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rounds

To Walk a Mile in Their Shoes – Gaining Perspective on the Life of a Resident

Before I started working at the ACGME, I had virtually no understanding of how a physician was trained. Like the majority of the American public, I knew about residency programs from television.

Watching episodes of *Scrubs* and *Grey's Anatomy* taught me that residency was a time of pranks and hilarious misadventures, full of steamy, inappropriate relationships with extremely good looking people, all underscored by swelling pop music that would crescendo at the height of every difficult patient experience. I had a lot to learn.



When I started working at the ACGME in the Department of Field Activities in 2005, my job did not involve any interaction with residents. After four years, I was feeling a need to have more direct connection with people and decided to look for a position change. I joined the ACGME's Office of Resident Services in 2009, and suddenly I was talking to residents every day, helping them resolve concerns and file complaints. Although I was able to do my job, I knew I could be more effective if I had more knowledge and a better understanding of the residents' actual experience.

Last year, Marsha Miller, associate vice president of the Office of Resident Services, mentioned that several years ago she had the unique privilege to shadow a resident for a week. Embedded in a surgery program, she was able to go on rounds with the residents, observe patient care, attend conferences and lectures, and even be on call overnight. She offered to set up a similar experience for me as a development opportunity. The possibility of this kind of experiential learning was thrilling to me. I could not imagine a more effective way to expand my understanding and empathy for the residents with whom I speak every day.

Marsha contacted a director from an internal medicine program who agreed to allow me to “live as a resident” for five days. After discussing a few options, the program director and I decided that I would spend the first three days on the general medicine floor with one team and take overnight call in the Critical Care Unit (CCU) with another.

While I was filled with enthusiasm about diving into this experience, I also found it quite daunting. For a year leading up to it, I had talked with many troubled residents and listened to their concerns and complaints. I had developed fears and expectations about residency programs that were hard to shake. My television-induced ideas about the residency experience had faded at this point, and were replaced with horror stories from the residents who called me. Although many of the terrible allegations I had heard

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reminders

Upcoming Meetings

American Medical
Association
Resident and Fellows
Section Annual Meeting
Chicago
June 16–18

American Academy
of Family Physicians
Kansas City, MO
July 28–30

American College
of Surgeons
Clinical Congress
San Francisco
October 23–27

had been proven to be unfounded, they had stuck with me. Part of me was expecting to walk into a nightmare, including abusive attending physicians who never took the time to teach and treated the residents like slave labor. I was expecting tension between the residents because they were competing so much that they were willing to sabotage each other's careers. My imagination had created endless possibilities for dangerous and damaging circumstances.

Day one

After a night of anxious dreams and fitful sleep, I arrived at the hospital and met with one of the chief residents, who took me to meet my team on the general medicine floor. When she walked me into the residents' office space and introduced me as "Amy from the ACGME," it felt as though the air had been sucked out of the room. I was met with looks of suspicion, tinged with fear. "Oh, great. They think I'm here to spy on them," I thought.

When I speak to residents on the phone, I often sense that many of them think of the ACGME as a kind of Special Accreditation Police Task Force that can shut down a program on a moment's notice. However, I had never been confronted with that perception in person. I immediately put my hands in the air as if to surrender, smiled, and said, "Don't worry. I'm not here to evaluate the program. I work with residents in the Office of Resident Services. I just want to get a full picture of what you do so that I can be more helpful. It's just for me and my own education." From that point on, I used variations of this speech as a standard introduction each time I met someone new. Luckily, it did not take much time for them to open up to me.

Within the first few minutes, my fears and expectations diminished. Already it was quite different than I had imagined, and full of pleasant and refreshing surprises. There was a wonderful spirit of collegiality and respect within my team and among the various teams that shared an office space. I saw a great deal of idea sharing, brainstorming, and moral support. Our attending physician was an approachable, accessible, and inspiring teacher. Hours were long, but I was surprised to see that my team often had time for research and reflection. Our senior resident was an impressive juggler. She not only had the ability to teach and mentor the medical students and the intern on our team while she managed her patients, but she also had time to coach a more junior resident who was on call alone and feeling overwhelmed about having to deliver bad news to a family.

