



AMERICAN OSTEOPATHIC ASSOCIATION

**Basic Standards for
Residency Training in
Emergency Medicine**

**American Osteopathic Association
and
American College of Osteopathic Emergency Physicians**

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SECTION ONE INTRODUCTION

These are the Basic Standards for Residency Training in Emergency Medicine as established by the American College of Osteopathic Emergency Physicians (ACOEP) and approved by the American Osteopathic Association (AOA). These standards are designed to provide the osteopathic resident with advanced and concentrated training in emergency medicine and to prepare the resident for examination for certification in Emergency Medicine by the American Osteopathic Board of Emergency Medicine (AOBEM).

SECTION TWO MISSION

The mission of the osteopathic emergency medicine training program is to provide residents with comprehensive structured cognitive and clinical education that will enable them to become competent, proficient and professional osteopathic emergency medicine physicians.

SECTION THREE EDUCATIONAL PROGRAM GOALS AND OBJECTIVES

The goals and objectives of the osteopathic emergency medicine program are to train residents to become proficient in the core competencies.

A. Osteopathic Philosophy & Manipulative Medicine

Osteopathic philosophy and osteopathic manipulative medicine: integration and application of Osteopathic Principles into the diagnosis and management of patient clinical presentations.

- 3.1 Training in osteopathic principles and practice must be provided in both structured educational activities and clinical formats.
- 3.2 Programs must provide the opportunity to develop Osteopathic Manipulative Medicine (OMM) skills and apply them to emergency medicine as illustrated by didactic sessions and documented procedures.
- 3.3 Programs must integrate OMM and its applications in the practice of emergency medicine.

B. Medical Knowledge

Medical knowledge: a thorough knowledge of the complex differential diagnoses and treatment options in emergency medicine and the ability to integrate the applicable sciences with clinical experiences.

- 3.1 The training program shall provide the opportunity to develop the teaching skills of residents in emergency medicine.
- 3.2 The program shall provide the opportunity to develop interest in and understanding of research in emergency medicine.
- 3.3 The program shall prepare residents to use critical thinking in making decisions for patient management.
- 3.4 The program shall prepare the resident to demonstrate proficiency in the psychomotor skills required of a competent emergency physician.
- 3.5 The program shall train the resident to read, interpret, and participate in clinical research.

C. Patient Care

Patient care: the ability to rapidly evaluate, initiate and provide treatment for patients with acute and chronic conditions in the emergency setting as well as promote health maintenance and disease prevention.

- 3.1 The program shall provide the emergency medicine resident with progressive patient care responsibilities, commencing with general medical skills and progressing to complete care of patients in need of emergency care.
- 3.2 The program shall provide training that shall enable the emergency medicine resident to rapidly evaluate, initiate treatment, and provide therapy, and disposition of the emergency patient.

D. Interpersonal and Communication Skills

Interpersonal and communication skills: use of clear, sensitive and respectful communication with patients, patients' families and members of the health care team.

- 3.1 The program shall provide residents with the opportunity to develop teaching skills in emergency medicine.
- 3.2 The program shall train residents on the methods in which to educate patients and their families concerning health care needs.
- 3.3 The program shall educate residents to become culturally sensitive to the patient populations served and implications of providing healthcare to them.

E. Professionalism

Professionalism: adherence to principles of ethical conduct and integrity in dealing with patients, patients' families and members of the health care team.

- 3.1 Programs shall provide the opportunity to learn and practice professionalism as manifested through carrying out professional responsibilities, adherence to ethical principles and sensitivity to diverse populations.
- 3.2 Programs shall provide a learning environment that encourages cultural sensitivity and patient safety.
- 3.3 Programs shall educate the residents so that they make sound judgments as to the expected risks arising from therapy as well as the condition being treated with an understanding of associated ethical and legal principles.
- 3.4 Residents shall be encouraged to participate in community and professional organizations.
- 3.5 Programs shall provide education as well as the opportunity to participate in continuing education to promote personal and professional growth for both the resident and teaching staff.

F. Practice-Based Learning and Improvement

Practice-based learning and improvement: commitment to lifelong learning and scholarly pursuit in emergency medicine for the betterment of patient care.

- 3.1 The program shall promote lifelong learning in medical education.

