticulously prepare the Program Information Form (PIF) to accurately reflect all aspects of the residency program.</li> <li>• Program Directors must communicate with the Program coordinator and the resident group in order to address any problems or issues.</li> <li>• Program Directors or their designees must meet with each resident individually at least twice a year to discuss their rotation evaluations and to provide constructive feedback and mentoring.</li> <li>• Program Directors are responsible for ensuring that the faculty is meeting its teaching and scholarly requirements.</li> <li>• Program Directors are responsible for ensuring that all components of the curriculum are in compliance with the program requirements.</li> </ul>
<b>Faculty</b>	
<p>What does "sufficient number of</p>	<p>The RRC expects programs to use common sense in determining the number of faculty</p>

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faculty to instruct and supervise all residents in the program” mean?	needed to teach the residents in their program. On a daily basis there must be sufficient faculty to ensure that each resident has adequate instruction and supervision.
What is the minimum number of Full-Time Equivalent (FTE) faculty members?	A program must have a minimum of 9 FTE faculty members, because one FTE faculty member is required for each of the 9 subspecialty areas. If residents rotate to an outside institution for pediatric radiology, the supervising pediatric radiologist at that institution may also count as a member of the program’s faculty.
Does the subspecialty chief, as required in the program requirements, have to be the departmental subspecialty section head?	No. The section head, however, is usually the most appropriate person to assign responsibility for organizing the didactic curriculum in a given subspecialty. Some departments are not organized by subspecialty; in these situations any qualified faculty member may be designated.
What are the qualifications required for the subspecialty chiefs?	<p>Programs are given a great deal of latitude in appointing subspecialty chiefs. Ideally, these individuals would have completed fellowship training in the subspecialty area, and if applicable, have current subspecialty certification (CAQs) in the subspecialty (neuroradiology, VIR, pediatric radiology, and nuclear radiology).</p> <p>Alternative qualifications include:</p> <ul style="list-style-type: none"> <li>• 3 years of practice and expertise in that subspecialty area,</li> <li>• Membership in the subspecialty society(ies), or Publications and presentations in the subspecialty, or Annual CME credits in the subspecialty, or</li> <li>• Participation in MOC with emphasis on the subspecialty</li> </ul>
How should the radiology faculty be involved in scholarly activity?	<p>A list of scholarly activities for faculty include:</p> <ul style="list-style-type: none"> <li>• Peer-reviewed publications in scientific journals</li> <li>• Textbook Chapters</li> <li>• Scholarly presentations at local, regional or national professional and scientific society meetings</li> <li>• Membership in national committees or educational organizations</li> </ul> <p>Please note that not every member of the faculty needs to be equally involved in these activities.</p> <p>Scholarly Activities specified in the Common Program Requirements are posted under the Diagnostic Radiology web page at the following URL:</p>

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	<a href="http://www.acgme.org/acWebsite/navPages/nav_420.asp">http://www.acgme.org/acWebsite/navPages/nav_420.asp</a> scroll down and click on Common Program Requirements.
<b>Other Program Personnel: Program Coordinators</b>	
We understand that the residency coordinator has to be assigned to the radiology department. What does having <i>sufficient time to fulfill responsibilities</i> mean?	<p>Programs should use common sense in determining the number of personnel required to fulfill the responsibilities of the program coordinator. Factors to consider include experience, accreditation status of the program, size of the program, number of institutions involved, etc. Depending on the size of the core program, the RRC believes that it could be appropriate in some cases for the coordinator to also have responsibility for one or more subspecialty radiology fellowship programs.</p> <p>In institutions in which the Radiology Department also includes the radiation oncology program however, the RRC would not advise assigning management responsibility for both the radiation oncology program and core radiology program unless both programs would be viewed as <i>small</i>. The coordinator should have no responsibility for programs outside the department.</p>
<b>Resources</b>	
Do on-call facilities (i.e., a room for sleeping/studying while on call) have to be private?	The diagnostic radiology requirement specifies that an on-call room be secure. The new <i>institutional requirements</i> however, specify that residents on call must be provided with adequate and appropriate sleeping quarters that are <i>safe, quiet, and private</i> . For clarification of the rationale regarding this change, please access the institutional FAQs.
What library facilities must a program provide for residents?	The department must provide, at a minimum, broad band Internet access 24/7 to full text journal articles. The collection should include major radiological journals plus general medical journals such as NEJM, JAMA, Lancet, etc. The program is also expected to maintain a selection of basic and subspecialty radiology texts in the on-call reading area. Further, residents must have access to a reasonably stocked medical library in the primary hospital.
Why did the RRC drop the requirement for a departmental teaching file?	On-line access to a wide variety of teaching cases which residents can study is readily available. This current access is the basis for deleting the requirement for programs to maintain a formal departmental file. The program, however, must purchase the American College of Radiology (ACR) Learning File or its equivalent for use by all the residents. Departments are certainly encouraged to build and maintain a formal teaching file if they choose.
<b>Resident Appointments: Number of Residents</b>	
What criteria are used to determine	A maximum number of residents in a program is set initially when an application is

