Life Cycle of the Chief Medical Resident

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APDIM SPRING 2018 CHIEF RESIDENTS MEETING
San Antonio, TX
Somebody has to do something, and it's just incredibly pathetic that it has to be us.

(Jerry Garcia)
Your Job Starts Today

• Actually – it has already started
• Your visibility as a Chief Resident begins the day you are selected
  – Role model
  – Future problem solver
  – Morale officer
  – Recruiting representative
  – Coverage for Chiefs
Job Description for a Chief Resident

- Scholarly Work
- Clinical Care
- Direct Teaching
- Mentee of PD
Concepts You Need to Understand Because Few Others Do!

- Population management
- Value Based Purchasing
- Accountable Care
- BundledPayments
- Global Health
- Milestones
- Adult Learning Theory
- Bioethics
- Cultural Humility
- Research Methods
The Seven Habits of Highly Effective People (Stephen Covey)

I. LEAD the residents
II. Relentless pursuit of how it should be
III. Begin on day one

IV. Don’t compromise, OPTIMIZE
V. There are two sides to everything
VI. Form as many alliances as possible
VII. Constantly update

* Getting to Yes, Fisher and Ury
Networking – Join AAIM Connect
Chief’s Reading List

- Daniel Goleman “Emotional Intelligence”, “Primal Leadership”
- The Spirit Catches You and Then You Fall Down (Anne Fadiman)
- Forgive and Remember: Managing Medical Failure (Charles Bosk)
- Sidney Dekker “Just Culture”, “Drift Into Failure”
- Kalet, Chou “Remediation in Medical Education”
- The Zander’s “Art of Possibility”
- Jim Collins “Good to Great”
- Brené Brown “Daring Greatly”
- Robert Wachter “Understanding Patient Safety”, “Internal Bleeding”
- Daniel Kahneman “Thinking Fast and Slow”
- Kotter “Leading Change”
- Kouzes and Posner “The Leadership Challenge”
- “Quality by Design”, “Value by Design” Bateldon, Nelson
- ACP Teaching Medicine Series (7 books) Ende, Skeff, Alguire, Wiese, Humphrey, Pangaro, Trowbridge

Don’t forget about studying for the Boards
The 15 Month Year

- **Final Quarter PGY III Year**
  - Preparation for next year
  - Schedules, policies, planning changes
  - Personal agenda

- **First Quarter Chief Year**
  - Assessment of baseline skills (all classes)

- **Second Quarter Chief Year**
  - Recruiting
  - Winter Doldrums
  - Milestone Based Formative Evaluations

- **Third Quarter Chief Year**
  - Matchlist preparation
  - Fellowship interviews
  - ITE and ABIM results
  - Program Evaluation
  - Choosing chiefs 1 year from now

- **Fourth Quarter Chief Year**
  - Milestone Based Summative Evaluations
  - Start mentoring new chiefs
  - Watch out for early disengagement
  - Plan end of year activities

If you are a Chief who is also a PGY III it is important that you do not forgo those formative experiences you need as a senior resident
The 15 Month Year

- Final Quarter PGY III Year
  - Planning/Skill Acquisition

- First Quarter Chief Year
  - Leadership/Change Management

- Second Quarter Chief Year
  - Teaching and Learning

- Third Quarter Chief Year
  - Wellness

- Fourth Quarter Chief Year
  - Evaluate and Revise
Last Quarter
Senior Year

• **PLANNING AND SKILL ACQUISITION**
  – Write down three things you would like to accomplish in your program next year
  – Next to each write what skills do you need to get started?
  – In the third column select a potential resource for that skill (human or otherwise)

<table>
<thead>
<tr>
<th>What I would like to accomplish</th>
<th>What skills do I need to make that happen</th>
<th>To whom or what can I turn to acquire those skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
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• Office
• **Boards preparation**—do **not** procrastinate
First Quarter Chief Year

- July – Honeymoon period
- Assess everyone’s skills
  - Some interns do not want to be there
  - Some residents are not ready to supervise
- Hospital survival skills
  - Be helpful but take care not to take over
- Be visible, Be everywhere
- Develop mentoring schedule with program director
- Summer activities
- Support efforts to decrease LOS, avoid readmissions, avoid HAC

August, Sept:
Same problems as July but you have less energy
People are getting tired

Boards
Change

Residents *always* view change as a bad thing (even when it may be good for them!)

