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Features of Effective Clinical Competency Committees

Rowland K, Edberg D, Anderson L, Wright K.J Grad Med Educ. 2023 Aug;15(4):463-468. PMID: 37637335

What makes for a really effective, really efficient Clinical Competency Committee (CCC) meeting? This article assessed actual practices of family medicine CCCs through a national survey (response rate 43%), and sought to determine specific features that correlated with effective and efficient CCC performance.

Program Directors (n=291) reported on methods, policies, faculty development, structure, and time for their program CCCs. They also self-assessed whether or not their CCCs were successful in identifying struggling or excelling residents. A majority of respondents were from community-based, university-affiliated programs (56%), and the most common resident complement size was 19-31 (46%).

Regarding efficacy, the majority of respondents (89%) unsurprisingly reported that their CCC is successful at identifying struggling residents. Features that were associated with this success include the presence of formal policies as well as specific faculty development.

Regarding efficiency, respondents reported wide variability in time that CCC members devoted to each CCC meeting: < 3 hrs (19%), 3-5 hr (31%), 5-7 hr (20%), and > 7 hrs (30%). Programs reporting on the low end of this spectrum were less likely to be able to identify struggling residents.

While this data was generated from family medicine programs, it would be reasonable to extrapolate this information to emergency medicine. By allowing for adequate time, creating formal policies around remediation, and offering faculty development regarding resident assessment, we can ensure that our CCCs are effectively assessing resident competence.

-Carmen Wolfe, MD

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The Knowledge Gap: Mentorship in Emergency Medicine Residency

Sobel J, Hayden SR, Wardi G. *Ann Emerg Med.* 2023 Jul;82(1):47-54. PMID: 36841659

The Mentor-Mentee dynamic is a well-known and well-studied relationship that has stood the test of time. These relationships date back as far as Homer's *Odyssey* and show the benefit of these types of relationships. However, "It [mentorship] is like a lot of things in academic medicine. Nobody teaches you how to do it, you are just expected to do it" - Straus et al.

In this narrative review, investigators reviewed the benefit of a mentor-mentee relationship in Emergency Medicine (EM) and reviewed benefits of learning models that move away from traditional dyadic models. The authors use a literature search review including terms "Emergency Medicine," "resident," "residency," "mentor," and "mentoring." The available literature included 90 studies of which 36 were found relevant and included in the review.

The authors explained the limitations in training of mentors and expectations of mentees including differences between mentor, advisor and coach. To glean the most out of a mentor-mentee relationship the responsibilities and duties should be clear at the start of the relationship. Being able to trust each other was noted to be an important component in the mentor-mentee relationship, as this allows for freedom of sharing between the individuals.

Studies of mentorship in EM show that mentored residents are two times more likely to describe their career preparation as excellent as compared to non-mentored peers, and ninety four percent stated that mentorship was the key to success in residency.

The investigators examined differences between mentorship programs and found that mentorship networks had the highest value to the mentee. These networks included a diverse subset of mentors able to give guidance in both mentees' professional and personal lives. Sixty three percent of EM residents reported having more than one mentor during residency. An additional benefit of mentorship networks allowed for mentees to meet via video conference and access individuals that may not be available at their site of training.

The authors also demonstrated that women and underrepresented minorities (URM) have additional barriers to obtaining career mentors which ultimately produced lower rates of promotion to leadership positions. Roughly twenty five percent of women at University of California reported "lack of mentorship as one of the most negative experiences in their career." Additionally, URM make up less than ten percent of practicing EM physicians and had significant barriers in obtaining effective career mentorship that also affects promotion rates to leadership roles. Finally, the authors concluded their discussion with their proposed approach to mentorship – nontraditional methods like mentorship networks obtain the highest benefit to the mentee and mentors alike.

-Brandon O'Keefe, MD (MedEd Fellow)
Benjamin Cooper, MD, MEd



Investigating Social Media to Evaluate Emergency Medicine Physicians' Emotional Well-being During COVID-19

Agarwal AK, Mittal J, Tran A, Merchant R, Guntuku SC. *JAMA Netw Open.* 2023 May 1;6(5):e2312708. PMID: 37163264

Multiple surveys and studies have confirmed that the COVID-19 pandemic has had negative effects on the mental health and burnout levels of healthcare workers; this is especially true for front-line workers such as EM physicians. The objective of this unique study was to utilize the publicly available Twitter posts of Academic EM physicians and residents to evaluate and identify changes in content and language to gauge well-being. A cross sectional approach was used to analyze posts over a 4-year period (2 years prior to March 2020 and 2 years after) and focused on 10 U.S. counties with the highest COVID-19 burden during that time frame. Program websites, photos, Twitter handles, and prior posts were cross-referenced to confirm identities resulting in content from 471 physicians and a total of 198,867 posts. Validated methods and language analysis models were used to evaluate themes, topic variation over time, and linguistic features correlating with mental health.

