

In This Issue

From the Editor

Based on a review of quality improvement (QI) submissions in their role as editors, Wong and Sullivan highlight common problems and offer guidance to help prospective authors prepare QI reports for publication (p. 128); and a guest editorial by Thibault introduces the Clinical Learning Environment Review Program's supplement of initial findings and discusses developing closer links between education and health care delivery (p. 134).

Perspectives

Siegler et al discuss approaches to enhance resident decisions around opioid prescribing in the ambulatory setting by focusing on short-term and long-term benefits and risks (p. 138).

MacLeod discusses ethnographic research as a way to gather explanatory information for phenomena in graduate medical education (p. 142).

Cilliers and Tekian emphasize the importance of designing faculty development to maximize transfer of learning to the workplace (p. 145).

Ellman and colleagues define continuity of care as a commitment that reflects the ideals of the profession, and calls on education leaders to apply these values in the design of resident education (p. 150).

Sajisevi et al argue that the concepts of education and service during residency are integrated and collectively achieve the goal of professional identity formation in physicians (p. 154).

Reviews

A narrative review by Hauer and colleagues applies knowledge from the literature on group decision making to inform the work of clinical competency committees, focusing on group membership, leadership and process, and the use of information in decision making (p. 156).

Original Research

Abdel-Razig and colleagues from the United Arab Emirates describe a consensus process to develop a medical professionalism framework for the region and the resulting framework (p. 165). Commentaries by Cruess and Cruess (p. 265), Ho and Al-Eraky (p. 268), and Jha and Robinson (p. 271) discuss the conceptualization of professionalism in different nations and social contexts.

Gil and colleagues find variation in case volume in peripheral nerve surgical procedures for residents in 5 specialties, and suggest that didactics, mentoring, case breadth, and complexity also play important roles (p. 173).

Musgrove and colleagues find variability in the use of clinical reasoning terms in problem solving exercises and recommend that teaching clinical reasoning would benefit from common nomenclature (p. 180). A commentary by Dhaliwal and Ilgen emphasize clinical reasoning terms as a shared language for teachers and trainees to dissect how they think and learn from clinical problems (p. 274).

A quantitative study shows residents are more inclined to pursue self-directed learning when topics are well-presented, focus on clinical reasoning, and include a summary statement (Fraser et al, p. 185).

Use of a 5-point centered scale and faculty education reduced the incidence of "grade inflation" in rotation evaluations of nephrology fellows (Yuan et al, p. 191).

An intervention using white boards and business cards to increase patients' recognition of their physicians resulted in increased use of both tools, but had no impact on patients' recognition (Broderick-Forsgren et al, p. 197).

Rice et al assess a simulation-based assessment tool for ultrasound-guided peripheral intravenous line placement, finding acceptable interrater reliability and ability to distinguish between different performance levels (p. 202).

Caniano and Hamstra analyze strengths and opportunities for improvement identified by residents in 5 surgical specialties (p. 208). A companion study in the News and Views section highlights consensus and differences in

resident and faculty perceptions (Caniano et al, p. 291). Collectively, the 2 studies offer insight into key stakeholder perspectives of the surgical learning environment for use in ongoing improvement.

Educational Innovation

An innovative institutional resident engagement program and electronic health record–based quality tool were associated with improved system-wide quality performance and stroke care process measures (Hussain et al, p. 214). A commentary by Augustine discusses the benefits and drawbacks to the pay-for-performance concept (p. 277).

Lin et al describe a free, national, expert developed curriculum and high-quality teaching materials for emergency medicine residents' individualized, asynchronous learning (p. 219).

Training residents in a patient-centered medical home model resulted in high resident satisfaction and small improvements in resident knowledge and confidence (Hasley et al, p. 226).

A surgical QI initiative in which chief residents analyzed data and reported improvement interventions at departmental grand rounds resulted in improvements in several clinical outcomes (Abelson et al, p. 232).

Brief Report

An electronic health record–based simulation is used to understand and improve the accuracy of intern progress notes (March et al, p. 237); Teaching Health Center Graduate Medical Education training sites deserve further study as a model to improve primary care distribution (Barclift et al, p. 241); a “July phenomenon” is absent in operating room efficiency (Sanford et al, p. 244); an exit survey finds senior residents interested in health care cost containment, but with deficiencies in their knowledge about costs (Long et al, p. 248); a study of the characteristics and curricular elements of simulation fellowships suggests a need for a common set of guidelines (Ahmed et al, p. 252); and an intervention to reduce burnout in first-year internal medicine residents using facilitated group discussion did not result in improvements (Ripp et al, p. 256).

Rip Out

A Rip Out on entrustment as assessment by ten Cate offers practical suggestions for the use of entrustable professional activities in resident assessment and determinations about the need for resident supervision (p. 261).

Using an example of an effort to improve residents' interprofessional rounds, a Rip Out by Paradis and colleagues offers practical advice for selecting data collection methods in qualitative research (p. 263).

To the Editor

In the *Comments* category, Medina suggests interactive learning as a solution to decreasing surgical exposure in response to an article by Gupta et al from the *JGME* September 2015 issue (p. 279); and Smith comments on the review by Stephenson-Famy and colleagues in the December 2015 issue, describing his own experience with behavioral interviewing to improve selection and reduce resident attrition (p. 280).

In the *Observations* category, Venkatraman and Kumar describe a 1-month intensive training experience in EEG interpretation skills (p. 281); a letter from the Mayo Clinic discusses linking technology and learning theory in curriculum development (Bois et al, p. 283); Elghul discusses the impact of ACGME accreditation on residency program organization and structure (p. 285); Wanat et al present the results of a survey of dermatology program directors about teledermatology, finding it holds great potential as an educational and patient care technology (p. 286); and Sharma discusses research design in medical education (p. 288).

On Teaching

In his essay, Sgro uses an intern introduction to highlight that meaning does not flow directly from experience, and it is not something that can be taken for granted (p. 289).