- 3.2 The program shall prepare the resident to meet board eligibility requirements of the AOA through the American Osteopathic Board of Emergency Medicine.
- 3.3 The program shall train the resident to manage clinical problems in an emergency department setting, employing basic scientific principles and evidenced-based medicine.
- 3.4 The program shall develop measurable objectives to assess the progression of the resident in the four-year training program.
- 3.5 The program shall teach basic skills and clinical practices needed in the emergency department to medical students, interns, and other residents within the context of the residency program.

G. Systems-Based Practice

Systems-based practice: skills to lead healthcare teams in the delivery of quality patient care using all available resources.

- 3.1 The program shall provide learning experiences that promote a broad understanding of the role of emergency medicine as it relates to other medical disciplines.
- 3.2 The program shall provide the opportunity to develop professional leadership and management skills.
- 3.3 The program shall train the resident to provide cost-effective care to emergency medicine patients.
- 3.4 The program shall train the resident to collaborate and share knowledge with colleagues and allied health professionals.
- 3.5 The program shall train the residents to perform the basic skills needed for mass casualty management and coordination for the hospital and community.

**SECTION FOUR
INSTITUTIONAL REQUIREMENTS**

A. Department of Emergency Medicine

The Department of Emergency Medicine at the base institution shall:

- 4.1 Have a chairperson who is currently certified in emergency medicine by the AOA through the American Osteopathic Board of Emergency Medicine (AOBEM) or the American Board of Emergency Medicine (ABEM). He or she shall maintain continuous certification. Lifetime certificate holders are not exempt from this recertification requirement.
 - 4.1.1 The Chair of the department may not be the program director
- 4.2 Have a program director that fulfils the requirements for core faculty. The program director’s responsibilities are outlined in Section Six.
 - 4.2.1 The institution must compensate the program director for at least 12 hours non-clinical time per week. However, this shall be adjusted to compensate for larger clinical or more complex programs.
- 4.3 Have an associate/assistant program director for emergency medicine programs with 32 or more residents.
 - 4.3.1 The institution must compensate the associate/assistant program director for at least 8 hours of non-clinical time per week.

- 4.4 Emergency departments must have an attending physician on duty at all times who is certified by the AOA/AOBEM or ABEM or in the process of being certified.
- 4.5 Have faculty and core faculty to teach and supervise residents.
 - 4.5.1 The role and duties of the core faculty shall be clearly defined. This requires at least four (4) hours of compensated, non-clinical time per week.
- 4.6 Ensure that all physicians that are clinically supervising emergency medicine residents are certified in emergency medicine by the AOA/AOBEM or ABEM or in the process of being certified.
 - 4.6.1 Direct resident supervision by faculty members shall be provided 24 hours a day.
 - 4.6.2 Emergency Departments must have an attending physician on duty at all times who fulfills the faculty requirements.
- 4.7 Have a minimum of one (1) core faculty member for every four (4) residents; however there shall be a minimum of four (4) core faculty members regardless of program size. Combined programs in Emergency Medicine/Internal Medicine or Emergency Medicine/Family Practice shall have one (1) additional core faculty member for every 8 combined residents
- 4.8 Have the scope, volume, and variety to support a residency program with at least four (4) approved residency positions per year. A minimum volume of 30,000 Emergency Department visits annually at the base institution or previously COPT- approved consortia is required.
- 4.9 Provide experience and training in the management of emergency department patients. This training shall take place at the base hospital and its affiliated sites; however, at least 50% of the training shall take place at the base institution.
- 4.10 Adopt formal program policies that are shared with the resident upon commencement of training and develop a resident manual that includes the complete emergency medicine curriculum.
- 4.11 Adopt formal departmental policies that are shared with the resident upon commencement of training.

B. Additional Emergency Department Sites

Institutions must provide training in at least one secondary emergency department.

- 4.1. Additional emergency medicine sites shall each have a minimum volume of 15,000 Emergency Department visits annually, and have patient acuity that shall supplement the educational program to offer residents a complete educational experience.
- 4.2 Emergency departments must have an attending physician on duty at all times who is board certified by the AOA/AOBEM or ABEM or in the process of being certified.
- 4.3 Ensure that all physicians that are clinically supervising emergency medicine residents are certified in emergency medicine by the AOA/AOBEM or ABEM or in the process of being certified.
- 4.4 Direct resident supervision by faculty members shall be provided 24 hours a day.