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the number of trainees that a program is permitted?	reviewed and an accreditation status of initial accreditation is approved. The resident complement number is re-evaluated at each subsequent survey/RRC review. Considerations typically include the volume and variety of cases performed in the department, the number of faculty, the board pass rate, and an assessment of the areas of non-compliance that have been identified.
<b>Notice of Program Changes</b>	
What type of change in the program is considered major and requires notification to the RRC?	<ul style="list-style-type: none"> <li>• Increase in the resident complement. See Diagnostic Radiology Homepage/Resident Complement</li> <li>• Addition of an integrated institution/facility. Prior RRC review and approval is required for the addition of an integrated institution, regardless of the duration of the rotations at the integrated institution.</li> <li>• Participation of an affiliated institution providing more than three months of rotations must be approved by the RRC. Significant loss of faculty. The RRC should be notified if the program no longer meets the required 1:1 FTE faculty to resident ratio.</li> <li>• Change in sponsorship. (See below "How do we change the sponsoring institution?")</li> </ul> <p>Check with the Executive Director of the RRC regarding other changes.</p>
<b>Educational Program</b>	
Why are the nuclear medicine requirements so detailed?	The detail ensures that upon completion of training, residents will meet the Nuclear Regulatory Commission (NRC) eligibility requirements for Authorized User status. This eligibility status will be noted on the ABR certificate.
Are residents permitted to take vacation or other significant time off during the 4 months of nuclear medicine and still meet NRC	The fixed requirement is for 700 hours of nuclear medicine including 80 hours of didactic training.
What are the expectations regarding education of residents in radiologic physics?	Residents will be provided some sort of formal teaching in radiologic physics that extends throughout the four years of residency. This can take the form of interactive lectures or completion of on-line modules and can be incorporated into the core didactic lecture series. Attendance at a formal offsite course in radiological physics is considered acceptable as just one element of the ongoing educational process. Henceforth, the resident is expected to demonstrate on an ongoing basis an awareness of radiation safety principles. Programs are encouraged to utilize the Diagnostic Radiology Residents' Physics Curriculum. Site surveyors will be instructed to ask for details regarding the physics education that programs provide for their residents.

Question	Answer
Does the RRC require or recommend resident attendance at the Armed Forces Institute of Pathology (AFIP)?	The RRC is only concerned that the residents gain experience with radiologic-pathologic correlation. The program can determine how this requirement is fulfilled.
If my residents cannot attend AFIP, or if AFIP ceases to offer a formal course in radiologic-pathologic correlation, how can my program meet the requirement for teaching this topic as part of the general didactic curriculum?	<p>There is no prescribed method of meeting this requirement. However, the following description might be one method for ensuring that a resident is introduced to radiologic-pathologic correlation across the spectrum of disease:</p> <p>Residents may be assigned to prepare one lecture on radiologic-pathologic correlation for each of the nine subspecialty areas of radiology or for each organ system. Residents would select several cases representing common disease conditions in that area and then work with the pathology department to assemble and present the correlating gross and histopathological findings. For example, in cardiothoracic radiology, the resident might select bacterial pneumonia, lung cancer, mesothelioma, emphysema, cardiomyopathy, atherosclerotic disease of the coronary arteries, etc and then show both the imaging and pathology findings during a one hour conference. <i>The conference and its content should be documented.</i></p> <p>A pathology rotation <i>per se</i> is not considered adequate.</p>
<b>ACGME Case Log System/ Resident Procedure Logs</b>	
What is the difference between the 1) Case Log System and 2) the Resident Procedure Logs?	<p><u><i>The Case Log System</i></u> is a mechanism for entering direct resident involvement with a limited, but representative, group of cases (listed by CPT codes) into the ACGME database at least annually. This record must be reviewed by the program director and submitted in hardcopy to the ACGME. Data may be entered by the resident or by another individual designated by the department (e.g. program coordinator). To count a case, the resident must have either given a preliminary interpretation (e.g., during night float) or dictated the case.</p> <p><u><i>Resident procedure logs</i></u> may be maintained on paper or an electronic database (e.g., HI-IQ) and should document each interventional case with which the resident is involved, including image-guided biopsies and drainages, vascular interventional radiology (VIR) cases, and neurointerventional cases. Documentation should describe how the resident was involved in the case (primary operator or assistant), if he/she dictated the case, and any complications. The program director or designee should document review of procedure logs with each resident twice a year. This documentation will be reviewed by the site visitor</p>

