ASSOCIATE PROGRAM DIRECTORS

HANDBOOK

Association of Pediatric Program Directors

APD Executive Committee | 2026 Edition

To ensure the health and well-being of all children, APPD leads the advancement of pediatric medical education, the development of a sustainable and diverse workforce, the cultivation of an inclusive learning environment, and the promotion of educational innovation.

Welcome Letter from the APD Executive Committee

Dear Associate Program Directors,

Welcome — or welcome back. The Associate Program Director (APD) role sits at the intersection of clinical medicine, educational scholarship, and program administration. It is demanding, varied, and consequential for the residents you train and the programs you help lead.

This handbook is a practical companion for APDs at all stages — newly appointed or experienced. It follows the natural arc of the role: establishing yourself, executing core responsibilities, and investing in your own development.

It is organized around a few principles: practicality over exhaustiveness, equity and wellness integrated throughout aspects of the APD role rather than treated as add-ons, and guidance grounded in real scenarios rather than policy language.

We welcome your feedback — reach out through APPD Connect or at info@appd.org.

With gratitude for everything you do for your residents and programs,

APPD APD Executive Committee (2026)

Zarina Norton, MD — Chair

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Meghan O'Connor, MD — Member at Large (2025–2028)

William Sasser, MD — Member at Large (2026–2029)

Sam Zhao, MD, MEd — Member at Large (2026–2029)

The APD Executive Committee would like to acknowledge the original authors and editors of this resource.

Original Authors:	Editors (2019)
Maneesh Batra, MD, MPH	Ndidi Unaka, MD
Aditee Narayan MD, MPH	Brian Lurie, MD
Megan Aylor, MD	Ariel Winn, MD
Sara Multerer, MD	Ross Myers, MD
Glenn Rosenbluth, MD	Rhett Lieberman, MD
Daniel Schumacher, MD, MEd	Mollie Grow, MD, MPH
Hillary Franke MD, MS	

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Starting Strong

1.1 Understanding Your Role as an APD

Starting a new role as an Associate Program Director is exciting — and can feel overwhelming. Unlike many positions in academic medicine, the APD role is rarely defined by a single concrete task. It is broad, varied, and shaped substantially by the program in which you work, the PD you partner with, and the gaps you are best positioned to fill. The flexibility of the position can be one of its most valuable features, allowing an APD to mold the position to their interests and strengths. However, this same flexibility may unintentionally lead to ill-defined roles and workload creep. Understanding this landscape early is one of the most important things you can do.

What Does an APD Actually Do?

Please see Section 2 for a more detailed discussion of many of the core responsibilities of APDs. While specifics may differ across programs, APDs commonly lead or share responsibility for:

- Resident development and support
- Advising and coaching
- Assessment and evaluations
- Advocacy and communication
- Promoting equity and inclusion
- Educational leadership
- Curriculum development and evaluation
- Resident recruitment and selection
- Resident well-being and professional development
- Scholarly and career development
- Faculty development
- Program operations and administration

In smaller programs, one APD may wear all of these hats. In larger programs, responsibilities are often divided among multiple APDs, each with a domain of focus. Neither model is inherently better — what matters is that your specific responsibilities are clearly defined and mutually agreed upon.

Establishing Your Job Description

If you do not have a written job description, this should be a priority conversation with your Program Director. A clear job description protects you professionally, enables you to advocate for protected time, and ensures that both you and your PD have aligned expectations. Consider discussing:

- Which specific tasks are your primary responsibility vs. shared responsibility
- How many hours per week are expected (and how that maps to your FTE)
- What protected academic time looks like and how it is defended
- Who your backup is when you are on clinical service or on vacation
- How your contributions will be recognized in annual review and promotion, including opportunities for scholarship and/or other forms of professional fulfillment.

> **Pro Tip: The First Conversation**
>
> Schedule a 1:1 with your PD in your first two weeks. Come with a draft list of what you understand your responsibilities to be, and ask them to confirm, correct, or add to it. This conversation sets the tone for your partnership and surfaces misalignments before they become problems.

How the APD–PD Partnership Works

Your most important working relationship is with your Program Director. The best APD–PD partnerships are characterized by clear communication, mutual respect, and a division of labor that plays to each person's strengths. Some practical guidance:

1. Be explicit about communication preferences early — how often to meet, how to raise urgent issues, how to handle disagreement in front of residents or faculty, and what to bring to the PD vs handle on your own.
2. Be aware of the chief resident(s) role in program leadership – what are their responsibilities, how do they overlap with yours, what role do you have in the professional development and support of chief residents.
3. Understand your PD's priorities for the year so your work advances shared goals rather than running parallel to them.
4. When you disagree with a decision, voice your perspective privately and directly — not through residents, faculty, or coordinators.
5. Protect each other. If a resident escalates an issue to you that properly belongs to your PD, route it appropriately rather than stepping into that space unilaterally.

Program Size and Role Variation

The APD experience varies significantly by program size. The table below provides a rough orientation — your experience may differ.

Program Size	Typical APD Role	Common Challenges
Small (< 30 residents)	Single APD covering all domains; very close partnership with PD	Risk of over-extension; limited peer support within program
Medium (30–60 residents)	1–2 APDs; usually some domain specialization begins	Role boundaries can be unclear; coordination needed among APDs
Large (> 60 residents)	Multiple APDs with distinct domains; more formal structure	Risk of siloing; intentional communication required across APDs

Self-Assessment: What Kind of APD Do You Want to Be?

Before you dive into the mechanics of the role, take a few minutes to reflect on what you hope to bring to it. The most effective APDs have a clear sense of their own values and how those values shape their approach to residents, faculty, and program culture.

Reflection: Starting Strong

What drew you to this role? What are you most excited about?

What are your strongest skills as an educator? Where do you most want to grow?

What does your ideal resident-mentor relationship look like?

How do you want to be known by residents — and by faculty — a year from now?

What aspects of your program's culture do you most want to help shape or change?

Vignette: New APD, Unclear Role

Dr. Chen started as an APD in July after being nominated by her PD largely because of her strengths in resident advising and letters of recommendation. Three months in, she found herself chairing a curriculum subcommittee she hadn't agreed to, fielding calls from distressed residents about scheduling, and covering the PD's administrative email during a clinical stretch. When she finally sat down with her PD to review her job description, they realized there wasn't one. They spent an hour together creating a written document that clarified Dr. Chen's three primary domains — mentoring, LOR writing, and recruitment — and identified who was responsible for the items that had been falling to her by default. The conversation was uncomfortable for about fifteen minutes, and invaluable for the next three years.

1.2 Getting to Know APPD

As an APD, you are automatically part of the APPD community — an organization whose primary purpose is supporting you and your colleagues in doing this work well. The more actively you engage with APPD, the more you will get from it. Here is what you need to know.

The Associate Program Director (APD) Executive Committee

The APD Executive Committee represents the interests of all APDs within APPD's governance structure. The Committee facilitates communication between APD members and the APPD Board, develops resources, and organizes APD-specific programming at national meetings. Reach out through APPD Connect or via email — and consider applying for the Executive Committee yourself when you are ready!

- The APD Executive Committee provides educational content, mentoring, professional development and a forum for idea sharing for the APD section throughout the year.
- The APD Executive Committee:
    - Organizes and sponsors APD Peer Mentoring Groups. These are groups of 6-10 APDs from varying programs who meet approximately once per month. These meetings are a chance for APDs to come together to share challenges, ideas, and discuss monthly discussion topics relevant to APDs. Members can join Peer Mentoring each year in the spring.
    - Provides educational content and professional development primarily through APD-specific programming at the APPD spring and fall meetings and virtual cafes on APD-relevant topics throughout the year.

- Works to highlight achievements of APDs across the country, primarily through providing a platform for showcasing APD scholarly work at the APPD spring meeting.
- Facilitates and collaborates on scholarship relevant to the work and role of APDs.
- Aims to foster connections between APDs across programs.
- Develops and/or disseminates resources on topics relevant to APDs.
- Periodically performs needs assessments of the APD membership to guide future efforts.

APPD Meetings

APPD holds two national meetings annually. Both are high-yield and worth attending, especially early in your career. In recent years, the APPD has also sponsored the Pediatric Medical Education Conference, held adjacent to the APPD Fall Meeting.

- Annual APPD Fall Meeting (September/October): Geared toward new program leaders. Features an APD-specific session led by the APD Executive Committee, networking and mentorship opportunities, introduction to Learning Communities, and sessions geared toward learning the basics of program leadership in GME. If you are new to your role, this meeting is particularly valuable.
- Pediatric Medical Education Conference (September/October, adjacent to the APPD Fall Meeting): Meant to bring together established and emerging leaders across the spectrum of pediatric medical education to share innovations, scholarship and collaborative approaches to the challenges facing pediatrics. The conference is held in partnership with additional pediatric medical organizations including COMSEP, CoPS, AMSPDC, the APA and the AAP.
- Annual APPD Spring Meeting (March/April): A broader conference for leaders in pediatric graduate medical education, covering evolving program requirements and hot topics in GME, scholarship and curricular innovation, best practices, and professional development. Highlights include the APD Section Session, Table to Able roundtable discussions, Enhanced Learning Sessions (hands-on workshops), regional lunch gatherings and sessions with representatives from the ACGME and ABP.

