resident review

Spring 2010

Accreditation Council for Graduate Medical Education

ACGME

rounds

Anchors Aweigh, My Doctors, Anchors Aweigh: A Pediatric Anesthesiologist's Experience in Afghanistan

My first job out of my pediatric anesthesiology fellowship was supposed to be a mix of pediatric and adult anesthesia at an academic tertiary care medical center. Instead, the U.S. Navy, to whom I owe my medical school and residency training, called in the debt with orders to Afghanistan. I certainly had no idea what to expect – anything I knew about war I learned from TV shows and movies. A short two months later, I found myself training with the U.S. Marine Corps in Camp Pendleton, California, as my group readied themselves for a forward deployed position supporting the troops in the heart of the fighting in southern Afghanistan.

Our mission was "damage control" – everyone in the chain of command acknowledged our lack of gear, our Spartan facilities, and the incredible amount of dirt that got in to everything, including supposedly sterile fields. So the plan as we understood it was that only the worst cases, the ones that couldn't tolerate a Medevac ride to a better facility, would come to us. We would save what we could, and push them farther back to better-equipped care as fast as possible.

Back in the United States, the three branches of the military maintain a robust graduate medical education system.

Dr. Dainer (center) prepares to take a helicopter from Camp Leatherneck to Camp Dwyer, along with LT Brooke Basford (left), a recovery room nurse, and LT Tatiana Ellsworth (right), a ward nurse.

In the theater of war, however, there are no residents or fellows, and no official role for graduate medical education. Given my interest in academic medicine, my personal challenge was to find a role for education in what appeared to be an entirely practical endeavor.

When we arrived at (at that time) a small base in Helmand Province called Camp Dwyer, we were greeted with an expanse of sand and dust, punctuated by small beige tents. The soundtrack of our next seven months would be the rattling of generators and helicopters. The exhausted group we were relieving happily handed us the reins to the small

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reminders

Upcoming Meetings

American Academy of Family Physicians National Conference of Family Medicine Residents and Medical Students
Kansas City, Missouri
July 29–31, 2010

American Academy of Pediatrics National Conference and Exhibition
San Francisco, California
October 2–5, 2010

American College of Surgeons Clinical Congress
Washington, D.C.
October 3–7, 2010

American Medical Association Annual Meeting
Chicago, Illinois
June 10-12, 2010

hospital they had cobbled together from parts and pieces, and, in the blink of an eye, a few thousand Marines trusted we would save them from whatever befell them in war.

"We" were a strange group – to the Navy, we filled holes as standard pegs – surgeon, anesthesiologist, orthopedist, etc. But the reality was an incredible mix of sub-specialized individuals – a bariatric surgeon, a surgical oncologist, a spine surgeon, and a pediatric anesthesiologist, in addition to the generalists. Our support personnel, however, were not quite as experienced. Our group had corpsmen with training equivalent to a basic paramedic; ward nurses; a couple of emergency medicine, recovery room, and intensive care unit nurses; two physician assistants; and a few lab/X-ray/surgical technicians. Many of these young men and women had never been deployed, seen trauma, or assisted in an emergency room/operating room environment.

Because we were building a hospital system from the ground up, we needed every helping hand. Each of the corpsmen, nurses, and technicians were important, and training was paramount. Giving them the education they required in competencies such as patient care or medical knowledge was simple – something we all did daily back home anyway. The mission itself gave us all a sense of purpose that promoted professionalism at all times. We all practiced communication and interpersonal skills dealing with the warrior culture of the U.S. Marine Corps. The two competencies that we struggled with, however, were practice-based learning and improvement and systems-based practice.

We set to work right away – the training schedule was diverse, from things as simple as teaching the corpsmen how to spike IV bags to running through a trauma evaluation with the nurses. Humanitarian care was thrown upon us as well, even though we were woefully undersupplied, so we quickly threw together lectures and practical training on how to care for the pediatric patient, both medically and perioperatively. We all learned that military working dogs are considered active duty soldiers – so a crash course in treatment from the veterinary techs brought us up to speed on resuscitating a canine.