SECTION FIVE PROGRAM REQUIREMENTS AND CONTENT

A. Program Environment

The educational program for emergency medicine shall be based on a learning environment that is based on education not service. It shall contain professional teaching and experiences that provide measurable means to assess the resident's progression through the curriculum outlined below.

B. Curriculum

The emergency medicine program shall create and adhere to a four-year curriculum (OGME-1 to OGME-4) that meets or exceeds the requirements listed within this document.

- 5.1 Each program shall have a written, curriculum on file at its institution that is updated and distributed annually to all residents.
- 5.2 Residency programs shall have written goals and objectives.
- 5.3 Progression through the residency program shall be based upon the following:
 - 5.3.1 Meeting stated goals and objectives of the program;
 - 5.3.2 Demonstrating increasing competence in emergency medicine skills and techniques.
 - 5.3.3 Proficiency in the use of diagnostic and therapeutic modalities.
 - 5.3.4 Ongoing demonstration of professional behaviors.
- 5.4 The curriculum shall be evaluated and updated annually by faculty and residents.

C. Rotation Structure

- 5.1 Each resident shall complete the following 48 month program. The following may be scheduled as one-month blocks or four-week rotations or any combination thereof.
 - 5.1.1 Emergency medicine for a minimum of 24 months with a minimum of four (4) rotations training per year.
 - 5.1.2 Critical care for a minimum of two (2) months.
 - 5.1.3 General medicine that may include training in general internal medicine, medical subspecialties, or hospital based family practice in any combination for two (2) months.
 - 5.1.4 Surgery, e.g., general surgery or subspecialty surgeries, including but not limited to: anesthesiology, ophthalmology, ENT, hand or plastic surgery for a minimum of two (2) months.
 - 5.1.5 Orthopedics for a minimum of one (1) month.
 - 5.1.6 Pediatrics for a minimum of two (2) months. Strong consideration shall be given to a pediatric emergency medicine or pediatric intensive care unit rotation.
 - 5.1.7 Trauma for a minimum of one (1) rotations month.
 - 5.1.8 Emergency medical services for a minimum of one (1) month.
 - 5.1.9 Administration/related activities, e.g., research, medical legal, quality assurance, etc., for a minimum of one (1) month.
 - 5.1.10 Female reproductive medicine for a minimum of one (1) month; a minimum of 50% of this time spent in obstetrics.
 - 5.1.11 Selective rotations for a minimum of six (6) months, selected by and at the discretion of the program director. These rotations shall be used to strengthen academic competence.

- 5.1.12 Elective rotations for a minimum of two (2) months at the discretion of the program director.
- 5.1.13 Remaining rotations, vacation, and selective time shall be scheduled at the discretion of the program director.

D. Procedures

- 5.1. The emergency medicine resident must have accomplished the following minimum number of procedures prior to the completion of the emergency medicine residency. Although this list represents a minimum number, it is expected that all procedures performed shall be logged. It is understood that numerous critical procedures in emergency medicine are infrequent/rare. In consideration of this some procedures may be completed after demonstrating proficiency in an animal lab setting, or simulation lab. Such procedure requirements shall be allowed with the approval and at the discretion of the program director.
 - 5.1.1 Cardioversion / Defibrillation – 10 procedures
 - 5.1.2 Central Venous Access – 20 procedures
 - 5.1.3 Chest Tube Insertion – 10 procedures
 - 5.1.4 Closed Fraction Reduction – 20 procedures
 - 5.1.5 Dislocation Reduction – 10 procedures
 - 5.1.6 Splinting – 20 procedures
 - 5.1.7 Procedural Sedation – 15 procedures
 - 5.1.8 Cricothyroidotomy – 3 procedures
 - 5.1.9 Intraosseous Line – 3 procedures
 - 5.1.10 Intubation – 35 procedures
 - 5.1.11 Laceration Repair – 50 procedures
 - 5.1.12 Lumbar Puncture – 15 procedures
 - 5.1.13 Osteopathic Manipulative Therapy – 30 procedures
 - 5.1.14 Pediatric Medical Stabilization – 15 procedures
 - 5.1.15 Pediatric Trauma Stabilization – 10 procedures
 - 5.1.16 Thoracotomy – 1 procedure
 - 5.1.17 Transvenous Cardiac Pacing - 2 procedures
 - 5.1.18 Pericardiocentesis – 3 procedures
 - 5.1.19 Ultrasound, Bedside – 40 procedures
 - 5.1.20 Vaginal Deliveries – 10 procedures

E. Didactic Educational Activities

- 5.1. The program shall provide an average of four (4) hours of didactic educational activity per week.
 - 5.1.1 Core faculty shall be involved in both the planning as well as the administration of the educational activities.
 - 5.1.2 These activities shall be based upon the four-year core curriculum.
 - 5.1.3 The content shall be covered in its entirety at least once during the residency training program.