All these meetings are excellent venues for connecting with APDs and other leaders from programs across the country who are navigating the same challenges you are. Many APDs describe the collegial network built at APPD meetings as one of the most durable and fulfilling benefits of membership.

Learning Communities

Learning Communities (LCs) are groups of APPD members who share interests and collaborate on projects, scholarship, and shared models. They are low-barrier, flexible in time commitment, and an excellent way to find your people within the organization. Current LCs span areas including Assessment, Behavioral and Mental Health, Community Health and Advocacy Training, Curriculum, Faculty and Professional Development, Healthcare Simulation, Educational Technology, LGBTQA+, Pediatric Global Health, Research and Scholarship, Underrepresented in Medicine, Quality Improvement/Patient Safety, and Remediation and Skill Development. Visit the APPD website for current listings (APPD Learning Communities) and join through APPD Connect (APPD CONNECT).

Grants and Research Support

- Grants: APPD offers financial support (up to $10,000) for projects that advance APPD's mission. Proposals are due each January. If you have a program innovation or educational research idea, this is a meaningful pathway for support and visibility: APPD Grants and Special Projects.
- APPD LEARN: This group within APPD provides an infrastructure for multi-centered, collaborative research projects and a centralized data collection system. APPD members can propose studies, which are reviewed by APPD LEARN leadership three times a year. This is a great opportunity to get expert guidance on survey and study design and utilize existing infrastructure for new projects! Learn more here: APPD LEARN.

Additional APPD Resources and Communities

It would be impossible to list all the resources, communities and action teams available through the APPD here! Please consider browsing the APPD website, where you can find information on things like:

- APPD Regions and Region-Specific Programming
- APPD's Confronting Racism Task Force and Initiatives
- Recruitment Information and Best Practices
- Competency Based Medical Education (CBME) Hub
- APPD's Professional Development Programs
- Well-Being Action Team
- ...and so much more!

How to Get the Most Out of APPD in Your First Year

Attend the Fall Meeting — the APD session is directly relevant to where you are.
Join one Learning Community in an area where you have genuine interest.
Connect with one APD from another institution who you can call when you have a difficult situation.
Consider joining an APD Peer Mentoring Group.
Explore the Resources section of the APPD website, particularly the APD-specific resources page: APD Resources

1.3 A Year in the Life of an APD

The APD role can feel unpredictable, but much of the academic year follows a reliable rhythm of deadlines, cycles, and recurring responsibilities. Understanding this rhythm in advance allows you to plan strategically rather than react perpetually. Below is a practical calendar organized by season.

⚠ Common Pitfall: All Seasons

A common mistake APDs make is treating every season as equally urgent. It isn't. Recruitment season is genuinely all-consuming. Early summer is generally lighter. Protect your lighter periods for projects, scholarship, and recovery — do not let them fill up by default with tasks that could wait or be delegated.

June – August: Transitions and Goal Setting

New interns arrive, senior residents take on supervisory roles, and the program resets. This is a time to establish a shared vision for the year and build the scaffolding that will support everything that follows.

1. Meet with your PD and leadership team to set shared goals and priorities for the academic year.
2. Lead or support intern orientation — and extend orientation frameworks to second and third years stepping into new supervisory roles.
3. Use orientation as an intentional opportunity to establish expectations around professionalism, communication, equity, inclusion, and psychological safety.
4. Complete an August PEC meeting to review program performance and prepare for WebADS updates.
5. Establish the program calendar: schedule PEC meetings, CCC meetings, residency program events and retreats, program leader check-ins, and key program dates to protect faculty and clinical calendars.
6. Support the incoming chief residents — they are navigating a significant role transition and benefit from proactive check-ins.
7. Administer the In-Training Exam (ITE).

> ⚠ **Common Pitfall: June–August**
>
> New APDs often underestimate how much energy intern orientation requires — and then have nothing left for goal setting with their PD. Block time for both before the interns arrive.

September – December: Recruitment Season

Recruitment is among the most time-intensive responsibilities APDs carry. Planning early, distributing the workload deliberately, and building in faculty preparation time are the keys to a successful season.

1. Establish a clear recruitment strategy with the leadership team: application review criteria, interview day structure, faculty preparation, resident involvement, and ERAS fundamentals.
2. Ensure faculty and resident interviewers are trained on prohibited questions, bias mitigation, and behavioral interviewing techniques before the first interview day.
3. Prepare and complete fall PEC and CCC meetings.
4. Complete semi-annual resident evaluations and meetings.
5. Attend the APPD Fall Meeting.
6. Submit Enhanced Learning Session proposals (November–December) and poster abstracts (December–January) for the APPD Spring Meeting.

> ⚠ **Common Pitfall: September–December**
>
> Interview season tends to colonize all available time. If you have scholarship, curriculum, or personal development work in progress, protect specific days as off-limits to recruitment logistics before the season begins — or accept that those projects will pause until January. Be aware of deadlines for abstract and workshop submissions to meetings such as the APPD spring meeting, PAS, and COMSEP.

January – March: Post-Interview and Renewal

The end of interview season is often a welcome exhale. Programs have a bit more space, and many APDs find this period useful for scholarship, professional development, and reflection. At the same time, residents and faculty can experience increased stress and burnout during winter — stay attuned to team wellbeing.

1. Finalize rank list review and submit to NRMP by the February deadline.
2. Finalize and submit individual resident milestone and EPA data to the ACGME (January).
3. Submit QI/research abstracts to APPD (January).
4. Prepare for and track ACGME resident and faculty survey completion (February).
5. Celebrate Match Week — it matters to residents and deserves acknowledgment.
6. Use spring PEC meetings to discuss curriculum updates and schedule changes for the next year.

> 💡 **Pro Tip: January–March**
>
> This is the best time of year to work on scholarship, attend a professional development program, or have exploratory conversations about your own career growth. Block it before it fills with catch-up work from the fall.

April – June: Celebration and Renewal

Spring brings the energy of a new incoming class and the opportunity to celebrate your graduating seniors. It is also a period of significant logistical work to close out one academic year and prepare for the next.

1. Finalize resident schedules for the next academic year.
2. Attend the APPD Annual Spring Meeting.
3. Complete end-of-year CCC meeting and submit milestone and EPA data to ACGME (June).
4. Complete semi-annual resident evaluations and meetings.
5. Complete end-of-year PEC and develop the Annual Program Evaluation.
6. Finalize orientation plans for the incoming class.
7. Acknowledge the work of coordinators, chief residents, and the leadership team — consider a team gathering or retreat.
8. Celebrate your graduates. Be specific and personal in your acknowledgment of their growth.

Equity Lens: Throughout the Year

Equity considerations belong in every season of program leadership, not just in recruitment.

June–August: Examine your orientation structures. Do they actively establish belonging for all residents, or do they passively assume it?

September–December: Review your application screening rubrics for proxies of privilege. Involve your Diversity Committee in rank list deliberations.

January–March: Check in individually with residents who are underrepresented in medicine — post-interview season can surface isolation for those who saw few applicants who looked like them.

April–June: Consider whether your graduation recognition reflects the full range of contributions residents make — not only research or procedural achievement.

SECTION 2

Core APD Responsibilities

The APD is a key educational leader within the residency program and serves as a critical link between residents, faculty, program leadership, and the broader clinical and educational environment. The role supports the Program Director in ensuring the program meets or exceeds all accreditation, regulatory, quality and safety, educational, and institutional standards — and, beyond compliance, in continuously improving it. Specific responsibilities vary according to program structure, size, and assigned duties, but all APDs share a common responsibility for supporting resident development and advancing the educational mission of the program.

The role encompasses six complementary functions — advisor, coach, mentor, evaluator, advocate, and educational leader. These frequently overlap, but each serves a distinct purpose, and the most useful habit is recognizing which one a given situation calls for.

The situation	Your role
The resident is asking for direction	Advisor
The resident needs help understanding or improving performance	Coach
The resident needs perspective, connection, or career guidance	Mentor
The program needs a judgment about performance or progression	Evaluator
The resident needs help navigating a challenge or the system	Advocate
The program needs to change because of what we are learning	Educational leader

Responsibilities operate at two levels. Core responsibilities are generally expected of every APD. Potential additional responsibilities are determined based on program needs. The distinction provides clarity without rigidity — no single APD is expected to fulfill every function of the program independently, and roles should be clearly defined, distributed equitably across the APD team, supported with appropriate authority and resources, and reviewed periodically as needs evolve.

2.1 Core Responsibilities

Resident Development and Support

APDs contribute to residents' longitudinal development by building meaningful relationships and maintaining regular communication; supporting educational, professional, and personal growth; helping residents identify strengths, growth areas, and individualized learning goals; promoting resident ownership of that development; connecting residents with appropriate faculty, mentors, and opportunities; and recognizing residents who may benefit from additional support, communicating concerns to program leadership.

Advising and Coaching

APDs serve as both advisors and coaches — related but distinct functions. As advisors, APDs help residents navigate the program: requirements, educational opportunities, career planning, and progression through training. As coaches, APDs help residents interpret feedback, reflect on performance, identify developmental goals, and build strategies for improvement, emphasizing reflection, inquiry, and learner ownership rather than simply providing solutions.