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	at the time of a program's site visit.
How will data from the Case Log System be used?	<p>Case Log data will be used by the ACGME and RRC to develop benchmarks for resident involvement in clinical work. These benchmarks will be national in scope and will facilitate objective comparisons of individual resident experiences for each program. Ultimately, these individual outcome measures will replace the need for reporting institutional volume data.</p> <p>The Program Director should use case log data on an ongoing basis to ensure that each resident has sufficient experience in the specified areas.</p>
Is a resident permitted to count cases that he/she has only observed?	No. Only cases in which residents were directly involved can be claimed.
Is more than one resident permitted to claim credit for participation in the same interventional procedure in their procedure logs?	Yes. If more than one resident is <i>directly involved</i> in an interventional procedure, each may enter that procedure in their procedure log. The degree of involvement, however, must be clearly stated. Examples of involvement include formally assisting in the procedure, actually performing part of the procedure and dictating the report, etc.
<b>Conferences and Lectures</b>	
Who is expected to prepare and present the core didactic lectures?	The faculty is expected to prepare and present the <b>core</b> didactic lectures. This does not prevent the resident from preparing and presenting other didactic or interactive conferences on occasion. However, the RRC expects the large majority of conferences to be presented by faculty members.
How extensive does the core didactic lecture series have to be?	Each of the 9 designated subspecialty chiefs are responsible for organizing the lecture series, which should include the spectrum of anatomy, physiology, and imaging of most disease processes encountered in that subspecialty area, both common and rare. Generally speaking, 9-10 lectures would probably be sufficient to do this effectively. These lectures should be updated, and presented at least every 2 years. The site surveyor will request to see a didactic lecture schedule for each of the 9 subspecialty areas.
<b>Scholarly Activities</b>	
What qualifies as a "resident scholarly activity?"	All residents must be involved in laboratory research, clinical research, the analysis of disease processes (e.g., a retrospective review), the analysis of imaging techniques (e.g., development or assessment of techniques), and/or the analysis of practice management activities (e.g., a systems-based practice activity of some sort). The outcome of this type of activity must be published, or presented at a local, regional, or national scientific gathering.

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	The program must be able to document compliance at the time of a site visit.
Does resident participation in lectures on critical thinking skills or in a journal club fulfill the requirement for scholarly activity?	No. This type of activity is required <b>in addition to</b> involvement in scholarly activity, as defined above.
I am trying to count our residents' and fellows' scholarly activities according to the description in the newsletter. How does this work?	During the course of their training, residents and fellows must complete one project to obtain 1 point. This project could be a publication or a presentation at a meeting (local, regional, or national).
Can faculty points for scholarly activity be averaged? Some of our faculty members publish articles and some focus exclusively on teaching and education.	Yes, faculty points can be averaged for the review cycle. If you have 10 faculty members, your program needs to obtain 20 points total during the review cycle (typically five years). Some faculty members may be awarded grants, some may publish articles, others may serve on a national committee, and some faculty members may not engage in any of these activities.
How are the scholarly activity points counted? For instance, if one of our faculty members serves on a national committee for 5 years does that result in 5 points?	No, serving on a committee is a one-time activity and results in 1 point. Receiving a grant counts as 1 point. However, publishing 5 different articles in peer-reviewed journals is 5 points. Making 2 presentations is 2 points.
Do faculty members, residents, and fellows have to earn 1 point each year of the review cycle? What is the period of time within which this should take place?	Think of your review cycle as a block of time (typically 5 years) during which faculty members must complete scholarly activities that result in an average of 2 points each. During this same period of time, residents and fellows must be on track to complete their scholarly activities that result in 1 point for the length of their training. That is, fellows should complete 1 project during their 1 or 2 year fellowship and residents should complete 1 project during their four- year program. These activities do not have to be completed annually. Scholarly activities must be completed within a program's review cycle.
<b>General Competencies</b>	
What are some examples that describe how to incorporate the general competencies into residency training?	As of July 1, 2007, the ACGME expected each residency program to: <ul style="list-style-type: none"> <li>• Write goals and objectives to ensure that at each level of every subspecialty rotation you address what you want the resident to learn about patient care, what additional medical knowledge should be mastered, how they will improve their communication skills, what you expect from them as a professional, how they will</li> </ul>