- 5.1.4 Greater than fifty percent of these activities shall be planned and presented by non-resident educators.
- 5.1.5 The core faculty and residents shall participate in required OPTI educational programs.
- 5.1.6 Residents shall be excused from all in-house clinical duties to attend these activities.
- 5.1.7 Residents shall be required to attend the didactic activities unless excused by the program director.

F. Professional Development

Programs shall require residents to:

- 5.1 Participate in available seminars, workshops and conferences provided through regional, state and national professional organizations.
- 5.2. Learn teaching skills by actively participating in the process of instructing medical students, other residents and allied health professionals.

G. Transfers and Advanced Standing

Requests for transfers and/or advanced standing shall be submitted by the accepting program director on the official form available on the ACOEP's website. Approval shall be granted on a case-by-case basis.

- 5.1 The accepting program must receive written verification of previous educational experiences and a statement regarding the performance evaluation of a transferring resident prior to acceptance into the program.
- 5.2 The prior program is required to provide verification to the accepting program of resident's educational progress in their program for residents who may leave the program prior to the scheduled completion date of their training.
- 5.3 Potential advanced standing for non-AOA approved emergency medicine training or for non-emergency medicine training must be approved by the ACOEP's committee on graduate medical education.

SECTION SIX PROGRAM DIRECTOR AND FACULTY

- 6.1 Any proposed changes in program director or core faculty staffing shall be submitted in writing and approved by the ACOEP Committee on Graduate Medical Education prior to appointment.

B. Program Director

- 6.1 The program director may not serve as or act in the capacity of the chair of the department of emergency medicine, or as program director of more than one residency program. He or she may be the director of medical education if the institution has three or fewer osteopathic residency programs.
- 6.2 The program director of the emergency medicine residency program shall possess the following qualifications:
 - 6.2.1 Active, full-time staff membership (a minimum of 30 hours per week which includes clinical as well as educational activities) within the department or section of emergency medicine at the base institution.

- 6.2.2 Certification by the AOA through the American Osteopathic Board of Emergency Medicine and recertified within the prescribed time frame of the AOBEM. He or she shall maintain continuous certification. Lifetime certificate holders are not exempt from this recertification requirement. Program director candidates having graduated from residency training after 1991 must have completed a minimum of four years of AOA approved postdoctoral training.
 - 6.2.3 Specialty expertise and documented educational and administrative experience acceptable to the Committee on Graduate Medical Education of ACOEP.
 - 6.2.4 Three (3) years experience as full time faculty within an emergency medicine residency program, or full time practice of emergency medicine for a minimum of five (5) years.
 - 6.2.5 Fulfill and maintain the qualifications as a core faculty member of an emergency medicine residency program, in addition to administrative and demonstrated leadership skills, and completion of the AOA's Continuing Medical Education requirements, emergency medicine training skills, and faculty development.
- 6.3 The program director shall have the following responsibilities:
- 6.3.1 Direct the emergency medicine residency program and ensure that the resident receives the training outlined in the written program description.
 - 6.3.2 Ensure the arrangements of outside rotations with formal affiliation agreements as needed to meet the program's educational objectives.
 - 6.3.3 Evaluate the residents, faculty, and the emergency medicine residency program.
 - 6.3.4 Submit reports to the ACOEP as required.
 - 6.3.5 Verify the completion of didactic and clinical schedules.
 - 6.3.6 Actively participate in postdoctoral education and training at the base institution.
 - 6.3.7 Notify the ACOEP of all residents in training on an annual basis.
 - 6.3.8 Verify residents participating in the annual resident in-service examination.
 - 6.3.9 Advise the ACOEP's Committee on Graduate Medical Education, in writing, of the Resident's inability to participate in the examination within ten (10) days of the examination and request a substitute examination.
 - 6.3.10 Participate in the annual ACOEP Program Directors' Faculty Development workshop. Attendance at this annual conference is mandatory for the program director or his/her designee. The program director shall attend a minimum of once every two years.
 - 6.3.11 Ensure that the program complies with the standards, policies, and procedures of the AOA.
 - 6.3.12 Prepare for and participate in the AOA inspection of the program in cooperation with the Division of Postdoctoral Education and the designated evaluator.
 - 6.3.13 Inform the AOA, OPTI, and ACOEP's Committee on Graduate Medical Education of major changes in the program, including but not limited to, changes in institutional ownership, affiliation, department chair, or other major administrative changes within thirty (30) days of their occurrence.
 - 6.3.14 Develop written goals and objectives for each rotation and maintain these through periodic updating.
 - 6.3.15 Maintain the appropriate ratio of qualified core faculty for the program.