Within a competency-based framework, the aim is to turn assessment information into developmental conversation: assessment identifies where the learner is; coaching helps the learner determine how to move forward. Coaching does not require having all the answers — an important part of both functions is helping residents identify the resources, people, and experiences that will support their development.

Assessment and Evaluation

APDs contribute to longitudinal assessment and to decisions about progression and entrustment. Responsibilities may include reviewing and synthesizing assessment data; identifying patterns across workplace-based assessments, milestones, EPAs, and narrative feedback; providing clear and actionable feedback; identifying residents who may require additional support or remediation; participating in CCC activities as assigned; communicating expectations and concerns consistently; and contributing to decisions about readiness for increasing responsibility.

APDs should distinguish formative coaching from summative evaluation while recognizing that both are essential. When these roles overlap, be transparent with the resident about the purpose of the conversation.

Advocacy and Communication

APDs advocate for residents while upholding program standards: maintaining open communication with residents and faculty, helping residents navigate challenges, facilitating communication among residents, faculty, leadership, and clinical services, identifying systemic barriers to education or well-being, bringing resident perspectives to leadership, and supporting fair and transparent application of policy.

Advocacy does not mean shielding residents from accountability. It means ensuring residents understand expectations, can access appropriate support, and are treated fairly throughout the educational process.

Educational Leadership

All APDs contribute to continuous improvement of the program. The habit that distinguishes strong educational leaders is treating individual learner experiences not only as opportunities to support that resident, but as information about the educational system itself. A resident who cannot get feedback on a rotation is a resident problem; three residents who cannot get feedback on the same rotation is a program problem.

Responsibilities may include identifying educational needs and opportunities for improvement, contributing to curriculum development and evaluation, supporting implementation of competency-based medical education, participating in faculty development, using learner and program data to inform decisions, and supporting educational innovation.

Promoting Equity and Inclusion

APDs promote an educational environment in which all residents have equitable access to learning opportunities, mentorship, professional development, and support. Responsibilities may include recognizing and addressing barriers that disproportionately affect individual residents or groups of learners; considering equity

and inclusion in advising, assessment, scheduling, assignments and opportunities for advancement and recognition; ensuring that expectations and policies are applied fairly and transparently; creating space for residents to share concerns and perspectives; and partnering with program leadership and faculty to identify and address inequities within the learning environment.

Promoting equity and inclusion is both an individual and systems responsibility. APDs should recognize that residents may experience the training environment differently based on their backgrounds, identities, circumstances, or access to resources, while avoiding assumptions about any individual resident's needs or experiences. The goal is not to provide identical experiences, but to ensure that each resident has a fair opportunity to learn, develop, contribute, and succeed. When patterns of inequity are identified, APDs should bring those concerns forward and support changes that improve the educational environment for all residents.

Recruitment and Resident Selection

APDs contribute to the recruitment and selection of residents who align with the program's mission, values, and educational goals. Responsibilities may include reviewing applications, participating in applicant interviews, helping to develop and implement the recruitment process, engaging with applicants throughout the interview season, and contributing to resident selection and the development of the incoming class. The specific role of the APD in recruitment and selection varies greatly among programs, depending on program structure, size, and the division of responsibilities among the program director, APDs, and other faculty. However, some involvement in recruitment and resident selection is an important part of the APD role and provides an opportunity to help shape the future of the residency program. This topic is discussed in greater detail later in the Section 2.3.

2.2 Potential Additional APD Responsibilities

Individual APDs may be assigned specific areas of programmatic responsibility — leading the development, oversight, and evaluation of a component of the training program. These should be clearly defined by the Program Director and may evolve as program needs change. Examples include:

- **Assessment and CBME —** milestone and EPA processes, workplace-based assessment, CCC coordination, monitoring evaluation completion by both residents and faculty, and faculty development in assessment.
- **Curriculum and Educational Program —** curriculum development and evaluation, goals and objectives for rotations and longitudinal experiences, conferences and didactics, consistency across sites, and gap identification.
- **Resident Progression, Remediation, and Academic Support —** ILPs, remediation plans, academic support, and collaboration with the PD and CCC on promotion.
- **Resident Well-Being and Professional Development —** wellness initiatives, mental health resources, resident retreats, and programming in professional identity formation and resilience.
- **Faculty Development —** teaching skills, feedback and assessment training, and faculty recognition.
- **Scholarly and Career Development —** scholarly opportunities, research and QI support, fellowship advising, and mentorship.
- **Program Operations and Administration —** scheduling and rotation management, chief resident selection and support, policy, requirement tracking, and GME coordination.
- **Equity, Diversity, and Inclusion —** recruitment and retention strategy, equity review of assessment and selection processes, learning environment climate, and bias mitigation training.

- **Chief Resident Support and Development —** APDs may play a formal or informal role in the professional development of Chief Residents, as they navigate time management, boundary-setting, giving difficult feedback, and other leadership and communication skills.

Two things are helpful to clarify when additional roles are discussed. The first is the distinction between what an APD is primarily responsible for and what they contribute to. It can be helpful for everyone to know which is intended. The second is the reporting structure: APDs often report to their division or department director for clinical and academic activities and to the PD for GME activities. Noting both can help ensure that educational contributions are visible during annual review.

2.3 Resident Recruitment and Selection

Recruitment is one of the most consequential things your program does and will promote learners finding programs that match their career goals, learning environment, and culture. APDs often have a large role in this work — from reviewing applications to structuring interview days, preparing faculty, engaging residents in the recruitment process, conducting interviews, and supporting development of the rank list. Approaching recruitment with intention and a commitment towards equity fosters positive outcomes for your program and for applicants.

Review and be familiar with current recommendations of national organizations (including APPD, COMSEP, AMSPDC, FuturePedsRes, and NextGen Pediatricians). These groups collaborate annually to provide shared expectations for the recruitment season. In addition to national recommendations, maintain close communications with your local GME office and department leadership for institutional guidelines. Review information from the Recruitment Action Team on the APPD website: APPD Recruitment Resources.

Holistic Review Principles/Mission-Aligned Selection and Retention

Holistic review moves beyond Step scores, grades and class rank to consider the full context of an applicant's preparation, experiences, and potential. When implementing holistic review in your program:

- Define the experiences, competencies, attributes, and metrics you are actually seeking in a resident that align with your program's mission, curriculum, and needs of the workforce and community — and make sure you review and adjust your rubric to best reflect your program's values.
- Train reviewers on your rubric before the season opens. Consider removing or de-emphasizing photos and demographic identifiers from initial review to reduce implicit bias.
- Involve your Diversity Committee in application review, interview day, and rank process.
- Regularly audit your rank and match outcomes for patterns that may reflect bias.

Interview Day Structure

A well-designed interview day serves two purposes: it allows you to assess applicants, and it allows applicants to assess you. The best programs treat interview day as a two-way encounter.

- Brief your faculty interviewers on the day's schedule, the program's mission and priorities, and best practices for interviewing.
- Provide training on recognizing and reducing bias and microaggressions during the recruitment process.

- Provide interviewers with a structured interview guide and a clear framework for documenting their assessments as well as a tip sheet for them to refer to when asked questions about the program by the applicants.
- Train faculty explicitly on prohibited questions (see below) and on how to respond if an applicant volunteers information they should not ask for.
- Engage residents meaningfully — their input is valuable, and their authentic interactions with applicants are often the most informative part of the day.
- Solicit and use coordinator feedback — coordinators observe professionalism behaviors throughout the entire interview day that faculty may miss.

Prohibited Questions and NRMP Guidelines

Federal law and NRMP policy prohibit making employment decisions on the basis of protected characteristics. This is not just a legal formality — it is a matter of fairness to applicants and integrity in your process. Specifically:

- Federal law prohibits employment decisions based on race, sex, age, religion, national origin, or disability. This also applies to discrimination based on pregnancy and child-rearing plans. In some states it is also illegal to discriminate based on sexual orientation and gender identity.
- NRMP prohibits asking about other programs applied to, including names, specialties, or geographic location.
- Do not ask about marital status, number of children, plans for children, or FMLA.
- Become familiar with national guidance and follow NRMP guidance carefully on post-interview communication and second-look visits.

Virtual Recruitment

Virtual interview formats are now standard in pediatric residency recruitment. Considerations specific to virtual platforms include:

- Ensure your program's virtual presence (website, social media, virtual tour) is up to date and accurately reflects your culture and training environment.
- Invest in brief videos featuring diverse residents and faculty — these can be impactful when applicants cannot visit in person.
- Train faculty on virtual interview best practices: lighting, background, attention cues, and how to build rapport through a screen.
- Create structured virtual opportunities for applicants to engage informally with residents.

Vignette: Holistic or Mission-Aligned Review in Practice

During rank list deliberations, the faculty interviewer for an applicant noted that her Step 1 score was below the program's historical average. A member on the recruitment committee pointed out that this applicant had worked full-time during medical school, had written a compelling personal statement about her motivation for pediatrics, and had received consistently strong letters emphasizing her clinical reasoning and commitment to underserved communities. The APD facilitated a structured discussion that helped the committee weigh these factors against the board score. The applicant matched, completed residency with no performance concerns, and is now a pediatric hospitalist at a safety-net hospital. The committee cited this deliberation as a turning point in their approach to holistic review.