Results showed that EM Physicians and residents produced large volumes of Twitter posts both prior to and during the pandemic with use remaining fairly consistent. Themes of posts changed significantly across the time period analyzed; prior to March 2020, FOAM, resident education, gun violence, QI in healthcare, and resident professional societies were the top 5 subjects. After COVID-19 onset, predominate topics changed to healthy behaviors during COVID-19, pandemic response, vaccination, unstable housing/homelessness, and emotional support during the pandemic. Themes also shifted across the distinct phases of the pandemic initially including general COVID-19, public health/safety, masking, race/equity, and staying home then evolving to include vaccination, teamwork, hope, and the opioid epidemic. Language used became more negative during the pandemic with significant increases in references to loneliness, anxiety, anger, stress, and depression. This led the authors to posit open access social media as a possible novel method to observe physician wellness/mental health.

The authors acknowledge limitations including inherent bias towards those who are actually posting on social media (i.e.- they are more likely to share thoughts/opinions), selection bias towards the regions most affected by COVID-19, and the fact only Twitter was used vs other platforms. However, given the need for improved wellness resources and strategies to monitor physician/resident well-being, this interesting study highlights a potential innovative approach for institutions and educators to assess wellness and raise awareness of key topics that are significant to resident physicians.

-Amy Stubbs, MD

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The Norms and Corporatization of Medicine Influence Physician Moral Distress in the United States

Beck J, Falco CN, O'Hara KL, Bassett HK, Randall CL, Cruz S, Hanson JL, Dean W, Senturia K. Teach Learn Med. 2023 Jun-Jul;35(3):335-345. PMID: 35466844

Moral distress is described in this article as a condition in which a person's "moral integrity is seriously compromised, either because [they] feel unable to act in accordance with core values and obligations, or attempted actions fail to achieve the desired outcome." Moral distress in physicians has not been well studied. These authors sought to describe situations which cause moral distress for physicians using grounded theory methodology by conducting semi-structured interviews with 22 pediatric hospitalists and 18 pediatric residents. They found two major themes for causes of moral distress:

1. Cultural norms of medical education: the hierarchical structure of academic medicine caused moral distress when physician desire to advocate for patient care, values, and preferences was negated by unilateral attending decisions and discouraged as unprofessional or with negative evaluations.
2. Corporatization of the healthcare system: as an example, one resident explained, "In our ER we have triage nurses who order a bunch of tests without a physician laying hands on the kids to help with throughput, and it's distressing...that we are having to do these sorts of things".

They also felt that administrators' goals to increase patient volume and the bottom line without increasing staffing or resources led to moral distress. They described the disconnect between non-physicians making policies and protocols that had no physician input and were counterproductive to workflow and patient care. The authors conclude that physician-focused solutions to build resiliency are unlikely to successfully address these issues. They frame moral distress as a complex social problem heavily impacted by the culture of medicine and the healthcare system. They do an excellent job using qualitative methodology to further unpack moral distress. For those in leadership positions this is an excellent article to help you prime for exploring the moral distress of your learners.

- Matthew Gaubatz, MD (PGY-3) / Aaron Danielson, MD, MAS



Association of Surgical Resident Competency Ratings With Patient Outcomes

Kendrick DE, Thelen AE, Chen X, Gupta T, Yamazaki K, Krumm AE, Bandeh-Ahmadi H, Clark M, Luckoski J, Fan Z, Wnuk GM, Ryan AM, Mukherjee B, Hamstra SJ, Dimick JB, Holmboe ES, George BC. Acad Med. 2023 Jul 1;98(7):813-820. PMID: 36724304

ACGME milestone assessments have been associated with residency outcomes such as achievement of proficiency at the time of graduation, test scores, etc., but there is limited data on how they correspond to patient outcomes. The authors of this very interesting study looked at the final year milestone assessments for general surgery residents, and examined their association with the graduates' surgical complications. As an initial investigation and in order to maximize the study power, they focused on high-complication, frequently-performed procedures such as partial colectomy, and excluded any residents who had gone on to fellowship training. They limited their scope to procedures performed within 24 months of graduation, and looked at the universe of residents by getting data from the ACGME and CMS. While they primarily considered mid-final-year CCC assessments, they also looked at the last assessments prior to graduation, and further grouped certain milestones into domains of operative performance, professionalism and leadership. After accounting for patient risk factors, hospital factors, and surgeon case variation, the authors did not find any statistically significant associations between milestone ratings and patient outcomes. The outcome was contrary to the existing validity evidence on milestones and illustrates the complexity of using patient outcomes to assess educational interventions. The authors propose several theories regarding why they were unable to find an association, such as whether the milestone assessments of individual residents accurately reflect their performance, or whether the milestones may not encapsulate the skill set required to safely practice as a surgeon. The study is an important contribution towards the goal of implementing competency-based medical education, and provides a framework on how we may be able to do a similar investigation in our field.

-Nikhil Goyal, MD

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