There were practices in place on the general medicine floor that appeared to create opportunities for success. For instance, every day we took five to ten minutes to meet for interdisciplinary rounds. Communication was transparent and detailed and different opinions were valued. Conferences were engaging and residents appeared to feel supported and empowered. The spirit of camaraderie and good humor seemed to fill the work environment. The general medicine floor, for all of its ailing patients, appeared to have very healthy doctors.

The busy CCU

Then I arrived in the CCU.

To be clear, the team that I followed in the CCU was wonderful. I can't say enough good things about them, but the experience could not have been more different from my

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reference

ACGME Definitions**Transferring resident**

Residents are considered as transfer residents under several conditions including: moving from one program to another within the same or different sponsoring institution; when entering a PGY 2 program requiring a preliminary year even if the resident was simultaneously accepted into the preliminary PGY1 program and the PGY2 program as part of the match (e.g., accepted to both programs right out of medical school). Before accepting a transfer resident, the program director of the 'receiving program' must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation from the current program director. The term 'transfer resident' and the responsibilities of the two program directors noted above do not apply

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time on the general medicine floor. I was struck first by how huge rounds were. The giant group that we rounded with could rarely fit into a patient's room. At times it was difficult to hear what was being said. When I could hear the attending physicians, they spoke briskly and jumped to the point; they seemed significantly more removed, colder, and more clinical. And they did most of the talking. It was clear that they were running the show and that the residents were along for the ride. The empowering teaching that I had witnessed on the general medicine floor was gone. This felt more like a lecture. It was a bit off-putting, but as the day went on, I began to understand the attitude a bit more; or at least question it with curiosity.

In a crowded, busy environment with such an incredibly ill and complicated patient population, where it takes several hours to see all of the patients and the circumstances are truly life or death, how does one find time for teaching moments?

Time moved differently in the CCU. After we completed rounds, it felt like hours flew by in minutes. There was little time for reflection or research. There was barely time for taking care of basic needs. Finding a moment to eat lunch proved nearly impossible, but the needs of the patients seemed to keep hunger at bay. Because the interaction with patients was steady and their illnesses were so severe, adrenaline would take over and I would completely forget about the rumbling in my stomach. Although I was only observing, I was completely engrossed in the moment-to-moment work. I felt present and alert each time we walked into a patient's room. My own needs were secondary.

The reality of residency

In the late afternoon, I witnessed a reality of resident life for which I was unprepared. I followed my team to meet with the family of a patient who had been admitted a few hours earlier. I was under the impression that the attending physician was going to update the family on the patient's prognosis, and, naively, I thought the patient would be fine. I thought the conversation would be about next steps for care, and I was eager to learn the plan to "fix" this young man. Instead, I watched while the patient's family was told that they were out of options.

It was surreal to observe this moment. Again, time seemed to change, to move in slow motion. It felt like a violation to sit there among the residents, wearing scrubs, looking like one of them but feeling like an imposter, watching as the family took in this news. The family members' anguish was so powerful. I wanted to connect with them, to offer some kind of counsel and express empathy. I wanted to cry with them. But I knew it was not my place; it would have been wildly inappropriate, even intrusive. Instead, I stared at the floor and took deep breaths. I tried to put up a wall to keep out the feeling of grief that seemed to radiate in the room. I pretended that I was someone who had gone through this before, and tried to listen.

I was, once again, struck by the attending physician's tone. He was removed, clinical, and so scientific in his explanation that it took a while for the family to understand what was happening. He went through each option that would normally be used to care for a patient with their relative's diagnosis, and then explained why each option would not be successful under the specific circumstances. After listing multiple procedures that would not work, the family

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reference (continued)

to a resident who has successfully completed a residency and then is accepted into a subsequent residency or fellowship program.

Transitional-Year Program

A one-year educational experience in GME, which is structured to provide a program of multiple clinical disciplines; it is designed to facilitate the choice of and/or preparation for a specialty. The transitional year is not a complete graduate education program in preparation for the practice of medicine.

Transitions of care

The relaying of complete and accurate patient information between individuals or teams in transferring responsibility for patient care in the healthcare setting.

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

was left with confusion, only asking, “Where does that leave us? What will you do to make him better?” The response: there was nothing left to do, and it was only a matter of time before the patient’s heart would stop working.