2.4 Mentoring and Coaching

Mentoring and coaching are the primary vehicles for the resident development described in 2.1. As mentors, APDs offer perspective, sponsorship, and career guidance drawn from their own experience; as coaches, they help residents find their own answers. It is also worth stating what coaching is not: therapy, mentoring, advising, or remedial training.

	Advisor	Mentor	Coach
Who sets the agenda	Faculty member / program	Shared	Resident
Primary approach	Directive guidance; navigating requirements	Advice, sponsorship, networking	Questions, reflection, goal setting
Content expertise	Yes — program-specific	Yes — domain-specific	Not necessarily required
Relationship to evaluation	Usually evaluative	Variable	Depends on program design

The distinction between coaching and advising is teachable and should be taught explicitly rather than assumed — after a single one-day faculty coaching retreat, faculty ability to correctly classify described interactions improved from a median of 90% to 100%, and curiosity and a resident-driven approach appeared in faculty descriptions of an effective coach only after training.

Setting Up the System

Most programs assign each resident a faculty mentor, and some add an upper-level resident mentor as well. Whatever the structure, the program-level work is ensuring every resident has access to one or more mentors, monitoring whether the relationships are functioning, and reaching out to residents who appear under-mentored rather than waiting for them to ask.

Outstanding mentors in academic medicine share a consistent set of characteristics: they model the qualities they hope residents will develop, act as career guides who tailor support to each resident's goals, make genuine and protected time commitments, support personal and professional balance, and help residents build networks.[3] Depending on the moment you may serve as listener, challenger, role model, advocate, or career guide — the best mentors are fluent across these and choose deliberately. Mentoring is also bidirectional; residents should understand what is expected of them in terms of preparation, initiative, and follow-through.

Coaching and the Evaluative Role

Programs should decide explicitly whether coaches participate in resident evaluation, because pediatric programs have answered this differently — some deliberately separate coaching from evaluation, others include coaches in CCC discussions. A non-evaluative coach buys candor and costs the CCC its most richly informed voice; an evaluative coach gives the CCC a member who has directly observed the resident, and costs candor.

This matters more for APDs than for most faculty, because you are usually already inside the evaluative chain and cannot opt into a non-evaluative model simply by asserting it. Be explicit with residents about which role

you actually occupy, what may be shared with program leadership, and what you are obligated to report regardless — safety concerns, professionalism breaches, and mandated reporting.

Individualized Learning Plans

ILPs are an ACGME requirement in pediatrics and should be living educational tools rather than compliance documents. Use the mentoring or coaching relationship to build and revisit goals, and connect the ILP to the semiannual review described in 2.6.

Equity Lens: Mentoring and Coaching

Mentoring opportunities are not equally distributed. Residents from marginalized or underrepresented groups may face barriers to finding mentors who understand their experiences or interests. Proactively identify residents who may be under-mentored — while recognizing that preference-based matching can place disproportionate demands on a small number of faculty, so track mentor load as well as resident satisfaction. Coaching can complement, but does not replace, efforts to create an equitable learning environment.

Vignette: The Resident Who Went Quiet

An APD noticed that a resident she had been mentoring had become unusually withdrawn and stopped responding to check-ins. Rather than assuming the cause, she sent a brief message: "I've noticed you've been quieter lately — just wanted to check in, no agenda." The resident disclosed a family crisis and fear that it was affecting performance. The APD connected the resident with appropriate resources and helped arrange a temporary schedule accommodation. The resident later identified that simple act of noticing and reaching out as pivotal.

2.5 Competency Based Medical Education and the Clinical Competency Committee

In a competency-based medical education (CBME) framework, assessment is viewed as an ongoing process that supports trainee development over time rather than relying on intermittent summative evaluations. In pediatrics, Entrustable Professional Activities (EPAs), sometimes referred to as Everyday Pediatrician Activities, define the expected outcomes of training. The curriculum is designed to prepare trainees to perform the EPAs, while assessment data are gathered continuously through multiple methods and from multiple sources in a low-stakes manner to guide learning and development. Within this system, the CCC, a required component of all accredited residency programs, plays a central role by synthesizing information from a variety of assessment sources, interpreting both qualitative and quantitative data, and making informed decisions about a trainee's progression and readiness for increasing levels of responsibility. Here we provide some information and evidence-based recommendations on how the CCC can support CBME.

Collecting Assessments: Purposeful, Workplace-Focused, and EPA-based

A robust assessment system begins with a deliberate plan for collecting meaningful information about trainee performance across a variety of pediatric clinical settings and experiences. Rather than viewing assessments as isolated evaluation events, CBME continuously collects assessments and treats each one as a low-stakes data point that contributes to a broader longitudinal picture of a trainee's development. Thoughtful selection of

assessment data can help ensure that both trainees and the CCC have information that supports growth and informs decisions about progression toward unsupervised EPA performance.
Workplace-based assessment (WBA) plays an important role in CBME because it can provide rich, context-specific information that is closely aligned with the essential activities of clinical practice (EPAs). Frequent observations and narrative feedback can help trainees recognize strengths, identify opportunities for improvement, and guide ongoing learning.

Pro Tip: Deciding what assessment data to collect

- When deciding what assessment data to gather, it can be helpful to start with the desired outcome: readiness to perform the EPAs without supervision.
- Consider two complementary questions: **What information does the trainee need** to understand their progress toward this goal and guide their learning? And **what information does the Clinical Competency Committee (CCC) need** to understand the trainee's development and make informed decisions about advancement?
- Relevant data may come from multiple sources, including multisource feedback, end-of-rotation evaluations, structured direct observations, simulation activities, standardized patient encounters, In-Training Examination (ITE) scores, Individualized Learning Plans (ILPs), and self-assessments. When considered together and aligned with pediatric EPAs, these sources can provide a more complete picture of residents' growth and readiness for practice.

Clinical Competency Committee Structure

Thoughtful attention to the structure and composition of the CCC can enhance the quality of discussions and strengthen decision making. Consider the following strategies:

- Recruit a diverse committee. Include members with varied clinical experiences, perspectives, and expertise. Diverse representation enriches discussions, strengthens decision making, and helps mitigate individual biases.
- Define roles clearly. Establish clear expectations for the committee members. Thoughtful role definition can promote balanced participation and encourage all members to contribute their perspectives.
- Use structured review processes. High-functioning CCCs rely on consistent approaches for reviewing assessment data, discussing learners, reaching consensus, and documenting decisions. Structured processes improve efficiency, fairness, transparency, and defensibility.
- Ensure there is sufficient time to discuss all residents. This may involve multiple meetings for larger programs.
- Use data visualization tools. Dashboards and other visual displays can help committee members contextualize performance across EPAs, observe growth trajectories over time, and immediately identify missing data or systemic gaps in assessment collection.

CCC Process – Running the Meeting

Successful CCC meetings are supported by clear processes, intentional facilitation, and a shared mental model of the expectations of training and the CCC's purpose . Consider the following strategies:

- Cultivate a Shared Mental Model Through Faculty Development: Establish a common understanding among committee members regarding CCC goals, supervision frameworks, what it means to be practice-ready, and expectations related to EPA performance. Provide ongoing faculty development focused on interpreting assessment data, navigating group decision-making, and recognizing potential sources of implicit bias.
- Optimize Time in the Meeting Through Pre-Review and Administrative Support: Utilize designated pre-reviewers to synthesize assessment information before meetings, allowing committee time to focus on meaningful deliberation, interpretation, and decision-making.

- Orient Around a Growth Model: Perform holistic reviews of every resident during each CCC cycle, not only those who need additional support, to promote individualized progression toward practice readiness. Ask not only, "Where is this trainee now?" but also, "What is the trainee's next developmental step, and what will they need to get there?"
- Prioritize Longitudinal Trajectories and Narrative Evidence: Draw on multiple sources of evidence to develop a comprehensive understanding of each trainee's progression over time. Pay attention to patterns across settings, alignment between self-assessment and observed performance, and behavior-based narrative feedback, which often provides richer and more actionable insight into a trainee's developmental strengths and areas for growth.
- Focus on Prospective Judgments of Practice Readiness: Frame discussions around future readiness for greater responsibility and less supervision rather than solely retrospective evaluations of performance. Ask, "What is this resident ready to do moving forward?" When making prospective decisions about readiness, consider essential factors related to trust across all EPAs, such as clinical reasoning, accountability, and help-seeking behaviors, alongside EPA-based assessments.
- Standardize Deliberations to Reduce Bias and Groupthink: Implement consistent review procedures by defining what is reviewed, by whom, and through the use of a standard template; establish discussion norms; and maintain strict confidentiality. Meeting leaders should intentionally encourage all voices to contribute, invite less-senior members to share perspectives early, explore differing interpretations of the data, and challenge premature consensus to support balanced and defensible decisions.

CCC Output and Programmatic Integration

Effective CCC outputs translate assessment data into meaningful actions for residents and programs.

- Provide clear advancement and supervision decisions with rationale in a standardized format to ensure transparency and consistency.
- Provide actionable feedback that can be incorporated into the resident's individualized learning plan (ILP) to guide learning.
- Share CCC outputs with trainees through a coaching or advising process that helps residents interpret feedback, reflect on performance, and establish meaningful goals for future growth. Learn more about how these conversations can be conducted in Section 2.5, Feedback and Assessment.