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	<p>make practice-based learning (e.g., evidence-based medicine, annual learning plan) a part of their daily routine, and how they will most effectively use all the systems in a modern medical center to make their practice of radiology more efficient.</p> <ul style="list-style-type: none"> <li>• Link the evaluation of the residents to the goals and objectives including each of the six competencies into your forms so you will be able to document improvement, or lack thereof, in all six competencies.</li> <li>• Use the information obtained from this process to improve the program.</li> </ul> <p>Documentation must be archived in the resident learning portfolios. Faculty should be informed and be on board with the process. The residents are expected to know that this new emphasis will serve them well as they enter clinical practice.</p> <p>More specific examples are available from the Association of Program Directors in Radiology (APDR) and many of the subspecialty societies. This is what residency training is all about in today's world. Further, competencies are not unique to residency/fellowship programs but are being incorporated into medical school curricula and into clinical practice (licensing, Maintenance of Certification). Everyone must be familiar with them and they must be woven into all aspects of training programs. The aim of the competencies is to modify medical education to improve medical care.</p>
<b>Evaluation of Residents</b>	
<p>I'm confused by the new rules for evaluating residents. Please clarify them for me.</p>	<p>There are 3 methods that must be used to evaluate residents. All 3 are related to the 6 general competencies.</p> <p><b>Global faculty evaluation</b> is a standard evaluation most programs have been using following each rotation. However, the assessment tool should be modified to that it specifically addresses patient care, medical knowledge, practice-based learning, professionalism, interpersonal and communication skills, and systems-based practice. Examples of excellent evaluation forms incorporating the competencies are available through the APDR.</p> <p>The <b>360 evaluation</b> is to be used to evaluate a resident's interpersonal and communication skills, as well as the professionalism of the resident. "360 degrees" pertains</p>

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	<p>to obtaining feedback from personnel who work with the resident, such as radiology nurses, technologists, physician assistants (PAs), nurse practitioners (NPs), etc. Some programs also query patients. The form you use to obtain this input must specifically address communication skills and professionalism (e.g. How well does the resident relate to patients? How well does the resident explain procedures to patients? How does the resident relate to the techs? To the nurses? Does the resident show up on time and dress and act like a physician? etc.).</p> <p>The <b>Resident Learning Portfolio</b> is designed to reflect the multiple elements of resident education. The requirements clearly state what needs to be archived in this portfolio. The portfolio may be maintained as hard copy or in an electronic database. The portfolios should be available for review by the site visitor.</p>
<p>What do you mean when you say a resident has to have a yearly objective examination?</p>	<p>Most programs already meet this requirement. Residents, at least during their first 3 years of radiology residency, take the ACR In-Service Examination. Program Directors should keep the results as part of a resident's portfolio. During the third or fourth year, residents take the written board exam. If for some reason your residents do not take either of these exams, it will be necessary to formulate a credible exam for your program, administer it annually, and archive the results in residents' portfolios.</p>
<p>How are we supposed to formally evaluate the quality of resident dictations?</p>	<p>Similar to many of the requirements, there is no prescribed way to complete this responsibility. One way that would satisfy the RRC is to: Have one of your faculty give a lecture on how imaging reports should be prepared (e.g., organization, conciseness, standardized language, pertinent negatives, definitive results whenever possible, etc.) and document that your residents attended the lecture. Assign a faculty member to mentor each resident's dictations, perhaps reviewing a percentage of them during the first three months of residency and providing written feedback as to how they should be improved. Document this process.</p>
<p>What is meant by the requirement for residents to do an annual "self-assessment and learning plan?"</p>	<p>The self-assessment and learning plan is designed to teach the residents to be introspective and to regularly assess where they are in their educational pathway to become a radiologist. This professional behavior is expected to extend throughout one's career. Once a year each resident should look back on the previous 12 months and ask the question, "in what area or areas could I improve?" For example, did the resident do poorly on a particular section of the in-service exam? In selecting cases to present in conference, was there some subspecialty area in which the resident did not do as well as he/she would have liked? Once the problem area(s) is/are identified, the resident needs to work with a mentor in formulating a plan to correct the deficiency.</p>

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	The learning plan might be to read additional chapters and articles as suggested by the mentor, review cases from various sources, and then see if performance in this area is improved. This process could be documented in one or two pages, which should then be archived in the learning portfolio. More information on this process will be available from the ACGME in the near future.
<b>Program Performance on ABR Certifying Exam</b>	
In calculating the board pass rate, why does the RRC allow the resident to condition only one section of the oral board exam when the ABR allows up to 3 section conditions?	Permitting <i>more than one condition</i> did not prove to be discriminatory in evaluating program performance.
<b>Duty Hours</b>	
Who should be included in the interprofessional teams?  <i>[Program Requirement VI.F]</i>	All interprofessional team members must participate in the education of residents, and team members include ancillary personnel, attending diagnostic radiology physicians, diagnostic radiology technologists, nurse practitioners, nurses, physician assistants, and radiation safety personnel. The team may also include individuals from referring clinical services, medical physicists, and radiopharmacists.

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