A rudimentary system to collect, transport, triage, treat, and evacuate patients was in place – we had to learn on the job how the system worked and how to improve it to facilitate the flow of patients. Our most senior physicians quickly took the administrative reins and started meeting the higher-ups to smooth out the multiple kinks in the process, mainly to speed the evacuation of our sickest Marines to the higher level of care where they had such niceties as a CT scanner, blood banks with platelets, and full laboratory capability.

It was painfully obvious that we would not successfully resuscitate any significant blast injury or gunshot wound without a solid blood bank, but our storage capacity for blood and fresh frozen plasma was small, and we completely lacked the ability to store platelets. No solution was forthcoming – there would be no more refrigerators or freezers given to us, and no platelets would be shipped to us. In the past, when faced with such a situation, the military has used something called the "walking blood bank" which draws from donors and immediately transfuses into the patient the fresh whole blood obtained. It is incredibly effective, but fraught with risk. The risk of transmission of blood borne disease is higher than with banked blood in the U.S., and using the fighting Marines as blood donors

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has the risk of knocking out yet another Marine from the fight – one who is now too weak from having donated. We set up an extensive pre-screening process to identify those willing and able to donate, keep a certain minimum fighting force who did not donate at all, and weed out individuals with high-risk behaviors.

The walking blood bank itself is very labor intensive – we had to condition command centers on the base to respond to a call for donors at any time of the day or night. We needed to arrange transport for these donors from their tents to the hospital and back. Then we had to process, re-test and screen, and phlebotomize donors. In addition, we had to recover the donors, just as any blood bank would. With practice, we were able to get the first unit of blood hanging in the operating room within 45 minutes after the first call for donors.

As the pieces and parts of our system fell into place and the ancillary personnel started to learn the nuts and bolts of their supporting roles, the physicians realized quickly that the scope of our practice was pretty limited to trauma. We needed to keep our skills and knowledge base sharp. Our Internet access was extremely limited and textbooks were too heavy to haul out there – all we really had was each other. We organized a weekly grand rounds, tapping into the deep subspecialty expertise embedded in our group. Each of us gave talks related to our fields, targeted to other physicians, on topics ranging from breast reconstruction after mastectomy to the perioperative management of the adult with congenital heart disease.

The last piece of the puzzle was practice-based learning and improvement. We didn't really have the resources to consistently search the literature for evidence, since our Internet access was extremely slow and often cut off. Instead, we organized weekly mortality and morbidity conferences in which we discussed every case, regardless of the outcome. We would methodically parse through the decision-making processes, the technical aspects, and the systems-based issues hoping to refine our practices. Through this, we were able to standardize our transfusion practices among ourselves and streamline our walking blood bank, as well as standardize how and when we ordered lab work (again, limited resources), and optimize our post-operative "ICU" care.

My vision of this deployment was based on television shows like *MASH* – lots of action, maybe some drama, but not a lot of teaching. The reality was a tremendous experience, filled with exciting cases, maybe a little drama, and an incredible opportunity to teach, learn, and grow. ■

Written by Lieutenant Commander Rupa J. Dainer, MD, USN, chair of the Council of Review Committee Residents and a member of the ACGME Board of Directors.

Improving Residency Training through the Program, Institution – and ACGME

For the resident who truly wants to improve the program or institution in which they work, there are many avenues from which to choose. It is always best to start at the local level – talk to your chief resident, associate program director, or program director. Sometimes the problem – such as inadequate parking or lack of healthy meals available late at night – is too big for the resident to handle. The next step is to contact your house staff council or peer-selected representative on your graduate medical education committee

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(every accredited institution has these committees or their equivalent). If that doesn't yield results, you can speak to your institution's designated institutional official – the link between your institution and the ACGME.

Now let us say this just has not worked, and your program is about to have a site visit. To alleviate the understandable anxiety surrounding a site visit, it is important to know the route a resident complaint takes in a site visit. The site visitor just brings back the facts – none of his or her personal opinions – to the Review Committee. The Review Committee looks at the program as a whole and looks at the resident issues in the context of the entire program. Sometimes the issues revealed by the residents warrant a citation – the purpose of which is only to incite positive change in the program, not to punish. Most of the time, this citation results in a constructive change by the program.