And…generate program-level recommendations. Beyond informing decisions about individual learners, aggregated CCC findings should serve as a key source of data for the Program Evaluation Committee (PEC). CCC trends can identify curricular gaps, unassessed EPAs, rotation-specific feedback, assessment system weaknesses, faculty development needs, and potential sources of bias in assessment and decision-making. This creates a continuous feedback loop that supports program evaluation, promotes fairness and equity, and drives ongoing quality improvement.

Equity Lens: CCC and Assessment

No assessment system is free from bias. CBME attempts to mitigate biases and promote equity in several ways including using multiple assessment sources rather than relying on a single evaluation and focusing assessment on an individual's growth toward the expected outcomes rather than comparison to peers. However, inequity persists. If left unexamined, bias can systematically disadvantage trainees from underrepresented groups and influence committee judgments. Check out the table for steps you can take to promote equity in your CCC.

Equity Recommendation	Practical Actions
Ensure diverse CCC membership	Intentionally recruit members with diverse demographic backgrounds, perspectives, clinical expertise, and educational roles to broaden viewpoints and reduce the influence of individual biases.
Provide ongoing faculty development	Train CCC members in implicit bias, equity-minded assessment, and effective group decision-making to promote fair and consistent evaluation practices
Use transparent, standards-based assessment	Ground deliberations in clearly defined expectations aligned with EPAs and established competency standards rather than subjective impressions or learner-to-learner comparisons.
Promote transparency in CCC processes	Clearly communicate CCC processes, expectations, and decision making approaches to both faculty and trainees to build trust and accountability.
Monitor for bias and inequitable outcomes	Regularly review assessment data, committee processes, and promotion or supervision decisions to identify potential bias and address disparities.
Use findings for continuous improvement	Apply insights from equity reviews to refine assessment systems, committee procedures, faculty development efforts, and learner support strategies to promote fair and defensible decisions for all trainees.

2.6 Feedback and the Semi-Annual Review

The work that makes assessment educational rather than merely administrative is the conversation that follows it. This subsection covers how to have those conversations.

What Makes Feedback Useful

Effective feedback is *observed* — based on behavior someone actually saw; *credible* — residents make judgments about the source before engaging with the content; and *specific and actionable*. "Be more efficient" is not usable. "You spent about eight minutes on the social history before establishing the timeline of the fever — try anchoring the chronology first" is.

After direct observation: label it ("I'd like to give you feedback on that family conversation"), since residents frequently do not recognize feedback as feedback; ask first ("how do you think that went?"); focus on one or two behaviors; describe what you observed and its impact; and end with one specific next step and a plan to reassess. Brief and timely beats comprehensive and late.

Running the Semi-Annual Review

ACGME requires that each resident receive a documented semiannual evaluation of performance with feedback. Done well, the meeting turns assessment data into an actionable development plan rather than walking the milestone grid. It is also where several distinct obligations converge: confirming the resident is advancing in responsibility per the curriculum, reviewing procedure logs against requirements for program completion and board eligibility, assessing progress on the ILP, and providing career planning and counseling.

The R2C2 model for Coaching provides a useful structure for the conversation itself.

Phase	Purpose	What it can sound like
Relationship	Establish partnership and purpose	"My job today is to help you get where you're trying to go. Before we look at any of this — how have the last six months actually felt?"
Reactions	Explore the resident's response to the data	"What's your reaction to seeing this?" "Is there anything here that surprises you, or that feels off?"
Content	Make sense of patterns in the data	"Where does this match your experience, and where doesn't it?"
Coaching	Develop resident-owned goals	"What's one thing you'd want to be different by the time we meet again?"

Send the data in advance and arrive with two or three patterns rather than a list of ratings — your synthesis is the value you add. Treat discrepancies between self-assessment and CCC assessment as the interesting part, and distinguish developmental expectations from true concerns, since residents routinely misread the grid as a report card. Leave with two or three goals in the resident's own words, set a mid-cycle follow-up, and revisit those goals at the next review — if you never return to them, residents learn the goals are ceremonial. Document the meeting; a final summative review must be retained in the permanent file for each resident.

Helping Residents Process Feedback from Others

Much of the feedback a resident brings you was written by someone not in the room and arrived stripped of tone and context. The goal is neither to defend the evaluator nor to dismiss the feedback, but to help the resident sort what is useful from what needs to be challenged. Stone and Heen describe three reasons feedback gets rejected; diagnosing which one has fired keeps the conversation from circling.[1]

Trigger	What it sounds like	What is actually happening	What helps
Truth	"That's not accurate." "That's not fair."	Evaluating the content and finding it wrong — often correctly in some detail, then using that detail to discard the whole	Shift from whether it is right to what it might mean.
Relationship	"He never actually watched me."	Responding to the giver rather than the content. The objection is frequently partly true, which makes it more persuasive, not less	Signpost that there are two separate topics; take them one at a time.
Identity	"Maybe I'm not cut out for this." Silence or shutdown	The feedback has landed on the resident's sense of who they are; the reaction exceeds the content	Address the reaction before the content

Two principles carry most of the weight. Separate intention from impact: residents judge themselves by what they meant, while evaluations describe what others saw, and both can be entirely true at once. And look for

patterns — one comment is an anecdote; the same theme across multiple evaluators and rotations is data. You hold the aggregate, which the original evaluator does not.

Then move from processing to action: choose one change rather than five, frame it as a small experiment with a defined window, normalize that a new behavior feels awkward at first, and teach residents to seek feedback specifically. "Would you watch my family update and tell me whether the plan was clear?" produces something usable; "any feedback for me?" produces "you're doing great."

⚠ When the feedback itself is the problem

Not all feedback should be accepted. If an evaluation is demeaning, unsupported by observation, or fits a pattern of bias, do not coach the resident to become more receptive to it. Address it with the faculty member and your PD, and make clear to the resident that you are doing so. A resident's report of biased assessment is also data about your assessment system, not only a reaction to be managed.

Delivering Corrective Feedback

Describe behavior and impact rather than character — "the nurse called twice before you responded, and the family escalated to the charge nurse" is workable; "you seem disengaged" is not. State the expected standard clearly, then ask the resident to summarize the concern back to you. Be explicit about whether the conversation is formative feedback, a warning, or remediation; residents should never be uncertain which one just happened. Document significant concerns contemporaneously, particularly when escalation is possible (see 2.6).

Closing the Loop on Evaluation Systems

Assessment is a two-way system, and the administrative half is easy to neglect. Programs must maintain mechanisms for periodic confidential resident evaluation of faculty and annual evaluation of the overall program, and someone has to monitor completion of evaluations by both residents and faculty. Chronically incomplete evaluations are not merely a compliance problem — they starve the CCC of the narrative data that makes semiannual reviews worth having.

Equity Lens: Feedback and Assessment

Narrative evaluations are particularly vulnerable to bias. Research has identified systematic differences in the language used to describe residents by gender — women more often described in terms of personal attributes and effort, men in terms of competence and autonomy — and discordance between narrative comments and numerical ratings. Comparable concerns apply to race and ethnicity.

Review narrative comments in aggregate before each CCC cycle and look for patterned or vague language; teach faculty through concrete examples rather than exhortations to be unbiased; and ensure residents receive corrective feedback rather than having concerns softened or withheld, which deprives them of exactly the information they need.

Vignette: The Evaluation She Couldn't Get Past

A PGY-2 asked to meet after an end-of-rotation evaluation described her as "resistant to input from the team." She was upset, and her first point was that the attending who wrote it had been on service for only four days of a four-week block.

Dr. Alvarez, her APD, resisted the urge to defend the attending. Instead he told her there were two separate questions on the table — whether that attending had seen enough of her work to judge it, and whether the concern itself was accurate — and asked which she wanted to take up first. She started with the attending. They spent ten minutes there, and Dr. Alvarez agreed the contact had been thin; he offered to raise the observation-volume problem with the rotation director.

Then he returned to the second question: was anything in the comment pointing at something real? After a pause, she said she had pushed back hard on a discharge plan she believed was unsafe, and had probably come across sharper than she intended. She had been describing what she meant to do; the evaluation had described how it landed. Both accounts were accurate, and recognizing that was what let her do something with the feedback.

2.7 Supporting Residents in Difficulty

Most residents who struggle do not identify themselves as struggling. APDs are often among the first to notice concerning patterns and play a central role in identifying concerns, partnering with the PD and GME leadership, and supporting the resident through remediation.

Concerns may emerge through direct observation, evaluation data, CCC discussion, faculty or co-resident reports, or resident disclosure; early identification allows earlier intervention. Deficiencies may map to one or more ACGME core competencies and may reflect clinical reasoning, organization, or knowledge gaps; communication or professionalism concerns; lack of belonging or psychological safety; motivation, burnout, or poor insight; mental health, substance use, or learning challenges; or significant personal or financial stressors.

Equity Lens: Identifying Struggling Residents

Be particularly aware of how stereotype threat, microaggressions, and lack of belonging can contribute to underperformance in residents who are underrepresented in medicine. A resident who appears disengaged or performs inconsistently may be navigating an environment that does not feel safe or supportive. Remediation that addresses performance without addressing environment is unlikely to succeed.