I understood that he needed to explain his thought process clearly, but I wondered if it offered false hope each time he mentioned a procedure, only to shoot it down again. Even when he expressed his sympathy, it came across as cold. It was a fellow who stepped in and warmed up the room a bit. He had a gentle, calming quality in his delivery and seemed more able or willing to connect and offer a bit of comfort.

I can’t stand in judgment of this process. I cannot imagine that there is a “right” way to deliver such terrible news. I don’t know if any delivery can lessen the grief in that moment. I certainly didn’t know if I would be capable of doing this. When we left the family, I rushed ahead of my group. As soon as I was sure that I was out of the sight of patients and loved ones, I ran into the conference room and cried. And I still want to cry whenever I think about that day, that family, and that patient.

The night offered plenty of distractions from this sadness. We continued to admit new patients. I watched as my team learned a new procedure that they successfully completed with the teaching help of another resident. I saw first-hand what supervision looked like in the middle of the night and how consultations worked. I tested my own mettle as we were paged for an emergency at three o’clock in the morning and had to sprint through the hospital. For the first time, I understood how duty hours might affect me and imagined what it would feel like after working this schedule for several years.

Time flew. Although I was tired and wanting sleep, any time we were needed, I felt wide awake. My brain snapped to attention. Overnight call was not torturous as I had imagined it would be. It felt necessary. I found it was difficult to leave the next day. I was too curious about the patients that I had come to know, and I still wonder what happened to them.

Reflections on the week

Before rounds the next morning, as the floor began to fill up with the residents that would take over for the day, I had a chance to sit in the conference room with them and share some of my experience. I told them about sitting with the patient’s family and the delivery of his prognosis. I told them that I didn’t know how they did it. I was too emotional. It made me too sad. I didn’t think that I would ever be capable of dealing with so much grief. One of the residents said, “In the first five weeks of my residency, I had to have a conversation with a family about removing their loved one from life support. I made it through the conversation. I made it through the entire day. Then I went home, and I cried all night. It gets easier. You get better at having the conversations. You get more distance. But I tell myself, if I ever have that conversation and there’s not a part of me that still wants to cry, I should give up medicine. I never want to be that removed.”

I thought about the attending physician who had delivered the news and wondered if that removal grows naturally over the years; if it’s a necessity to help maintain your own emotional health. How do you stay healthy and maintain a real connection with, and compassion for, your patients and their families? Perhaps it’s just personality differences that enable some to do it well, or better than others. I don’t

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know how you teach empathy. Will these residents be provided with the tools necessary to process their own grief around the loss of a patient? These questions still resonate with me today.

It would be foolish to say that I can fully understand the experience of residency. Those short five days barely touched the tip of the iceberg. I certainly left with more curiosity than I came in with, more questions and a greater desire to understand. I also left with a great respect and appreciation for all that residents do. It was a rare privilege and honor to be allowed into the lives of the residents I followed. I have so much gratitude for their willingness to share their experiences with me. I'm also hopeful that maybe I changed some people's perception of the ACGME in the process.

I did what I set out to do, and got far more than I had bargained for. I saw a glimpse of what it means not only to be a resident, but also a fellow, an attending physician, a patient, and a family member of a loved one who is ill. The experience has definitely enhanced my work and helped me to grow professionally, but I am far more grateful to have experienced this on a personal level. It was an experience that continues to change me, to humble me, and to call me to examine what it means to live a life of purpose. ■

Written by Amy Dunlap, Resident Services Associate.

Coaches Provide Feedback and Space for Reflecting for Residents in Dartmouth Leadership Preventive Medicine Residency

In sports, a coach helps an athlete perform at his or her highest level. In the Dartmouth Leadership Preventive Medicine Residency (LPMR) program, faculty members at Dartmouth Hitchcock Medical Center who serve as coaches help residents in the program achieve their highest level of learning.

At a session at the 2011 ACGME Annual Educational Conference, Tina Foster, MD, MPH, MS, associate director of the LPMR program, and Kathy Kirkland, MD, an infectious disease faculty member who serves as a coach, explained how coaching works and discussed its benefits to an audience of about 75 program directors, coordinators and designated institutional officials.