- Change provides an opportunity for chief resident-to build trust and a sense of team-to strengthen your leadership role
- Sell the problem
- Reduce resident anxiety and frustration by involving residents in the change process
- Consider *all* concerned parties, Involve everyone in the solution
- Be skeptical of representatives of the *whole* program
- Control rumors, *Never* allow mob dynamics to occur
- Don’t release the solution until it is *final*
First Quarter Chief Year – Setting the Tone

• Change Management
  • John Kotter (“Leading Change”)
    – Create a burning bridge
    – Recognize champions
    – Articulate the new vision
    – Make sure everyone knows what is the vision
    – Trust your people and let them run
    – Publicize when things go well
    – Don’t let success get in the way
    – Pass on the change to the next generation
Your Change Management Plan

- Column 1 – What needs changing?
- Column 2 – Who needs to be involved?
- Column 3 – What is their motivation?
- Column 4 – How will you sustain the effort?

<table>
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<tr>
<th>What needs changing?</th>
<th>Who needs to be involved?</th>
<th>What is their motivation?</th>
<th>How will you sustain the effort?</th>
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<td>3)</td>
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</tbody>
</table>
Chief Resident Do’s and Don’ts

DO…
1. Understand that all decisions are a new precedent for everyone
2. Keep your temper (except when you “lose it” on purpose)
3. Remember that no one really speaks for the whole program
4. Consider a second person be present and write everything down
5. Be receptive, flexible and respectful, embrace new ideas
6. Be willing to make your decision public

DON’T…
1. Form an opinion/make promises before all the facts are in
2. Lose enthusiasm
3. Fall back on previously learned skills
4. Try to please everyone (residents, faculty) or no one
5. Assume that operational, clinical and financial imperatives are someone else’s job
6. Take criticism personally
7. Allow Chiefs to be split
Second Quarter Chief Year

- Look for the troubled residents/remediation
- Plan interview season with program director
- **Sentinel events are happening! Do you recognize them?**
- Duty Hours: 23:59 – uncommitted, 24:01- inefficient
- Semi-annual Milestone reviews
- Fellowship match in December, ROL due in November
- Whining begins

**Recruiting:**
- The program director will be preoccupied for the next 3 months
- Rely on Chief Residents for creative initiatives
- Anticipate and appreciate the emotional drain of recruiting
Learners

• PGY 1 – Teach me, please teach me
• PGY 2 – Teach me if you can find me
• PGY 3 – Teach me ----

    --- If you dare
Models of Learning

**Bloom**

- **Does**
- **Shows**
- **Knows**

**Pangaro**

- **REPORTER**
- **INTERPRETER**
- **MANAGER**
- **EDUCATOR**

**Miller**

**Dreyfuss**

Figure 2. Bloom’s taxonomy, after Atherton (2011).

The “GME Envelope of Expectations” AKA - Milestones

- **Expert**
- **Proficient**
- **Competent**
- **Advanced Beginner**
- **Novice**

- **Aspirational Goal**
- **Finishing PGY 1**
- **Entering PGY 1**
- **Intermediate Level Resident**
- **Graduating Resident**
Behavioral Model of Education

• The “One Minute” Preceptorship
  Presentation
  Percent of Encounter
  Correct Errors
  Positive Feedback
  Teach General Principle
  Probe for reasoning
  Obtain a Commitment

The 5 Microskills - Ende
### Clinical Reasoning Step by Step

<table>
<thead>
<tr>
<th>1) Describe the patient (epidemiology, risk factors)</th>
<th>2) Pinpoint organ system involved and refine true chronology of events</th>
<th>3) Use Semantic Qualifiers to create a Problem Representation*</th>
<th>4) Consider the Differential Diagnosis (Mechanism of Injury)</th>
<th>5) Choose an Illness Script and Test hypotheses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Circulatory</td>
<td>Acute/Chronic</td>
<td>Infectious</td>
<td>HISTORY</td>
</tr>
<tr>
<td>Sex</td>
<td>Respiratory</td>
<td>Sudden/Gradual</td>
<td>Neoplastic</td>
<td>PHYSICAL</td>
</tr>
<tr>
<td>Underlying illness</td>
<td>Digestive</td>
<td>Delayed/Abrupt</td>
<td>Immunologic</td>
<td>LABORATORY</td>
</tr>
<tr>
<td>Risk Factors</td>
<td>Renal</td>
<td>Progressive/Waning</td>
<td>Metabolic</td>
<td>IMAGING</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Immune/Systemic</td>
<td>Constant/Intermittent</td>
<td>Toxic/trauma</td>
<td></td>
</tr>
<tr>
<td>Etc.</td>
<td></td>
<td>Solitary/Recurrent</td>
<td>Delivery</td>
<td></td>
</tr>
</tbody>
</table>

* Fried
R2C2 Feedback Model
(use the word “Feedback”)

1) ASK

2) TELL

3) ASK

Rapport Building
Explore Reactions
Explore Content
Coach for Change

Sargeant J et al

Lenox Hill Hospital
Northwell Health™

PM21

DONALD AND BARBARA ZUCKER SCHOOL OF MEDICINE
AT HOFSTRA/NORTHWELL
Cognitive Load

- Intrinsic Load: What we use to figure things out
- Germane Load: Collections of information we file away to be used as a chunk
- Extraneous Load: Information that is distracting
- Are struggling learners...
  - Making the necessary connections to turn parts of the “Intrinsic Load” into Germane Load?
  - Are they distracted by Extraneous Load crowding out their working memory?
Plan a Simple Curriculum

What Should Your Learners Know?