Sometimes a program is so far outside the ACGME requirements that multiple citations are issued and, potentially, an adverse accreditation action must be taken. Even then, immediate withdrawal of accreditation does not occur (this is reserved only for programs with extraordinary problems, such as life-threatening safety hazards or severe resident maltreatment, and has been employed only a couple of times in the history of the ACGME). The first step is a "proposed" adverse action – the program is notified and given an opportunity to rebut the citations. The rebuttal is reviewed at the next Review Committee meeting (a few months after the previous meeting), and citations are either upheld or dismissed. "Proposed probation" status does not have to be disclosed to potential applicants, so should not affect the pool of candidates from which your program chooses new residents.

If the probation is confirmed, the program is given yet another chance to correct deficiencies over a period of one to two years. In addition, the program has the opportunity to appeal the probation to the ACGME Appeals Committee.

Most programs do very well after a confirmed probation, but in the worst-case scenario, usually due to multiple factors, a program may continue to have severe deficiencies. When the program presents for review again, potentially the probation will be continued. The cycle length may be another one to two years. The next step for the unremediated program is a proposed withdrawal of accreditation, which may be rebutted, followed by withdrawal of accreditation. Such a decision may also be appealed by the program. All in all, the process is extremely lengthy and is designed so purposefully to give the program the maximum chance to meet the standards of excellence. The goal of the accreditation system is to create the optimal learning environment in which residents and fellows thrive and grow into competent, caring doctors – an environment that encourages physicians who are willing to strive for excellence in all they do and are unfazed by those who would spread fear, uncertainty, and doubt. ■

Written by Lieutenant Commander Rupa J. Dainer, MD, USN.

resources

Useful Websites

American Board of Medical Specialties
www.abms.org

Council of Medical Specialty Societies
www.cmss.org

Council on Review Committee Residents Has Had Productive Year with Launch of Leadership Conference, Work on ACGME Task Force, and Other Projects

The Council of Review Committee Residents (CRCR) is a relatively new ACGME advisory council. It was only 11 years ago that the ACGME Board of Directors adopted a bylaws change requiring a resident physician to serve on each Review Committee. At the same time, the ACGME Resident Task Force recommended that the Review Committee resident members meet annually, and thus the CRCR was formed. As noted in the ACGME's *Bylaws and Policies and Procedures,* the CRCR "serves as an advisory body to the ACGME concerning resident matters, GME, and accreditation." One resident member sits on each of the Review Committees; the RRC for Internal Medicine has two resident members because of the large number of internal medicine residency programs. The CRCR, composed of the 29 resident Review Committee members, meets twice a year in conjunction with the ACGME Board of Director meetings.

Here are some of the CRCR's recent accomplishments:

- advocated for similar and fair leave of absence policies across the specialty boards by calling the disparity to the attention of the American Board of Medical Specialties (ABMS).
- played a major role in assisting the ACGME Department of Education and the Office of Resident Services in designing its 2010 inaugural Leadership Conference for program directors and residents.

Dr. Blatman's term as chair ended September 30, 2009; Dr. Dainer's term as chair began February 1, 2010.

2008–2009 Council of Review Committee Residents

First row, left to right: *Todd Mondzelewski, MD; Joanna Fair, MD; Rupa Dainer, MD* (Chair-Elect); Karen Hsu Blatman, MD* (Chair); Adeline Deladisma, MD, (Vice-Chair); Charles Scales, MD.* Second row, left to right: *Stefanie Campbell, MD; Sara Brenner, MD; Hannah Zimmerman, MD; Jeffrey Kozlow, MD; Brian Freeman, MD; Audrey Woerner, MD; Matthew Poppe, MD; Jamie Bohl, MD; Deborah Erlich, MD.* Third row, left to right: *Gretchen Glaser, MD; Michael Swaby, MD; Alexander Khalessi, MD; Meredith Riebschleger, MD; William Walsh, MD, MPH; Stephen Tantama, MD; Meredith Runke, MD; William Huang, MD; Monica Rho, MD; Carla Marienfeld, MD; Samuel Seiden, MD.*

- created a PowerPoint presentation on the ACGME and Review Committee roles and responsibilities for resident members to use when speaking to resident organizations.
- crafted and proposed a new institutional requirement that will allow residents protected time for routine medical, dental, and vision care.
- appointed CRCR members to serve on the ACGME task force on quality care, professionalism and resident work hours and created its own task force to review the new requirements before they are published.