C. Associate or Assistant Program Director

- 6.1 The associate or assistant program director may not serve as or act in the capacity of the Chair of the Department of Emergency Medicine, or as program director of more than one residency program. He or she may be the director of medical education if the institution has three or fewer osteopathic residency programs.
- 6.2 The associate or assistant program director of the emergency medicine residency program shall possess the following qualifications:
 - 6.2.1 Active, full-time staff membership (a minimum of 30 hours per week which includes clinical as well as educational activities) within the department or section of emergency medicine at the base institution.
 - 6.2.2 Certification by the AOA through the American Osteopathic Board of Emergency Medicine or the American Board of Emergency Medicine and recertified within the prescribed timeframe. He or she shall maintain continuous certification. Lifetime certificate holders are not exempt from this recertification requirement.
 - 6.2.3 Fulfill and maintain the qualifications as a core faculty member of an emergency medicine residency program, in addition to administrative and demonstrated leadership skills, and completion of continuing medical education requirements and emergency medicine training skills and faculty development as required by the certifying board.

D. Core Faculty

Core faculty is the dedicated educators who demonstrate and provide ongoing academic leadership within the residency program above and beyond the valuable role of the clinical faculty.

- 6.1 Requirements
 - 6.1.1 The program director shall designate a minimum of four (4) core faculty who shall participate in the emergency medicine residency program.
 - 6.1.2 Additionally, a minimum of one core faculty member for every four (4) residents shall be maintained.
 - 6.1.3 Combined programs in Emergency Medicine/Internal Medicine or Emergency Medicine/Family Practice shall have one (1) additional core faculty member for every 8 combined residents.
 - 6.1.4 A minimum of fifty percent (50%) of the core faculty shall be osteopathic emergency physicians who participate in the training of residents.
 - 6.1.5 The program director may be counted as a member of the core faculty.
- 6.2 Qualifications: Core faculty must meet the following qualifications prior to and throughout the duration of their appointment:
 - 6.2.1 Core faculty members are specifically designated, full-time members of the department of emergency medicine at the base institution. Full time is defined as a minimum of 30 hours per week which includes clinical as well as educational activities.
 - 6.2.2 Core faculty members shall be certified or an active candidate in the process of certification by the AOA/AOBEM or ABEM. He or she shall maintain continuous certification. Lifetime Certificate holders are not exempt from this recertification requirement.