The Dartmouth LPMR is a two-year program in which residents earn a master's degree in public health and learn how to lead improvements in health care, while simultaneously participating in a residency program for their chosen specialty. During the second year of the program, residents develop and lead a project to improve health care in a clinical setting. The coaches meet regularly with the residents throughout the program.

A coach-resident relationship is not quite the same as a mentoring relationship, Dr. Foster and Dr. Kirkland noted. Unlike mentors, whom residents choose on their own, the program's leaders match each resident with a coach. The coaching relationship is also more structured than an informal mentoring relationship, they said. A coach must

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agree to coach a resident throughout his or her two years in the program. Coaches, who have supported time for their work, are expected to meet with their resident at least once every two weeks, as well as attend writing collaborative, work-in-progress sessions and journal club sessions with their resident.

“Coaches have to be committed to being part of a community...you are expected to attend all the leadership seminars with the residents and all the writing collaborative sessions with the residents,” said Dr. Kirkland.

During the coaching sessions, the residents discuss and reflect upon their experiences, while the coaches ask questions and give feedback. Coaches also provide a “space” for reflection, said Dr. Foster.

When asked to describe the coaching relationship, Dr. Foster and Dr. Kirkland said, residents have said that it “is like being on a nature hike with a docent who suggests looking under rocks to see what you might have missed on your own,” “produces a very rich set of reflections, insights and new discoveries,” and “similar to having a sage and dispassionate guide on your journey.”

Coaches in turn, have described being a coach as “fostering personal growth of the trainees as well as personal awareness and self-mastery by the coach” and “relies on mutual trust and respect” and “a learning experience for both coach and student.”

Over the eight years since the residency and the coaching program began at Dartmouth, the program leaders have observed that the mutual commitment to improving health care bonds together each coach-resident pair. Dr. Foster and Dr. Kirkland described this commitment to improving

health care as a “third thing,” referring to the title of an essay by poet Donald Hall described how the love of poetry was a “third thing” in his marriage to fellow poet Janet Kenyon.

Dr. Foster and Dr. Kirkland ended the session by asking participants to role play being a coach and resident by taking turns discussing a challenging situation or one that tied into larger professional issues. ■

Written by Julie A. Jacob, communications manager for the ACGME.

Welcome to the Resident's Corner, a new section created to answer questions frequently asked by residents and fellows. In each issue of *Resident Review* we will answer one such question, which will be added to a comprehensive FAQ document that can serve as a resource for future residents and fellows. In this issue, the common question being addressed is:

Should I review my resident/fellow file? How often? What should be contained in my file?

The Office of Resident Services is often surprised when residents and fellows report that they do not review their own files. Why should you?

The resident/fellow file is an important part of the postgraduate education process. Its purpose is to keep—in one place—documentation of each resident or fellow's educational progress, including specific curricular components for that individual's program "path," and the evaluation of his/her performance, educational needs, and assessment of progress over time.

Most programs allow residents/fellows to see their files in the presence of specified program administrators. In general, residents/fellows do not receive copies of monthly evaluations, summative evaluations, termination evaluations, or letters of recommendation, in order to protect the program from any alterations to the evaluations, and/or use of them for unauthorized purposes.

The individual's file should document ongoing evaluations of that resident or fellow, appropriate responses to negative evaluations and critical incidents by the program director and other supervisors, and prompt resolution of conflicting positive and negative evaluations. Only a complete file can demonstrate the fairness and applicability of the final conclusions and judgments of the program director and evaluation committee about a resident's/fellow's overall performance in the program.

Every resident and fellow should review his or her file at least annually and certainly before completing his or her residency or fellowship, so that there are no surprises later. For instance, there have been cases where a resident applying for a medical license discovered only then that he or she had been on probation during residency; others, when accessing their files, have reported finding letters that they did not know existed and which they had not previously seen.

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And yes, sometimes mistakes happen. Program directors change, and the myriad of responsibilities that impinge on their time may cause unintentional consequences. These matters need to be cleared up before the end of an individual's residency or fellowship, not after.