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- began dialogue with the Council of Review Committee Chairs Subcommittee on Common Program Requirements to clarify issues surrounding resident evaluation and to discern whether problems might be ameliorated by providing greater specificity in the Common Program Requirements or whether the problems stem from lack of compliance and enforcement.
- began exploring with the Institutional Review Committee ways to improve communication among the CRCR, Office of Resident Services, and residents.

In order to broaden its reach to residents, information about the CRCR and its work will soon be available on the ACGME website in the Resident Services section. ■

Written by Marsha Miller, associate vice president for resident services at the ACGME.

Institutional Guidelines Can Prevent Potential Social Media Problems

"How does your house staff use social media?"

Donald W. Brady, MD, the designated institutional official at Vanderbilt University Medical Center, posed that question at the beginning of "Twitters, Blogs, and GME: Professional Responsibility and the Internet," the session he presented at the 2010 ACGME Annual Educational Conference. The conference took place March 4–7 at the Gaylord Opryland in Nashville, Tennessee.

The large group of program directors, coordinators, and designated institutional officials responded that their residents use social media – Facebook, MySpace, Twitter, YouTube, blogs and other forms of interactive communication on the Internet – in many ways. One person said a chief resident uses it to communicate with residents. Another person noted residents use it to communicate with each other. Someone said residents use Twitter to send updates from the operating room to patients' families. Another attendee commented that residents who are parents use social media to exchange information on child care options.

Social media is "an important tool of communicating," said Dr. Brady. Because residents use social media tools so often, he explained, "it is important to think how they are using it."

Dr. Brady then presented several real-life examples of ways in which residents have used social media and asked the group to discuss the professional and ethical implications of the situations.

- At the request of a couple, a resident takes pictures of the woman during labor and e-mails the pictures to the woman's family.
- Two residents create a music video parodying colonoscopies, which features suggestive lyrics and images, and post it on YouTube.
- A resident who just moved to a new city creates a Facebook page that includes nude pictures of himself, along with the resident's work e-mail address.
- A program director discovers that a second-year resident has posted scathing comments about the residency program in an online forum for medical students.

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- A dermatology resident uses his cell phone to take pictures of dermatology lesions so he can later discuss the findings with the dermatology faculty. He will soon finish the program and move to another state, raising questions about what happens to the photographs stored on his cell phone.
- Two residents moonlight in the emergency department at a hospital in another county. They e-mail each other photos of interesting cases. A patient advocate calls the program director because a patient was upset that the doctors were taking pictures in the emergency room.

Each of the situations, the participants noted, raises questions about patient privacy, medical ethics, professionalism, freedom of speech, and the boundaries between residents' personal and professional lives. In lively small-group conversations, the participants discussed the "what-ifs" of each case. What if the resident sent the labor pictures to the wrong e-mail address? What if the resident didn't erase the pictures from his camera? What if the resident who posted the racy pictures on Facebook had not included his work e-mail address? What if a patient did a Google search of a resident and discovered a Facebook page? What if the negative comments a resident posted about his program were true?

Because social media is so widely used, it is crucial for sponsoring institutions to have written policies regarding its use. When creating a social media policy, noted Dr. Brady, an institution must determine whether the policy "is practical in the real-life environment of health care."

Vanderbilt Medical Center introduced a social media policy 2009. The policy includes the following provisions:

- Anyone who takes photos of procedures must immediately download them to a computer and erase them from their digital cameras or video recorders.
- Residents, faculty members, and staff who identify themselves as Vanderbilt employees on social media sites (Facebook, Twitter, blogs, YouTube) or use their work e-mail addresses are expected to adhere to Vanderbilt's professional conduct policy. They are required to disclose that any opinions they express are strictly their own, not official Vanderbilt policies. If contacted by the media, they are expected to call Vanderbilt's public affairs department for guidance.
- Anyone who posts something on a social media site should understand that the post is searchable and shareable.

In addition, new Vanderbilt residents are required to attend a one-hour presentation on the proper use of social media. The institution also has a "social media toolkit" posted on its website, which includes the social media policy, a description of popular social media platforms and a list of best practices in social media. The toolkit can be viewed here: http://www.mc.vanderbilt.edu/root/vumc.php?site=socialmediatoolkit. ■

Written by Julie A. Jacob

reference

ACGME Definitions

Site

An organization providing educational experiences or educational assignments/ rotations for residents/fellows.