Remediation Strategies

Once the concern is identified and mapped to specific competencies, select targeted interventions:

- Validated assessment tools (PREP, PediaLink) for knowledge gaps
- Case-based review with structured feedback
- Direct observation with timely, specific, behaviorally anchored feedback (see 2.5)
- One-on-one skill coaching with a designated faculty member (see the caution below)

- Simulation practice for procedural or clinical reasoning skills
- Wellness, sleep hygiene, or behavioral health intervention when indicated
- Professionalism resources (the ABP Professionalism Guide is an excellent reference)

> **⚠ Caution: Remediation is not the Coaching Program**
>
> Do not automatically place a struggling resident into a coaching program as the remediation intervention. Coaching is generally a voluntary, resident-driven developmental relationship; assigning a resident to coaching for performance remediation can undermine both the coaching relationship and trust in the program. If individualized skills coaching is needed, clearly identify it as remediation and consider using a faculty member other than the resident's assigned coach.

Documentation and Due Process

Documentation should include the remediation plan with specific, measurable goals (SMART framework, anchored to ACGME competencies); supporting evidence of the deficiencies identified, including evaluations and direct observation records; a clear statement of expectations and timeline; and clear delineation of the consequences of unsuccessful remediation, including possible non-promotion or termination.

Any disciplinary action must follow the sponsoring institution's written policies for evaluation, promotion, disciplinary action, and due process. Involve your GME office and legal resources early — the legal implications of remediation are often underappreciated. Designate a faculty mentor separate from the evaluative chain when possible, and keep records of all communications.

> **Vignette: Remediation Across Two Domains**
>
> A PGY-2 resident was flagged by the CCC for disorganized pre-rounding and below-expected Patient Care milestones. In conversation, the APD learned that the resident was also managing a parent's terminal illness from another state and had been afraid to ask for help. The resulting plan addressed both domains: structured clinical intervention with direct observation and feedback, and connection to wellness resources with temporary schedule accommodation. At the next CCC cycle, performance had returned to expected. A plan addressing only the clinical performance would likely have failed.

2.8 Writing Letters of Recommendation

Letters of recommendation are among the most consequential documents you will write on a resident's behalf. A thoughtful, specific, and well-supported letter can meaningfully strengthen a resident's candidacy. Conversely,

a generic, vague or unintentionally biased letter – even when intended to be positive – can weaken an otherwise strong application.

Step 1: Decide Whether You Can Write a Strong Letter

Before agreeing to write, consider whether you know the resident well enough to provide a *specific, evidence-based assessment of their strengths and readiness for the position or opportunity they are pursuing*.

- If another faculty member knows the resident better, consider whether they may be a more appropriate letter writer or whether a co-authored letter is appropriate.
- If you have significant performance concerns that would affect your ability to provide a strong endorsement, discuss the request with the resident and, when appropriate, seek guidance from program leadership.
- It is appropriate to decline if you cannot write a strong, substantive letter. Do so gently and promptly so the resident has adequate time to identify another writer.

Step 2: Gather Information

Ask the resident for information that will help you write a detailed and individualized letter. This may include:

- The information or forms required for the application process, including the resident's AAMC ID when applicable.
- An updated CV and personal statement, if available.
- The position, fellowship, program, or opportunity to which they are applying and their career goals.
- Two or three clinical, educational, leadership, research, advocacy or other experiences that they believe illustrate their strengths—particularly experiences you observed directly.
- A brief conversation with the resident can be especially valuable when significant time has passed since you worked closely together.
- When appropriate, offer to review their personal statement or application materials as part of your mentorship.

Step 3: Write the Letter

A strong letter of recommendation is specific, evidence based, competency-informed, and genuinely differentiating. It should help the reader understand not simply that the resident is "excellent," but what they do well, how you know, and what distinguishes them from their peers. The structure below is a reliable framework:

- Opening: Include the applicants identifying information required by the application system (i.e. AAMC ID for ERAS letters), a confidentiality/waiver statement when applicable, and a clear description of your relationship with the applicant: how long you've known them, in what capacity, and how closely you have worked together.
- Assessment: Describe the resident's knowledge, skills, professional behaviors, and development using relevant competency frameworks when helpful (i.e. ACGME Milestones) Avoid simply reproducing Milestone language or scores. Instead, provide specific examples that demonstrate the competencies you are describing.
- Evidence: Include one or more brief de-identified examples from your direct experience with the resident. Specific observations are generally more credible and memorable than a list of positive adjectives.
- Differentiating strengths: Highlight accomplishments and qualities relevant to the opportunity, such as clinical excellence, scholarship, teaching, leadership, advocacy, quality improvement, or service. Explain why those accomplishments matter rather than simply repeating items from the CV.
- Comparative language: When you can do so authentically, provide context that helps the reader understand how the applicant compares with other residents you have supervised at a similar stage

of training. Be consistent in how you refer to all trainees ("Dr. Last Name" is preferred over "First Name")

- Closing recommendation: State the strength of your endorsement clearly and unambiguously. Avoid unintentionally weakening a strong recommendation with vague or qualified language.
- Signature block: Include your name, credentials, academic and/or clinical title, division, institution, and appropriate contact information. Keep the signature block proportional to the letter — it should not be longer than the content.

Target length: Generally one to two pages, depending on the purpose and application requirements. Prioritize specificity and meaningful evidence over length.

Step 4: Review, Format, and Submit

Proofread carefully. Place on official letterhead. Submit by the deadline and promptly notify the resident when the letter has been submitted — they are waiting and trying not to ask.

Equity Lens: Letters of Recommendation

Research has consistently identified systematic differences in letters written for women and individuals from groups underrepresented in medicine. These differences may appear even when writers intend to be supportive. Letters may differ in length, use of standout of ability-focused language, emphasis on personal attributes versus professional competencies, and use of tentative or doubt-raising language.

Before submitting a letter, review it specifically for potential bias:

- Is the letter as detailed and enthusiastic as letters you write for similarly qualified applicants?
  - Does it emphasize competence, accomplishments, leadership, expertise, and potential—not primarily personality or likability?
  - Have you supported positive descriptors with specific evidence?
  - Are you using equally strong recommendation and comparative language across applicants?
  - Does the letter contain unnecessary references to personal characteristics, family roles, appearance, or other information unrelated to professional performance?
  - Would you use the same adjectives to describe a male or majority-group trainee?

Be particularly attentive to communal or gender-coded descriptors such as "lovely", "sweet", "caring", "kind", "pleasant", "warm", or "helpful." These qualities are not inherently negative, and some may be relevant to clinical practice. However, when they replace or overshadow descriptions of competence, expertise, leadership, autonomy, clinical judgement, scholarship, or achievement, they can inadvertently diminish the strength of a recommendation—particularly for women and trainees from groups historically underrepresented in medicine.

Consider using a tool such as the Gender Bias Calculator (free, web-based) to check for gendered language in your drafts.

2.9 Program Administration and Regulatory Compliance

The preceding subsections concern the resident relationship. This one concerns the machinery that makes the program legitimate. It is the least discussed part of the APD role and more likely to be related to a citation when a programmatic component is missing or incorrect.

Accreditation and Reporting

APDs commonly assist with, and sometimes own, the program's obligations to accrediting and institutional bodies:

- Preparing and submitting accurate, timely information to the ACGME, the sponsoring institution, and the GMEC — including program information forms and annual updates to ADS.
- Obtaining GMEC or DIO approval before submitting information to the ACGME.
- Assisting with Milestone and EPA reporting.
- Preparing for and participating in internal and external program reviews, and responding to identified concerns.
- Attending GMEC meetings when the PD cannot, and local GME meetings generally.
- Maintaining familiarity with ACGME and Review Committee policies as outlined in the Manual of Policies and Procedures.

Records and Verification

Programs must maintain records verifying the education of every resident — including those who leave before completing the program — and provide verification of residency education on request. Someone must also ensure procedure and case logs are complete and meet the requirements for program completion and board eligibility. Confirm explicitly who is responsible for this verification; it is a common gap and an unwelcome discovery at the point when a former resident needs verification.

Supervision, Duty Hours, and the Learning Environment

Monitoring resident supervision and duty hour compliance is a shared program responsibility that often lands with APDs in practice. Ensure policies exist and are current, including moonlighting, and that residents log their hours accurately, as well as identified violations are addressed and resolved rather than noted. Residents must also be informed of and perform in accordance with institutional policies, including medical staff bylaws and timely completion of medical records.

⚠ Common Pitfall: Compliance as an Afterthought

These responsibilities are invisible when done well and conspicuous when missed, which makes them easy to defer during recruitment season or a clinical stretch. Two habits help: put every recurring deadline on the program calendar at the start of the academic year, and name explicitly who owns each item — you or another APD, the PD, or the coordinator. Most compliance failures are not the result of someone doing the work badly; they result from everyone assuming someone else owned it.

Program Evaluation and Faculty

APDs contribute to evaluating the educational program as a whole and by postgraduate level at least annually — assessing strengths, weaknesses, and adherence to educational objectives — and to evaluating specific rotations against the same standard. This work belongs to the PEC and feeds the Annual Program Evaluation.

On the faculty side, APDs help evaluate program faculty and support decisions about continued participation, address resident concerns about faculty performance in a timely and confidential manner, and collaborate with department and other medical education leaders to offer faculty development and coaching or mentoring opportunities.