What Do Your Learners Know?

Decide on an overall learning objective

Create SMART* Learning Objectives

Decide How You Will Deliver This Learning**

How Will You Know That Your Learners Have Got It???

Learning Needs Assessment

*SMART = Specific, Measureable, Achievable, Relevant and Timely

**Lecture, Workshop, Small Groups, Self Directed, FOSCE, Etc

***Pre/Post, Written Report, Group Debrief, SOSCE
Third Quarter Chief Year

- Interviews continue, NRMP rank list due
- Program director re-emerges from recruiting haze
  - Suggest a vacation!
- Compliance gets sloppy
- Winter doldrums
- Begin to plan next year’s rotations
  - Set PGY-1 rotations for the coming year
  - Confirm number of rotators from Family Medicine, Ophthalmology, Emergency, Psychiatry, etc.

Have PGY I’s registered for USMLE III?
Anticipate Winter Doldrums

- Occurs in residents, faculty, staff, program director, and chief residents
- Resembles seasonal affective disorder
- You can modulate the severity
- Sometimes simple acknowledgment helps
- Plan activities to encourage positive attitudes
- Design ways for residents to vent constructively
- Don’t overreact
Wellness

• ERASE (Exercise, Relaxation, Activities, Supportive Relationships, Emotional Expression)
• Critical Event Debriefing, Schwartz Rounds
• Talent Show, Happy Hour(s)
• Theater or Sporting Event Outing
• Retreats
• Start planning and publicizing in Winter even if event is scheduled for Spring

Mindfulness: actively noticing new things
  Meditation vs Situational Awareness
    Somm.mp4
    1minutemeditation.mp4

Mindset: The Power of “Yet” (Carol Dweck)
  Change Pass:Fail into Yet:Not Yet

Resilience: You can’t turn off anxiety but you can learn to live with it (CBT - Greg Eels)
  Social Connection (Do something for someone, Role models)
  Attitude (Permanence, Pervasiveness, Personalization)
  Values (Balance ego and insignificance)
  Emotional Acceptance (Learn to live with uncertainty)
  Silliness (Don’t forget to have fun)
Wellness Exercise

• A patient is transferred to the ICU with severe sepsis. On review it appears that the tachycardia, tachypnea and hypotension were all on display for 2 days prior to the transfer. The intern following the patient is considering leaving the program

<table>
<thead>
<tr>
<th>Wellness Component</th>
<th>Mindfulness – noticing things</th>
<th>Mindset – Change in perspective</th>
<th>Resilience – Take strength, Living with uncertainty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe a course of action you can suggest to this intern in each of the areas of wellness</td>
<td></td>
<td></td>
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</table>
Impaired Physicians (Statistically 2% of us)

- Key warning sign – Change in behavior, appearance
- Spotty intermittent behavior (on–off–on–off)
- Angry
- Careless

- Fatigued (falling asleep in conference)
- Slovenly
- Do not confront them
- Talk to your program director
- They will need to be taken off duty until cleared

“Help, help, there’s a homeless man starting an IV on the woman in the bed next to me.”
Fourth Quarter Chief Year

• Time to evaluate and revise
  • What worked, what didn’t
  • Revise house staff manual, rotations, curricula
• Summative evaluations
• Annual Program Evaluation
  • ABIM Certifying Exam Results
  • ACP ITE Results
  • Resident Survey
  • Faculty Survey
  • The Match (analyze results, survey)
  • Meeting/Minutes/Action Item List
• Awards (faculty/residents)
• Graduation
• Board review
• Mentoring new Chief residents

Watch out for early disengagement
<table>
<thead>
<tr>
<th>Critical Deficiencies</th>
<th>Ready for unsupervised practice</th>
<th>Aspirational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not collect accurate historical data</td>
<td>Consistently acquires accurate and relevant histories from patients</td>
<td>Obtains relevant historical subtleties, including sensitive information that informs the differential diagnosis</td>
</tr>
<tr>
<td>Does not use physical exam to confirm history</td>
<td>Seeks and obtains data from secondary sources when needed</td>
<td>Identifies subtle or unusual physical exam findings</td>
</tr>
<tr>
<td>Relies exclusively on documentation of others to generate own database or differential diagnosis</td>
<td>Consistently performs accurate and appropriately thorough physical exams</td>
<td>Efficiently utilizes all sources of secondary data to inform differential diagnosis</td>
</tr>
<tr>
<td>Fails to recognize patient’s central clinical problems</td>
<td>Uses collected data to define a patient’s central clinical problem(s)</td>
<td>Role models and teaches the effective use of history and physical examination skills to minimize the need for further diagnostic testing</td>
</tr>
<tr>
<td>Fails to recognize potentially life threatening problems</td>
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</tr>
</tbody>
</table>