Major Participating Site: A Review Committee-approved site to which all residents in at least one program rotate for a required educational experience, and for which a master affiliation agreement must be in place. To be designated as a major participating site in a two-year program, all residents must spend at least four months in a single required rotation or a combination of required rotations across both years of the program. In programs of three years or longer, all residents must spend at least six months in a single required rotation or a combination of required rotations across all years of the program. The term “major participating site” does not apply to sites providing required rotations in one-year programs. (see “Master Affiliation Agreement”)

ACGME Honors Outstanding DIOs, Program Directors, Coordinators, and Residents at Annual Educational Conference Awards Luncheon

The ACGME held its 2010 awards ceremony and luncheon March 5 at the ACGME Annual Educational Conference, which took place March 4–7 at the Gaylord Opryland Hotel in Nashville, Tennessee. Approximately 1,600 people enjoyed the luncheon celebration honoring this year’s award recipients.

At the ceremony, the ACGME presented the following awards.

DeWitt C. (Bud) Baldwin Jr., MD, ACGME scholar-in-residence, received the distinguished John C. Gienapp Award for lifetime achievement in graduate medical education. Dr. Baldwin was honored for his illustrious academic career and extensive research into the learning experiences of residents.

Ten outstanding program directors were presented with the **Parker J. Palmer Courage to Teach Award**.

- Ramesh Ayyala, MD, ophthalmology, Tulane University
- John Frohna, MD, pediatrics, University of Wisconsin Hospitals and Clinics
- Michael Hart, MD, surgery, Swedish Medical Center
- Ronald Maier, MD, surgical critical care, University of Washington
- Eileen Reynolds, MD, internal medicine, Beth Israel Deaconess Medical Center;
- Michael Rhodes, MD, family medicine, Utah Valley Regional Medical Center
- Gregory Rouan, MD, internal medicine, University of Cincinnati
- Philip Shayne, MD, emergency medicine, Emory University
- Prathibha Varkey, MD, preventive medicine, Mayo Clinic
- Diane Wayne, MD, internal medicine, McGaw Medical Center of Northwestern University.

Three exceptional designated institutional officials received the **Parker J. Palmer Courage to Lead Award**.

- Arnold Eiser, MD, Mercy Catholic Medical Center;
- Norman Ferrari III, MD, West Virginia University;
- Mark Juzych, MD, Wayne State University.

New this year was the **David C. Leach, MD, Award,** which recognizes residents and resident teams that have improved learning, fostered innovation, increased communication, made processes more efficient, or advanced humanism in health care. The following residents received the award.

- Omar Bhutta, MD, pediatrics, Seattle Children’s Hospital
- Jenny Han, MD, internal medicine, Henry Ford Hospital
- Kyla Terhune, MD, surgery, Vanderbilt University Medical Center
- David Turner, MD, pediatrics, Duke University Medical Center

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Specialty Program
A structured educational experience in a field of medical practice following completion of medical school and, in some cases, prerequisite basic clinical education designed to conform to the program requirements of a particular specialty; also known as 'core' programs.

Definitions are from the ACGME Glossary. The entire glossary is posted online at http://www.acgme.org/acWebsite/about/ab_ACGMEglossary.pdf

- Christopher Young, MD, pediatrics, University of Florida, Gainesville

Descriptions of their award-winning projects are posted here: http://www.acgme.org/acWebsite/dcl_award/winningprojects/dcl_winningprojects.asp

For the first time, the ACGME recognized program coordinators with its **GME Program Coordinator Excellence Award.** Five well-deserving coordinators received this honor.

- Sherry Berka, internal medicine, University of Colorado
- Anne Hoffmann, emergency medicine, New York Presbyterian Hospital
- Vicky Huebner, internal medicine, Mayo Clinic
- Mary Liberty, psychiatry, Maine Medical Center
- Jeri Whitten, pediatrics, West Virginia University.

All awardees received a plaque, a monetary gift, and complimentary hotel, airfare, and conference registration. For more information about these winners, please visit the ACGME Web site, www.acgme.org, and scroll on the "ACGME Awards" link.