The ACGME's Residency Review Committees require that programs and institutions comply with the following Common Program Requirements. (The Common Program Requirements provide the outline and foundation for specialty-specific requirement development; these requirements appear in *every set* of specialty-specific requirements verbatim, and help make it possible for residents and fellows to access their files.):

V.A.1. Formative Evaluation

The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.

V.A.2. Summative Evaluation

The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy.

Be an informed resident or fellow – review your official file! If you are not permitted to access your file, please contact the institution's designated institutional official located in the Graduate Medical Education Office. If you are still unsuccessful, please contact the ACGME's Office of Resident Services for assistance at residentservices@acgme.org. ■

Written by Marsha Miller, Associate Vice President, Office of Resident Services.

House Staff Committee Helps Improve the Residency Experience

Institutions sponsoring ACGME-approved residency training programs are required to have a Graduate Medical Education Committee (GMEC) to establish and implement policies and procedures regarding the quality of education and the work environment for residents (ACGME Institutional Requirement III.B.). Voting membership of the GMEC includes residents who have been nominated by their peers, providing a mechanism for resident representation. Yet this arrangement tends to be ineffective in addressing many “lower-level” resident issues because the GMEC has a tremendous number of responsibilities including stipends and salary allocation, communication with program directors, monitoring of resident duty hours, resident supervision, communication with medical staff, curriculum and evaluation, resident status, management of institutional accreditation, and oversight of program changes.



So how can residents raise issues about the educational and training environment at their institution in a way that brings about positive change?

Another ACGME institutional requirement addresses this exact question. The sponsoring institution and its programs “must provide an educational and work environment in which residents may raise and resolve issues without fear of intimidation or retaliation. Mechanisms to ensure this environment must include an *organization or other forum* for residents to communicate and exchange information on their educational and work environment, their programs, and other resident issues” (II.F.1.a). At many institutions, this organization is known as a House Staff Committee. The House Staff Committee provides a means for communication between house staff and hospital administration. This committee takes on projects, programs, and issues that are of special importance to house staff with a focus on house staff quality of life. Another vital function is to serve as an advocacy body for house staff.

It’s not a surprise that House Staff Committee meetings at many institutions traditionally have low attendance and participation. Residents are extremely busy, and monthly meetings to discuss issues related to “the educational and training environment” rarely inspire much of a response, aside from clicking “delete” to appropriately triage the email reminder. Yet I doubt there is a single resident unable to list at least a few ways to improve the residency training experience at their institution. Take a moment and reflect: Are you happy with your cafeteria? Do you have quiet call rooms with clean sheets waiting for that elusive opportunity to get 30 minutes of sleep before morning rounds? If you had a baby during residency and need a place to pump day or night, do you have a lactation room well-stocked with supplies? Are you happy with your benefits and matching 401k retirement plan? How about parking, moonlighting opportunities, cell phones, financial planning or happy hours? Improving these aspects of residency training is one of the primary purposes of a House Staff Committee.

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If talk of happy hours and retirement plans hasn't captured your attention, there are several often overlooked personal benefits to serving as an officer on a House Staff Committee:

- Working with residents from other specialties to solve problems is a tremendous opportunity to collaborate and build relationships with other departments.
- Acting as a liaison to GMEC and hospital administration is an opportunity to improve your own communication and interpersonal skills.
- Mediating problems between residents and hospital staff is an opportunity to promote practices that support diversity, inclusion and cultural acceptance.
- You can participate in the development and implementation of new educational approaches and activities to improve GME for residents at your institution.
- In other words, serving on your House Staff Committee gives you the opportunity to develop and improve the skills necessary to become an effective physician leader.

In this brief review discussing the role of a House Staff Committee in improving the residency experience, I provided a broad overview of the positive impact residents can have by getting involved and being active participants. The time commitment is minimal – most residents attend only a few meetings each year to discuss specific issues that are important to them. If you are committed to becoming a physician leader, you can serve as an officer and work with residents from other departments, members of GMEC, and hospital administration to improve the training experience at your institution. Identifying problems and implementing solutions is a vital skill for physicians and can be an empowering experience. So, the next time you receive an email reminder for an upcoming House Staff Committee meeting, I hope you consider stopping by to see what opportunities await. ■

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Resident Member, RRC for Diagnostic Radiology*