

Articles in the second issue of the *Journal* encompass 4 themes: resident duty hours, simulation, professionalism, and resident burnout. Alone and in combination, these topics have been the focus of much discussion, and the December 2008 report by the Institute of Medicine (IOM) consensus committee heightened the intensity of the debate. The editorial by co-guest editor Kenneth Ludmerer, MD, explores the history of how residents learn from their patients and their faculty, and describes changes that simultaneously increased clinical demand and attenuated clinical learning in teaching hospitals. It also highlights the interconnectedness of 3 of the themes—duty hours, professionalism, and burnout.

Several works in the duty hour section describe tests of elements of the IOM recommendations. Auger et al (p 181) and Tessing et al (p 185) offer the perspectives of pediatrics chief residents and interns of a 1-month trial of a schedule fully compatible with the IOM-proposed limits. Mautone (p 188) summarizes 4 years of experience in a pediatrics program after eliminating overnight call. Several perspectives of program directors and other stakeholders included in the duty hour section suggest a link between the limits and “reduced professionalism.” In contrast, Gillespie et al (p 208) find other challenges to residents’ professionalism, including disrespectful behaviors and lapses in accountability or ethics, while Krain and Lavelle (p 221) report that perceptions of professionalism are mediated by clinical specialty and may incorporate attributes of professional skills.

Dr Ludmerer’s editorial notes that emotional and work stress are prominent features of physicians’ recollections of their residency experience. For some years, these stressors negatively affected some physicians in training, leading a condition that more recently has been termed “resident burnout.” IsHak et al (p 236) conduct a systematic review of the literature on burnout and describe its features and impact. Two articles focus on approaches to addressing burnout through a focus on wellness (Eckleberry-Hunt et al, p 225) and through Balint training to increase resident confidence in handling the psychological aspects of patient care (Ghetti et al, p 231).

If Dr Ludmerer’s editorial discusses the evolution of clinical education to its current form, the editorial by co-guest editor Richard Satava, MD, proposes revolution

through the use of simulation. Dr Satava proposes use of simulation ranging from common task-based forms using mannequins to new generations that include “in situ” simulation and simulation that takes the form of rehearsal, common to disciplines where haptic and cognitive performance must come together, such as individual and team sports and music, whether solo, ensemble, or orchestra. Krishnamurthy and colleagues (p 273) describe the use of cognitive simulation, focused on information management, emergency response, and decision strategy, as a supplement to faculty global assessments in these complex, real-world dimensions of clinical competence. A commentary by Salas and colleagues notes that simulation should be incorporated into the DNA of graduate medical education.

Dr Satava notes that in situ simulation can uncover systems-based errors and problems within teams in the care environment. Hamman et al (p 245) describe experience with in situ simulation across multiple health care settings and teams, adapting approaches from the study of teams in aviation and validating metrics for team dynamics and skills for team-based care. Hamilton et al (p 253) address team-based simulation of trauma resuscitation, focusing on team effectiveness and the relationship between team function and clinical outcomes. Two articles (Deering et al, p 260 and Best et al, p 264) show use of high- and low-fidelity simulation in clinical teaching and evaluation of obstetrics-gynecology residents, and a report on the use of simulation in teaching core competencies to interns (Shekhter et al, p 269).

Several articles in this issue focus on innovation in assessing the competencies or present practical approaches for adoption or adaptation by other programs. Chatterji and colleagues (p 287) continue their work deconstructing the competencies with an article focusing on evidence-based medicine as a dimension of practice-based learning and improvement. Paul et al (p 304) describe medical-legal partnerships as a means to teach residents about the social determinants of health while improving access to care. Meng et al (p 216) describe use of a 360-degree approach to assessing professionalism in the postanesthesia care unit. Weiss et al (p 316) expand the concept of the SOAP (subjective, objective, assessment, and plan) note by adding a second S to include teaching of health care error prevention as an integral part of every patient encounter. Swing (p 278) summarizes the work of the ACGME Advisory Committee charged with selecting assessment methods to facilitate national measurement of the competencies, and Duffy’s commentary (p 319) sets the stage for the accreditation model after next, suggesting that the most important element for the quality of resident

Ingrid Philibert, PhD, MBA, is Senior Vice President for Field Activities for the Accreditation Council for Graduate Medical Education and Managing Editor of the *Journal of Graduate Medical Education*.

Corresponding author: Ingrid Philibert, PhD, Field Activities Department, ACGME, 515 N State Street, Chicago, IL 60654, 312.755.7498, iphilibert@acgme.org

education after the competency phase is a focus on the quality of the clinical environment that offers the context for resident learning and participation in care.

The articles in the “ACGME News and Views” section echo the issue’s themes. Bush and Philibert (p 322) focus on work intensity and suggest judgment in the use of residents’ time and energies and application of “lean” principles as a companion, and potentially a prerequisite, to discussions about added restrictions on resident hours. Holt and Miller (p 327) analyze the ACGME Resident Survey data, focusing on the process for establishing compliance thresholds. Philibert et al (p 334), writing on behalf of the Work Group that developed the “blueprint” for the ACGME duty hour

standards, summarize the process of setting and implementing the standards and offer important lessons learned to guide the next set of revisions.

The articles in this issue offer a broad perspective of the 4 interrelated themes. They highlight challenges and inherent strengths of the current model of resident education, and they offer a look toward a future in which basic learning and advanced team training may occur away from the patient, facilitated by simulation.

This issue includes a listing of all reviewers who reviewed and suggested improvements to the manuscripts submitted to *JGME* in 2009 (p 338). The *Journal* is deeply grateful for their contribution.