The ACGME is now accepting nominations for its 2011 awards. Residents are encouraged to nominate outstanding program directors, designated institutional officials, resident/resident teams, and coordinators. Nomination information and forms are available on the ACGME website. The deadline for submitting nominations is July 1.

ACGME Creates New Subsidiary, ACGME International

The ACGME has created a new subsidiary organization, ACGME International, to accredit residency programs in other countries. Last fall, ACGME International signed an agreement with the Singapore Ministry of Health to accredit residency programs in that country. If all goes well with the accreditation of programs in Singapore, ACGME-I will eventually begin accrediting residency programs in other countries that request the service as well.

Thomas J. Nasca, MD, MACP, chief executive officer of the ACGME, serves as president of ACGME International. William E. Rodak, PhD, was named vice president, accreditation services, for ACGME International. Dr Rodak previously served as senior executive director, Group 1 Review Committees and executive director, RRC for Internal Medicine. Dr. Rodak will head the Department of Accreditation at ACGME International, serve as the expert on accreditation matters for sponsoring institutions in other countries, assist in the development of international accreditation standards, and lead the staff team that will support the ACGME International Committee on Accreditation.

More information on ACGME International can be found on the website, www.acgme-i.org

TImely, Specific Feedback Can Improve Resident Satisfaction with Evaluations

Feedback and evaluations are among the more important aspects of graduate medical education, but they are also among the more difficult to give and receive. Feedback, and the written evaluation which often serves to document the process, have multiple purposes including 1) documentation of professional progress and competency, 2) opportunities for improvement, and 3) obtaining employment and licensures after training is completed.

Ideally, the written evaluation should simply serve as documentation for a trainee's file after an oral feedback session has already occurred. Many times it may be the case that busy clinical duties stymie oral feedback, making written evaluation after the completion of the rotation the dominant feedback mechanism. This is less desirable (especially if negative feedback is included) as it makes it more challenging for a trainee to respond, ask questions, or clear up any potential misunderstandings or mistakes before the evaluation is submitted. Written evaluations also have the potential for clerical errors. For instance, one evaluation of mine noted that "she is having family difficulties" – a comment clearly meant for someone else as I am male and was not having any family difficulties. Correcting such mistakes may seem simple, but trainees may feel, or actually will be, labeled as a complainer or unable to accept feedback if they ask for clarification or correction to a written evaluation.

In a handful of specialties (including my own), written evaluations may occur as a group evaluation at the end of a rotation. This seems to occur in specialties where trainees may work with a different faculty member every day. Such group evaluations may effectively render the entire written evaluation anonymous for the trainee as individual comments may not be be ascribed to any individual faculty member, making clarifications or questions difficult or impossible.

Some faculty prefer anonymous evaluations of residents as there is a perception of fairness because trainee evaluations of faculty are anonymous. However, the hierarchy between trainees and faculty necessitates that if candid feedback is desired from trainees, anonymity is required. Faculty feedback is used for promotion and faculty development, and thus, such candor is needed. Even with ACGME-mandated anonymity, many trainees are skeptical that trainee evaluations of faculty are truly anonymous, and are thus already couched and hesitant in their remarks. Correspondingly, when faculty evaluations of trainees are not anonymous, some faculty are couched in their remarks out of concern for retaliatory evaluations of themselves. While constructive feedback, especially negative feedback, may be challenging to provide and receive, it is matter of professionalism that faculty should deliver honest and open feedback, and that trainees are receptive to it without responding with retaliatory evaluations.

Feedback should be timely and specific. Oral feedback ideally should occur in the last day or two of a rotation with a written evaluation following in the next month. It is not unheard of, though, for the sole feedback to be a written evaluation filed six months or more after the end of a rotation. Such feedback is clearly now so remote to the clinical experience that the formative use of this feedback is diminished.

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Specificity may best be accomplished with examples of exemplary or problematic behavior. For instance, feedback stating "needs to improve professionalism" is so vague as to be essentially useless, whereas "could improve professionalism of preoperative discussions with patients – seems rushed" identifies a specific behavior that the trainee can improve.

