seriously challenge physician well-being. Like swimming perpendicular to a riptide to prevent drowning, embracing physician self-care in our medical culture to prevent burnout is counterintuitive but crucial.

At my school, we have already included the above topics in our curriculum to bolster the numerous student support services offered. Students tell us that our burnout prevention classes are helpful and important. But mostly, they challenge us: Why don’t we do something about this “riptide”? It is not enough to teach students how to cope with a faulty system. They want it fixed!

Professionalism and quality of care are receiving much attention lately, and medical schools are taking measures to promote these issues. Correspondingly, we need systemic administrative changes in medical schools and teaching institutions nationwide to develop and support a culture of well-being at all stages of medical education and beyond. This is the surest way to prevent burnout in medical school and will go a long way to produce a resilient physician workforce that can deliver the quality of care and professionalism that our society rightfully expects.

Chantal M. L. R. Brazeau, MD
Associate professor of psychiatry and family medicine, New Jersey Medical School, Newark, New Jersey; brazeacm@umdnj.edu.

Rethinking Invasive Procedural Training

To the Editor: Residency programs should offer standardized procedural instruction in tandem with team training. Why do we propose this? Consider: At academic medical centers throughout the United States, residents perform the majority of invasive bedside procedures (e.g., central venous catheter insertion, lumbar puncture). Learning typically follows the apprenticeship model of “see one, do one, teach one,” and instruction is based on the variable approaches of their teachers. Additionally, achieving confidence and competence in the performance of these procedures is unique to each trainee. Some may approach mastery yet never attain it, and thus they are identified as unable to perform specific procedures independently at the conclusion of their training.

Some training programs have found ways to improve on this traditional learning approach by redefining procedural education. Simulation-based training1 (with feedback in a protected environment), ultrasound guidance2 (to minimize mechanical and infectious complications), use of a checklist3 (ensuring patient safe practice by adherence to critical steps), and team training4 (including direct observation) have been reported separately as beneficial. We and our colleagues at the University of Miami–Jackson Memorial Hospital combined these elements into a four-pronged approach, translating the knowledge and skill learned in the simulation center to the patient’s bedside where residents can develop the last piece of learning and proceed to mastery under attendings’ supervision. This combined approach enables residents to practice procedures both through simulation training and direct observation, to improve their confidence and competence, and ultimately to provide safer patient care.

Joshua D. Lenchus, DO, RPh, FACP
Assistant professor of medicine, Division of Hospital Medicine, Department of Medicine, University of Miami Miller School of Medicine, associate program director, Jackson Memorial Hospital Internal Medicine Residency Training Program, and associate director, University of Miami–Jackson Memorial Hospital Center for Patient Safety, Miami, Florida; jlenchus@med.miami.edu.

David J. Birnbach, MD, MPH
Professor of anesthesiology and public health, University of Miami Miller School of Medicine, and director, University of Miami–Jackson Memorial Hospital Center for Patient Safety, Miami, Florida.

References

How Valid Are Standard Self-Assessment Scales for International Medical Graduates?

To the Editor: In a recent article in Academic Medicine, Gozu et al1 concluded that international medical graduates (IMGs) are more likely to be less fatigued and have higher self-esteem and personal growth than U.S. medical graduates. They state that the self-assessment scales utilized in the study “have established validity evidence”: the Iowa Fatigue Scale, Perceived Stress Scale (PSS), Rosenberg Self-Esteem Scale (RSES), and Personal Growth Scale. However, we maintain that the cross-cultural validity of these scales for the extremely heterogeneous IMG group is questionable. Hence the data require cautious interpretation.

First, use of the Likert scale can generate variability of responses in different cultural groups.2 Chosen numbers on the scale may not accurately reflect the degree of the individual’s psychometric constructs. Individuals in some cultures may exhibit a negative-item bias, and individuals in others tend to avoid extreme options.3 Additionally, the threshold for reporting any psychological status publicly may also vary by the learned experiences of persons within individual cultures.

Second, the context of an IMG’s acculturation is essential in examining his or her psychological conditions. The questions in the PSS4 are so broad that they can mask some stresses provoked by unique challenges IMGs face during residency. Without stimulating a recall of each specific situation, subconscious and emotionally charged stresses may not surface.

Third, the type and heterogeneity of the populations previously examined for the scales should be equivalent to the population the authors investigated. The existing studies with the RSES sampled relatively homogeneous high school and college students,3,5 not culturally diverse medical graduates.