- 6.3 Scholarly Activity: Each core faculty member shall demonstrate scholarly activity prior to and throughout the duration of their appointment. Scholarly activity is the academic pursuits that serves either the specialty or profession and/or involves creative, intellectual work that is peer-reviewed and publicly disseminated.
- 6.3.1 Scholarly activity shall occur within a four-year period. Acceptable activities may include a minimum of 2 major or 1 major and 2 minor scholarly activity within this time frame for each core faculty member. Other activities may be accepted on an individual basis at the discretion of the ACOEP Committee on Graduate Medical Education. Scholarly activities for each core faculty member shall be well documented, to include dates, locations, and details.
- 6.4. Major Scholarly Activities: Major scholarly activities shall be defined as follows:
- 6.4.1 Serving as chair or vice chair of a national, regional or state medical society committee.
- 6.4.2 Serving as an active member of a committee of a national, regional or state medical association.
- 6.4.3 Publication of original research or review article in peer-reviewed medical or scientific journal, or chapter in medical textbook.
- 6.4.4 Receipt of grant funding for medical, educational or service research.
- 6.4.5 Presentation or publication of case reports or clinical series at national, regional or state professional and scientific society meetings and conferences.
- 6.4.6 Member of an editorial review board of a national, regional or state peer-reviewed publication.
- 6.4.7 Participation in item writing or as an examiner for a national medical certification board.
- 6.4.8 Presentation at a national, regional or state CME meeting or seminar.
- 6.5 Minor Scholarly activities shall be defined as:
- 6.5.1 Research projects currently in progress. The study has been approved by IRB and data-collection actively occurring.
- 6.5.2 Preparation of grant funding request material for medical, educational or service research.
- 6.5.3 Visiting professorship (guest emergency medicine lecturer to peers or residents at an outside institution).
- 6.5.4 Item writing for the ACOEP Resident In-Service Examination.
- 6.5.5 Serve in the capacity as an active judge (or evaluator) at a national, regional or state academic meeting.
- 6.5.6 Publication of an article or chapter in a non-peer reviewed medical or scientific journal.
- 6.6 Responsibilities

- 6.6.1 Core faculty shall be involved in the preparation and presentation of didactic educational program, such as formal lectures, case conferences and journal clubs and other requirements of the core curriculum.
- 6.6.2 Core faculty shall attend a minimum 33% of the program's required didactic educational activities.
- 6.6.3 Core faculty shall encourage and support residents in scholarly activities and act as mentors for required research projects.
- 6.6.4 Core faculty shall be provided compensated non-clinical time to provide instruction, leadership and participation in scholarly activities.

SECTION SEVEN RESIDENT REQUIREMENTS

- 7.1 Each resident shall adhere to established policies and procedures for residency training, as outlined in this document, and in the resident manual.
- 7.2 The resident shall maintain formal records and logs of all activities related to the educational program. These records and logs shall be submitted monthly to the program director for review and verification. Copies of these records and logs shall be kept on permanent file by the administration at the base institution and shall be available at the time of the inspection. These records and logs shall document the fulfillment of the requirements of the program, describing the volume, variety, and scope, and progressive responsibility on the part of the resident for emergency cases and procedures performed under supervision.
- 7.3 The resident shall complete a research project during the course of the emergency medicine training program that will be sent to the ACOEP in the following manner. The resident shall submit an outline for the project by the end of the OGME-2 training year, implementation and data collection methods and provide an interim report by the end of the OGME-3 year, and a final product suitable for publication six months prior to the completion of the OGME-4 year of residency. A permanent copy shall be retained in the resident's file at the institution. All research projects shall be approved by the program director.
- 7.4 The resident shall be required to participate in professional staff activities, e.g. department meetings, hospital committees, house/staff associations, OPTI committees.
- 7.5 The resident shall annually participate in the ACOEP Resident In-Service Examination.
- 7.6 The resident shall be certified as a provider in advanced cardiac life support (ACLS), advanced trauma life support (ATLS), or its equivalent, and advanced pediatric life support (APLS) or its equivalent.
- 7.7 Emergency medicine residents may not moonlight in the Department of Emergency Medicine at the base or affiliated training sites.

SECTION EIGHT EVALUATION

- A. The program shall document a formal evaluation process related to the resident's performance within the program. These documents shall be maintained by the institution and available to evaluators or the ACOEP on request. Evaluations shall document the resident's performance as related to the core competencies.
 - 8.1. The curriculum shall be evaluated annually by faculty and residents as a method for revision and updating of the documents.
 - 8.2. The program director, with faculty input, shall complete written quarterly evaluations of resident performance. This shall include evaluations from all affiliated training sites and supplemented rotation sites.
 - 8.3. Evaluations shall be learner-centered, developmental, foster continuous improvement, and based upon educational objectives for each assignment and program activity.
 - 8.4. Completed evaluations shall be shared with the resident in consultation for improvement. They shall be signed by the program director and resident to document that evaluation and counseling have occurred quarterly as required. Copies of evaluations shall be made available to the resident.
 - 8.5. The program director shall document that residents requiring remediation, redirection, or counseling as a result of the evaluation process must be given feedback and a corrective action plan in a timely manner. There shall be documentation of follow-up evaluations of these residents. The program director shall review these with the core faculty.
 - 8.6. The resident shall anonymously evaluate faculty on an annual basis.