There are 21 more of these covering all six general competencies. 5 PC, 2 MK, 4 SBP, 4 Prof, 4 PBLI, 3 ICS
<table>
<thead>
<tr>
<th>Critical Deficiencies</th>
<th>Novice</th>
<th>Advanced Beginner</th>
<th>Ready for unsupervised practice</th>
<th>Aspirational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not observe interns at work</td>
<td>Works with interns only early in the year</td>
<td>Works with interns and residents every 3 – 6 months</td>
<td>Meets with residents and interns regularly</td>
<td>Rounds regularly</td>
</tr>
<tr>
<td>Plays enforcer rather than coach</td>
<td>Teaches fundamental organizational skills</td>
<td>Identifies struggling trainees and helps to correct routine issues</td>
<td>Teaches a wide range of skills from work rounds to specific work-ups to multidisciplinary team management</td>
<td></td>
</tr>
<tr>
<td>Waits to be told what to do</td>
<td>Makes assignments randomly and evenly</td>
<td>Takes trainees needs into account making assignments</td>
<td>Readily contributes to program evaluation and planning</td>
<td></td>
</tr>
<tr>
<td>Only teaches medical knowledge</td>
<td>Involved in program meetings as a reporter</td>
<td>Participates in program meetings even adding to the discussion</td>
<td>Fully integrated into patient satisfaction and performance based initiatives</td>
<td></td>
</tr>
<tr>
<td>Plays favorites</td>
<td>Supports improved efficiency and pt experience</td>
<td>Awareness of and promotion of performance based initiatives</td>
<td>Innovates for Quality and Safety</td>
<td></td>
</tr>
<tr>
<td>Joins into frustration and anger</td>
<td>Works with interns only early in the year</td>
<td>Works with interns and residents every 3 – 6 months</td>
<td>Identifies areas that need improvement (communication skills, handoffs, etc) and designs and implements curricular interventions</td>
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</tr>
<tr>
<td>Believes that pt. experience is not in job description</td>
<td>Teaches fundamental organizational skills</td>
<td>Identifies struggling trainees and helps to correct routine issues</td>
<td>Designs scholarly work to share with others (workshops, papers, etc)</td>
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</table>

Comments:
60 yo M presents with a chief complaint of fevers, chills, redness and swelling from the right anterior mid shin to the knee. He was recently admitted to the hospital a week prior for pneumonia. He has history of DM2 on insulin. He takes no other meds. On physical exam, temperature is 102 F, blood pressure is 110/65, pulse rate is 105/min, and respiratory rate is 19. His physical exam is normal, except for the right shin, where there is an area of erythema, edema, and tenderness, without signs of lymphatic spread. Lab values show a white count of 15K and a vancomycin trough of 18. Blood cultures obtained at admission grew MRSA with a vancomycin MIC of 5.

Which of the following is the most appropriate management of his antibiotic management?

a) Add Rifampin and Levaquin
b) Continue Vanc at current dose
c) Decrease Vancomycin dose
d) Switch Vancomycin to Levaquin
e) Switch Vancomycin to Daptomycin

Step one: Read the first sentence
Step two: Jump to the question and the responses
Step three: This is a question about vancomycin resistance.
Step four: Look for info in the stem that speaks to the issue of interest
Step five: Know why the right answer is right and the wrong answers are wrong
Step six: Can you think of a way to re-write the question that will make one of the wrong answers correct?
Quality Improvement

“The 5 Whys”

Pareto Chart
# Improvement Plans

<table>
<thead>
<tr>
<th>Problem Identified</th>
<th>Find the Root Cause</th>
<th>Small Test of Change</th>
<th>If Successful, How to Scale It Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low or Dropping Board Pass Rate</td>
<td></td>
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<tr>
<td>Resident Survey Indicates high Service:Education Ratio</td>
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<tr>
<td>Clinic Outcomes Review Indicates High Healthcare Inequity</td>
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<tr>
<td>Residents Feel They are Not Getting Post-Rotation Oral Feedback</td>
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</table>
Special Responsibilities for the Chief Resident

• Setting example and expectations

“If you despair, your housestaff will despair.
“If you are disdainful of patients, your housestaff...
“If you are contentious with other services...
“If, on the other hand, you conduct yourself with optimism, openness, compassion, and kindness toward patients, colleagues, and other services, that example will be the one taken.
“It is the one I strongly recommend.”

Faith T Fitzgerald 3/93