A final note: ongoing scholarly activity and participation in academic societies are explicit expectations of the role in most job descriptions, not optional extras. Section 3 covers your own development in depth.

SECTION 3

Your Own Development

3.1 Wellness and Sustainability in the APD Role

The APD role is demanding in ways that are easy to underestimate. You are simultaneously a clinician, an educator, an administrator, and — for many residents — a primary source of support. Without deliberate attention to your own wellbeing and sustainability, the role can erode the very enthusiasm that made you effective in it. This section is about the structural and personal practices that allow you to do this work well over years, not just months.

The Specific Risks of the APD Role

APDs face a distinctive set of sustainability challenges and considerations:

- **Role ambiguity and scope creep:** Without a clear job description, the role expands to fill whatever available time exists.
- **Boundary challenges:** Residents come to you with serious distress, sometimes at moments when you have limited bandwidth. The line between mentoring and being over-responsible for a trainee's wellbeing is real and important to acknowledge.
- **Invisible labor:** Much of what APDs do — such as mentoring conversations, difficult emails, CCC preparation — is not easily captured in productivity metrics and may not be recognized in annual review.
- **Emotional labor:** Holding space for struggling residents, navigating difficult faculty conversations, and managing conflict within program leadership can be emotionally taxing
- **January–March burnout:** This period concentrates heightened resident stress with your own post-recruitment fatigue. Plan for it.

Practical Strategies for Sustainability

- **Protect academic time explicitly:** Block time in your calendar that is not available for clinical add-ons or last-minute meetings. Treat it with the same rigidity you would a clinical or procedural commitment.
- **Define the edges of your role:** Know what is yours to carry and what belongs to your PD, other APDs, coordiantors, the GME office, or resident wellness resources. Refer rather than absorb.
- **Build a peer network:** Connect with APDs at other institutions. These relationships — fostered through APPD meetings, Learning Communities and peer mentorship — offer perspective and support that your own program cannot provide.
- **Identify your own mentor:** It is valuable for APDs to have someone more senior whom they can consult about their own development. This person may be your PD, a vice chair for education or faculty development, or an APPD colleague.
- **Use your own reflection practices:** Whether through journaling, a regular check-in with a trusted colleague, or formal supervision, make space to process the emotional content of the role.
- **Name burnout when you see it in yourself:** The same signs you watch for in residents — withdrawal, cynicism, declining performance — can appear in you. Take them seriously.

Setting Boundaries with Residents

Residents will sometimes turn to you as a primary support person for issues that go beyond your role or your capacity to address. This is a sign of trust — and a situation that requires thoughtful navigation. Some principles:

1. **Be honest about the limits of what you can offer:** "I'm glad you came to me. This is beyond what I can support alone — let's connect you with [resource]. I'll stay in the loop and support you."
2. **Distinguish between being present and being responsible:** You can accompany a resident through a crisis without owning its resolution.
3. **Refer to the right resources explicitly and follow up to ensure the connection happened.**
4. **After a heavy interaction, attend to yourself:** these conversations carry weight.

Pro Tip: Annual Self-Assessment

At the start of each academic year, ask yourself:

- What am I most proud of from the past year in this role?
- What drained me most — and what can I change about that?
- What do I want to learn or develop this year?
- Am I getting the recognition and support I need from my PD and department?
- Do I need to renegotiate my job description?
- Taking 30 minutes to answer these questions in writing — and sharing your answers with your own mentor — is one of the highest-yield investments you can make in your sustainability.

Vignette: When the Role Expands Without Permission

By the end of her second year as APD, Dr. Torres had been added to four standing committees, was fielding an average of three resident wellness calls per week, and was running the program's didactic curriculum single-handedly while her PD focused on an ACGME site visit preparation. Her clinical partners had noticed she seemed exhausted. In a candid conversation with a colleague APD from another institution she met at the APPD Spring Meeting, she realized she had never said no to anything the role had asked of her. She scheduled a meeting with her PD, presented a written list of her current responsibilities, identified three she was going to step down from, and asked for formal recognition of the two she was keeping as part of her annual review. Her PD — who had not realized the scope had expanded so significantly — agreed to all of it.

3.2 Curriculum Vitae and Education Portfolio

Your CV and Education Portfolio are living documents that capture the work you do as an educator and administrator. Keeping them current — and intentionally constructed — pays dividends at promotion, in grant applications, and in your own clarity about your professional identity.

Curriculum Vitae

Your institution may have specific CV format requirements — check with your department administrator. General best practices:

- Update your CV in real time or on a quarterly schedule, not just before it is needed. Set aside time in your calendar to do so.
- Maintain a folder or running list of activities throughout the year to prevent items from being lost.
- Use headings clearly and consistently. Standard categories include Education and Training, Academic Appointments, Certification and Licensure, Honors and Awards, Professional Memberships, Leadership, Service, Educational Activities, and Research/Scholarship.

- List content consistently (chronological or reverse chronological — pick one and apply it everywhere).
- Include educational activities explicitly and prominently — workshops, curriculum development, mentoring, GME leadership roles. These are often undersold by APDs who think of them as "not real" scholarship. Also consider highlighting when you were invited to lead/facilitate activities such as workshops and lectures.

Educator Portfolio (EP)

An Educator Portfolio is the single most important document you can develop to document and advance your work as an educator. Unlike a CV, which lists activities, the EP articulates your educational philosophy, captures the impact of your work, situates your practice within the broader field of medical education, as well as provides an opportunity for reflection in your own educational journey. For APDs seeking promotion in academic medical centers, the EP is often the primary vehicle for demonstrating educational scholarship and productivity.

The Academic Pediatric Association Educational Scholars Program template (available through MedEdPORTAL, free) is an excellent starting framework. Key components include:

- Statement of Educational Philosophy
- Personal Goals as an Educator (short and intermediate/long term goals)
- Teaching
  - Description of Teaching Activities
  - Teaching Evaluations
  - Teaching Awards
- Assessment of Learners
  - Description of Learner Assessment Activities
  - Learner Assessment Tools
- Curriculum Development
  - Description of Curriculum Development Activities
  - Analysis of Curriculum Quality
- Mentoring and Advising
  - Mentoring and Advising Activities
- Educational Leadership and Administration
  - Program Leadership Description
  - Course Leadership Description
  - Educational Committee Participation
  - Reviewer/Moderator of Educational Activities (regional and national)
  - Professional Development in Education
- Products of Educational Scholarship
  - Publications Related to Education
  - Workshops and Peer-Reviewed/Invited Presentations on Educational Topics
  - Other Educational Products
  - Funded Educational Activities

Begin your EP early — ideally in your first year as APD — and add to it regularly. Even brief reflections on significant teaching interactions are valuable raw material. Similarly to updating your CV, set aside dedicated time throughout the year to update your EP.

3.3 Platforms for Disseminating Scholarship

Educational scholarship is a core responsibility of the academic APD — and APPD membership gives you access to a rich ecosystem of venues for sharing your work. The table below highlights key journals and conferences.

Key Journals for Scholarship Dissemination

Journal	Relevant Submission Types
Academic Pediatrics	Research; Brief Reports; Articles on Articles on Educational Research; View from the APPD (innovations); Nuts and Bolts: Faculty Development of the Busy Clinical Educator; Systematic Reviews; Scoping Reviews; Narrative Reviews; Ideas and Innovations; Scholarly Innovations; In the Moment – Personal Narratives; Healthcare Innovations
Academic Medicine	Research; Scholarly Perspective; Innovation Report; Review; Commentary; AM Last Page; Medicine and the Arts; Teaching and Learning Moments
BMC Medical Education*	Research
Advances in Health Sciences Education*	Research; Systematic Reviews
The Clinical Teacher	Research; Review Article; Conference Perspective; Innovation, Implementation, Improvement; The Clinical Teacher's Toolbox; How To...; Viewpoint
Journal of Graduate Medical Education (JGME)	Research; Educational Innovation; Brief Report; Reviews; Perspectives; On Teaching; New Ideas
Medical Education	Research; Medical Education in Review; Cross-Cutting Edge; Focus on Research Methods; Medical Education Mythology; Really Good Stuff; When I Say…
Medical Teacher	Research; Innovations; AMEE Guides
Perspectives on Medical Education*	Research; Review Article; Show and Tell; Eye Opener; Replication Studies; Health Care and the Arts; A Qualitative Space; Perspectives on Theory and Methods
Teaching & Learning in Medicine	Creative Non-Fiction; Critical Perspective; Data Note; Educational Case Reports; Groundwork; Investigation; Learners' Scholarly Insights; Method; Observations; Philosophy in Medical Education; State of the Art; Traveling Concept; Validation
MedEdPORTAL	Peer-reviewed teaching and assessment resources; free to publish and access
APPD LESSON	Virtual repository for pediatric educational materials; tech-enhanced, outcomes-based content

*Denotes journal that requires an article processing charge (APC)

Key Conferences for Scholarship Dissemination

Conference	Focus	Timing
APPD Fall & Spring Meetings	Pediatric GME; APD-specific programming	Sept/Oct and March/April
ACGME Annual Conference	Broad GME; accreditation and innovation	February/March
PAS (Pediatric Academic Societies)	Largest pediatric scientific meeting	May
COMSEP	Medical student education in pediatrics	April
AAMC (Learn Serve Lead)	Academic medicine; medical schools and teaching hospitals	November
AAP NCE Annual Meeting	Clinical and research content; regional meetings also available	September–November

3.4 Professional Development Opportunities

A career in medical education is developed over time with consideration of overall career goals that align with your mission, vision, and values. The programs below represent meaningful investments in your growth as an educator and leader. Through reflection, define your own learning goals and explore experiences that target the gaps identified.

