Your chiefly role as an inpatient attending….

Moving beyond “seen and agree”

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Introduction

• Our goals and objectives, what you will gain:

  • Understanding the complicated role of an inpatient attending
  • Tools to guide your teaching, organization, leadership
  • Preparation for challenges that you might face
  • Increased comfort and excitement for this next step!
Outline

• Setting expectations

• Rounding strategies and supervised autonomy

• Clinical teaching on the fly

• Feedback

• Resources
Making Expectations Clear

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Associate Chair for Education
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Establishing Expectations

• Decide in advance what your expectations are
  • Of yourself!!
  • Of the Upper Level Resident
  • Of the Interns
  • Of the Medical Students

• Write them down and give them to everyone in advance; be specific and detailed

• Most important: promise to stick to a daily schedule, keep your promise!!!

• Meet on the first day for 30 minutes for introductions, to review expectations, and answer questions
Day 1 Meeting Agenda

- You don’t have time not to do this

- Introductions
  - Why?
  - What to include?

- Reviewing expectations
  - Not negotiable

- Answering questions
Staying on Course

• Enforce expectations consistently

• If things are not going as you would like (and they almost certainly won’t the first time you do this) meet with individuals or the whole team as needed to go over expectations again
Have Fun !!!
Case for Discussion

• A week before you start on service, you send your expectations document out to all team members

• Later that day you get an email from the team upper level resident, whom you know from past experience to be a bit on the arrogant/entitled side

• S/he says that s/he cannot support your expectation that patients will be presented at the beside and asks (?demands) that you send the team a follow-up withdrawing that expectation

• How will you handle this?
Rounding Strategies

Bill Novak, MD
Associate Program Director
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Rounds Efficiency

• Round on your feet

• Finish in two hours or interns will disengage

• Present only summary and problem-based plans

• Present at the bedside!
Why Present at the Bedside?

• Discuss only once

• Observe degree of illness prior to plans

• Affirm patient participation in plans

• Instill patient’s trust in the team
Resident Leadership

• Ensure intern and resident always enter the room first

• Stand next to the resident, across from the intern

• When you are questioned by the intern or patient, pause and look directly at your resident

• Tolerate uncomfortable silence till your resident speaks
Resident Autonomy

- Encourage pre-rounds consults and interventions
- Redirect management questions back to the residents
- Require interns to run updates first past the resident
- Cope with letting go by using the EHR to spy...
Resident Redirection

• Revisit the often forgotten chief complaint

• Highlight data

• Ask how the proposed intervention will alter management
Role Modeling

- Emphasize good communication

- Demonstrate clinical reasoning & decision-making
  - Think out loud

- Most importantly, have fun!
Case: It’s September with a PGY 2 resident team leader

- Team is reluctant to present at the bedside, more comfortable presenting/ firming up plans first in the hall
- Rounds -long presentations/discussions repeated at bedside
- Only able to see 1/3 of the patients before noon conference -- Forget about any time for teaching
- On entering rooms the resident speaks little, you lead discussions
- Interns are speaking to you - you guide decisions, not the resident
- Interns get distracted after an hour and break off to write orders

How could you make things better?
Clinical teaching on the fly....

Debra L. Bynum, MD, MMEL
Director, Internal Medicine Residency Program
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Goals of the clinical teacher...

• Diagnose the patient
  • Ask questions

• Diagnose the learner
  • Get a commitment
  • Probe for supporting evidence (thought process)

• Teach
  • Teach general rules
  • Give feedback
  • Reinforce what was done right..
  • Correct mistakes
One Minute Preceptor

• 1. Get a commitment
• 2. Probe for supporting evidence
• 3. Teach general rules
• 4. Reinforce what was right
• 5. Correct mistakes
30 second preceptor....

• **What?**

• **Why?**

• **When....**
Tips for clinical teaching....

Be mindful of expectations you have set (time/efficient rounding)

Remember what you have learned to maintain resident autonomy

Be kind and humble, create a “no risk” environment

*ask questions, set the culture

*balance need to correct mistakes in front of group (when students/learners need to know what is wrong) vs feedback that should be given in private
Case...and practice....

- The night float resident is presenting to the team their new patient....
- “65 year old man, admitted with shortness of breath and lower extremity edema.....
- Massive LE edema, clear lungs.... And JVD to earlobes... And a blood pressure of 95/70....
- Assessment and plan – admit, treat for heart failure, and diurese
- You are concerned about potential tamponade....

1. What is usual practice for this type of interaction?

2. Use What/Why/When... Practice what you might say..

3. How can you incorporate feedback for the resident and the team?
Giving Feedback as a Chief:

*Leave the Sandwiches to Lunch Conference...*

Maureen Dale, MD
Assistant Professor of Medicine, University of North Carolina
Important Things to Remember about Feedback as a Chief

• You can’t give quality feedback unless you have first set expectations

• Feedback is for everyone—encourage residents and students to have feedback sessions too

• Your feedback matters to residents—this should be reassuring (but make sure you understand this responsibility)
Base your feedback on direct observations

• This helps make it less personal, and more about the work

• It also makes the feedback more useful and credible
Feedback should be timely and should happen regularly

- Feedback should happen throughout a rotation— not just at the end! Give people an opportunity to demonstrate change.

- It’s better to give feedback as close/soon as you can after an event, but make sure you think about what you want to say.
Start with a self-assessment

• Can help you find a way to frame the conversation

• Helps prioritize feedback— are you both on the same page?

• Can give you a sense of how you are doing as an attending

  “How did X go for you?”

• “How has it been managing the team as an upper level?”
Nobody likes a feedback sandwich

• ...Or at least they see it for what it is....

• Good feedback shouldn’t just feel like it’s serving as bookends!

• A different approach is starting with the strengths, and then moving to the areas for improvement
Make sure the feedback includes a plan...

Don't forget to follow up, reassess, and reinforce this feedback
Don’t forget to ask for feedback

• Don’t let this part scare you—ask for feedback from everyone: students, interns, residents

• It helps set up a healthier environment for feedback, and can also be enlightening as a new attending—sometimes there are things you don’t notice!
Feedback Case

You are on service with a new second year resident who is trying to do it all:

Resident puts in orders on rounds while students/interns present
   He breaks away from time to time to call consults
   He leads discussions with patients calmly and clearly, has a good grasp on each patient’s condition, and does an excellent job diffusing a difficult situation with a family

Case manager and a few nurses express frustration with poor communication with the team (interns unsure of patient plans)

You notice that a lot of medication and lab orders are being placed by the resident, not the interns, often late at night....
Summary

- Set expectations

- Round efficiently, use bedside rounding

- Deliberately encourage resident autonomy (not abandonment....)

- Role model

- Don’t just jump in... Ask ”What, Why”... Then When...

- Don’t be afraid of feedback... give it, ask for it... and be specific
Questions and Discussion