A variety of mechanisms have been established and tested to improve the quality and quantity of feedback given to trainees.[1] These include tools such as focused educational interventions,[2] clinical encounter cards[3] and exercises such as the mini-clinical evaluation exercise (mini-CEX), which provides focused feedback after a brief clinical encounter. These tools have been reported to lead to increased satisfaction of trainees with feedback, greater specificity and quantity of evaluations, and, ultimately, may lead to improved trainee performance and better clinicians – and creating better clinicians is the greatest achievement that feedback can deliver. ■

Written by Samuel C. Seiden, MD, a resident member of the RRC for Anesthesiology and a third-year anesthesiology resident at Stanford University Medical Center.

[1] Kogan JR, Holmboe ES, Hauer KE. "Tools for direct observation and assessment of clinical skills of medical trainees: a systematic review." *JAMA*. 2009 Sep 23;302(12):1316-26.

[2] Holmboe ES, "Effectiveness of a focused educational intervention on resident evaluations from faculty a randomized controlled trial." *J Gen Intern Med.* 2001 Jul;16(7):427-34.

[3] Greenberg LW, "Medical students' perceptions of feedback in a busy ambulatory setting: a descriptive study using a clinical encounter card." *South Med J.* 2004 Dec;97(12):1174-8.

Reflections from the Leadership Workshop Held during the 2010 ACGME Annual Educational Conference: Understanding Different Leadership Styles Leads to Greater Understanding

On March 6, 2010, the ACGME held its first leadership workshop for program directors, each of whom invited a resident or fellow to share in this experiential learning experience. The workshop focused on leadership skills that residents and program directors can use to improve themselves and residency training. Thirty-five participants spent the day learning about and from one another in a cohesive team approach. Two seasoned facilitators led the workshop: Robert Doughty, MD, PhD, ACGME senior scholar for experiential learning and leadership development, and Timothy Brigham, MDiv, PhD, ACGME senior vice president, Department of Education. One of the residents who took part in the workshop, William Andrew Todd, DO, a resident at the University of Tennessee College of Medicine in Chattanooga, Tennessee, shared his thoughts on the experience.

The ACGME leadership workshop gave me the unique opportunity to observe and discuss concerns and issues with my program leadership in both direct and indirect ways. Beginning the day with the Myer-Briggs personality inventory allowed me to identify areas of my personality that may complement those of my program leaders. More importantly, it helped to identify areas in our personalities where we diverge, which I foresee generating understanding of the opposite person, as well as facilitating a more efficient exchange between us.

The second half of the day allowed for brainstorming with other chief residents to anonymously identify talking points between chiefs and program leaders. The time to discuss key issues face-to-face with my program leadership was invaluable and synergized with the understanding of each other's personality. In the end, we identified several areas where we agreed and some issues where our opinions diverged. Most importantly, we communicated effectively, efficiently, and exactly to specific topics. The experience allowed the two of us to elevate our working relationship to a higher level of conscious strategy and subconscious understanding.

After the experience, we shared thoughts and feeling on an entirely different level of mutual understanding. In fact, I would say we shared more freely and clearly because our bond of trust had also been elevated to a higher level. The experience was invaluable and I wish I could have a similar experience with everyone that I work closely with. Understanding the principles of another individual's thought process and internal struggles allows his or her colleagues to harvest the best that the individual has to offer. ■

Written by William Andrew Todd, DO, a second-year resident at the University of Tennessee College of Medicine in Chattanooga, Tennessee

Resident Assistance with PIF Preparation Can be Rewarding for Both Residents and Program Directors

You don't have to be a member of your specialty's Review Committee or a program director to participate in the accreditation process at your institution. One of the first steps towards accreditation is submission of the Program Information Form (PIF), a document completed by the program director in preparation for a site visit by ACGME field staff. It is important that the PIF describe the residency program accurately and completely, as it reflects all educational and compliance-related aspects of the program.

Resident involvement in the preparation of the PIF can be a rewarding experience for both the residents and program director alike. It is an opportunity to critically evaluate various aspects of the program, develop efficient and effective practices structured around the core competencies, and institute program improvements that emphasize educational outcomes. Completion of the PIF does not have to be an endpoint in the accreditation process. Rather, it can be a starting point for creativity and innovation. Motivated residents, given the opportunity to be involved in the accreditation process, can serve as valuable resources for fresh perspectives, new ideas and innovative solutions.

Written by Jason N. Itri, MD, a resident member of the RRC for Diagnostic Radiology and a fourth-year diagnostic radiology resident at the Hospital of the University of Pennsylvania.