Questions to Guide Your Development Planning

- What are my current skills as an educator and leader? What are areas for improvement or continued development? Are there any knowledge, skills, or attitudes that can be further advanced to support my ability in the APD role? — and which of those gaps are most limiting my effectiveness in this role?
- Do I aspire to a Program Director role? Fellowship leadership? Am I interested in roles in the undergraduate medical education realm? Focus on building scholarly activity presence within academic medicine? What does my current FTE allow? Some programs below require significant time commitment — consider the organizational investment alongside your own.

APPD-Sponsored Programs

- **APPD LEAD** (Leadership in Educational Academic Development): Provides a unique opportunity for pediatric leaders in medical education to engage and learn from seasoned program directors, pediatric educators, and other pediatric national leaders. The curriculum focuses on organizational leadership, competency-based curriculum, faculty development, residency and fellowship program administration, scholarship, and career development. The curriculum is paced over three educational conferences, with additional group activities, readings, and project work expected between conferences. Highly recommended for APDs aiming for program director roles or education leadership.

  Learn more here: APPD LEAD

- **APPD FUEL** (Fostering UIM Education Leadership): The FUEL Program aims to increase diversity in pediatric medical education leadership through professional development and mentorship of underrepresented in medicine early-career faculty. Participants will be exposed to the many careers in

pediatric medical education, as well as professional development opportunities and educational leaders within the APPD community. The program is based on mentorship, sponsorship, and representation with a focus on experiential learning.

Learn more here: APPD FUEL

Other Highly Regarded Programs

- Programs within Academic Pediatric Association (APA) - applicants must be a member of the APA.
  - **APA Educational Scholars Program** (3-year program): Targets faculty who seek building skills in educational scholarship. Requirements include: Support from the department as scholars are expected to commit 10% FTE, annual PAS attendance over three years for instructional sessions and graduation the following year, formal review of PAS presentations or an equivalent professional meeting, developing an Educators Portfolio, conducting a mentored educational project with dissemination, and identifying mentor(s) for the project. Excellent for APDs pursuing educational research and interest in networking.
  - **APA Quality and Safety Improvement Scholars Program**: Targets faculty who seek building skills in quality and safety improvement science. Requirements include: Support from the department as scholars are expected to commit 10% FTE, yearly participation in the Quality Improvement Science Conference, additionally scheduled sessions at PAS and intersession activities, and completion of a mentored improvement project. APA Research Scholars Program
  - **APA Health Policy Scholars Program**: Targets faculty who seek development of a systematic and scholarly approach to health policy and advocacy. Requirements include: Support from the department as scholars are expected to commit 10% FTE, attend PAS sessions over 3 years and intersession webinars, develop an advocacy portfolio, and disseminate completed work.
  - **Transforming Horizons through Reflection, Inspiration, Vitality, and Engagement (THRIVE):** Developed by the National Academy of Distinguished Educators in Pediatrics (NADEP), THRIVE is a 1-year program designed to foster career vitality, engagement, and joy among academic pediatricians through an interactive hybrid curriculum with in-person sessions at PAS and virtual intersessions, peer group mentorship and networking.
  - **Advancing Pediatric Educator eXcellence (APEX):** Longitudinal program offering opportunities to expand teaching skills and competence in evidence-based educational strategies through interactive sessions. Participants will apply learned theory and skills at their own institution with direct observation by a local mentor and will develop educational workshops for submission for national presentation.
  - **Advancing Pediatric Leaders (APL):** Two-year program to advance leadership competencies of mid-career academic pediatric health professionals (at least 5 years at rank of assistant professor or associate professor and who have a leadership opportunity or position). Program includes one-on-one and peer group coaching and interactive hybrid curriculum and networking.
- **Harvard Macy Faculty and Fellow Courses**: Intensive programs including Program for Educators in Health Professions, Assessment and Evaluation: Systems Thinking in Health Professions Education, Leading Innovation in Health Care and Education, technology and AI: Transorming Health Professions Education, and others. These courses are nationally recognized and are highly competitive.
- **Master of Medical Education Programs**: Available from a number of universities, both in-person and online. Consider if you are building toward a career primarily in medical education scholarship or administration.

3.5 Leadership Resources

The APD role is inherently a leadership role — not in the hierarchical sense, but in the sense that you are consistently working to influence culture, support growth, navigate conflict, and advance shared goals. Investing in your leadership development should be part of your role .

Common APD Leadership Challenges

The challenges below come up repeatedly in the APD experience. Thinking about them before you encounter them is useful preparation.

- Managing up: Learning to influence your PD, department leadership, and GME office effectively — including how to disagree, how to advocate, and how to know when to defer.
- Navigating faculty conflict: APDs may frequently find themselves in the middle of disagreements between faculty and residents, or between faculty members about how to approach a trainee in difficulty. Understanding your conflict style — and when to use it — matters.
- Working across a divided leadership team: Programs where PDs, APDs, and chief residents are not aligned create real difficulties. Proactively investing in team communication structures pays off.
- Being the "safe" person: Residents often bring concerns to APDs that they would not bring to the PD — both because of the APD's role and because of personal relationships through mentoring, sponsorship, coaching, or interactions in different settings. This is valuable but requires clarity about your obligations and limits.

Know Your Conflict Management Style

The Thomas-Kilmann Conflict Mode Instrument identifies five conflict styles: Avoidant, Accommodating, Compromising, Competing, and Collaborative. Effective leaders are fluent in all five and select deliberately based on context — rather than defaulting to one regardless of the situation.

Personality and Strengths Tools

Understanding your own strengths and tendencies is foundational to effective leadership. Commonly used tools include DISC, Myers-Briggs, and True Colors for personality; VIA Institute on Character and StrengthsFinder 2.0 for strengths. These are most useful when used in conversation with a mentor or coach, not just in isolation.

Recommended Reading

- Discover Your True North — Bill George
- Start with Why — Simon Sinek
- Leaders Eat Last — Simon Sinek
- Switch: How to Change Things When Change Is Hard — Dan and Chip Heath
- Getting to Yes — William Ury and Roger Fisher
- The 5 Dysfunctions of a Team — Patrick Lencioni

SECTION 4

Resources & Reference

4.1 Online Resources

The following organizations and resources are useful reference points for APDs. Note that URLs and specific program details are subject to change — verify current information on each organization's website. This list is updated with each handbook revision.

Acronym	Organization	Website
AAMC	Association of American Medical Colleges	aamc.org
AAP	American Academy of Pediatrics	aap.org
ABMS	American Board of Medical Specialties	abms.org
ABP	American Board of Pediatrics	abp.org
ACGME	Accreditation Council for Graduate Medical Education	acgme.org
APA	Academic Pediatric Association	academicpeds.org
APPD	Association of Pediatric Program Directors	appd.org
COMSEP	Council on Medical Student Education in Pediatrics	comsep.org
CoPS	Council of Pediatric Subspecialties	pedsubs.org
ECFMG	Educational Commission for Foreign Medical Graduates	ecfmg.org
ERAS	Electronic Residency Application Service	aamc.org/services/eras
FREIDA	Fellowship and Residency Electronic Interactive Database	freida.ama-assn.org
MedEdPORTAL	AAMC Peer-Reviewed Health Education Resources	mededportal.org
MPPDA	Medicine-Pediatrics Program Directors Association	mppda.org
NRMP	National Resident Matching Program	nrmp.org
PAS	Pediatric Academic Societies	academicpeds.org/meetings
SHM	Society of Hospital Medicine	hospitalmedicine.org

4.2 Quick Reference: APD Annual Calendar

Season	Key Priorities
June–Aug	Goal-setting with PD; intern & senior orientation; PEC meeting; program calendar; ITE administration; chief resident support
Sept–Dec	Recruitment (applications, interview day, faculty prep); PEC/CCC; semi-annual evaluations; APPD Fall Meeting; ELS proposals
Jan–Mar	Rank list finalization; ACGME milestone submission; NRMP deadlines; resident/faculty surveys; Match Week; spring PEC
Apr–Jun	Schedule finalization; APPD Spring Meeting; end-of-year CCC & PEC; Annual Program Evaluation; graduation; orientation planning

4.3 Ongoing Development of APD Handbook

We hope this APD Handbook has provided valuable information to you in your APD role. This Handbook is a living document. The following areas have been identified as priorities for future editions:

- Expanded guidance on CCC structure, milestone interpretation, and narrative summaries, especially given the current evolving landscape of Competency-Based Medical Education
- Detailed frameworks for difficult resident conversations — including professionalism issues, non-promotion and termination
- Guidance on program climate assessment and culture change
- APD experiences in Med-Peds and combined program settings
- Updated recruitment guidance as national norms continue to evolve

We welcome contributions from APDs across the country. If you have developed a resource, vignette, or framework that belongs in a future edition, please share it with the APD Executive Committee through APPD Connect.

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