Welcome to the Chief Residents

When everyone else’s noise is your signal - Simple principles of Leadership for the Chief Resident

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Pangaro 2020
Disclosure

• I have no financial conflicts.

• The opinions and assertions expressed herein are mine and do not necessarily reflect the official policy or position of the Uniformed Services University or the Department of Defense.
What is your role?

Chief residents
- support the key missions of their residency program and
- provide direction for their residents,
- functioning as key mentors and advocates.

“Opportunity for leadership in the clinical setting.”

Northwell Health
Why are we here?
Beyond survival, personal goals for the year

• “This is what I did.”

• Write down a few of your interests or themes.
Simple principles of leadership

Embrace complexity, act with simplicity.

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A promise of duty and expertise
Why are we here as teachers?
The goal: progressive independence of the learner

after Stanford FacDevPropgram
6 ACGME competencies, 7 CanMed roles

13 EPAs for students

23 milestones
23 sub-competencies
The rhythm of RIME:

H&P.............. ......S.O............ Reporter
Assessment....... ....A............. Interpreter
Plan............... .....P............. Manager/
                  Educator

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<table>
<thead>
<tr>
<th>Manager/Educator</th>
<th>PGY1</th>
<th>PGY2</th>
<th>PGYn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpreter</td>
<td>X</td>
<td>X</td>
<td>Xx</td>
</tr>
<tr>
<td>Reporter</td>
<td>X</td>
<td>XX</td>
<td>XXXX</td>
</tr>
</tbody>
</table>

x = proficiency with a patient

What’s in the core for your specialty?
Expectations = expertise and duty

- Of residents
- Of yourselves
- Matching leadership style to needs and situation
Your expertise and duty = Leadership

- a process
- whereby chief residents
- influence
- residents
  - to assure patient care
  - and to progress to independence

Based on Northouse, 8th edition, 2019
Education = leadership

- E-ducation
  - Ex- ducere
  - to lead out of (dependency)
- Ped-agogy
  - leading a child (to adulthood)

→ Leading = balance of tasks and relationships
### Relationships (duty)
- focus on feelings
- flexibility
- motivating
- independence of others
- “transformation”
- influence

### Tasks (expertise)
- focus on understanding
- consistency, standardization
- achieving outcomes
- consistency of others
- “transaction”
- control

After Blake, Mouton, 1985; Northouse, 2019
Three cases and leadership principles

1. The beginner or resident with skill problems

2. The resident with problems in professionalism

3. The advanced resident
The beginner or resident with expertise problems

- Dr MR is a 32yo PGY1
  - an accountant before Osler Med School.
- In October MR starts a clinic month
  - outpatient attendings tell you MR seems to get all the clinical facts,
  - but does not offer own diagnoses, much less a plan.

- What are minimal expectations?
UNDERSTANDING ➔ ACTION

reporter/interpreter ➔ manager/educator

medical school ...... residency
Frame of Reference

**Performance Dimensions**

**REPORTER**
- Gather a history and perform a physical exam
- Document a clinical encounter in the patient record
- Provide an oral presentation of a clinical encounter
- Collaborate as a member of an interprofessional team

**INTERPRETER**
- Prioritize a differential diagnosis following a clinical encounter
- Recognize a patient requiring urgent or emergent care
- Recommend* and interpret common diagnostic and screening tests

**MANAGER**
- Enter and discuss orders and prescriptions
- Give or receive a patient handover to transition care responsibility
- Obtain informed consent for tests and/or procedures
- Perform the general procedures of a physician

**EDUCATOR**
- Form clinical questions and retrieve evidence
- Identify system failures and contribute to safety and improvement
# Gathers and Synthesizes Essential Information

1. **Gathers and synthesizes essential and accurate information to define each patient’s clinical problem(s), (PCL)**

<table>
<thead>
<tr>
<th>Critical Deficiencies</th>
<th>Observer</th>
<th>Reporter</th>
<th>Interpreter</th>
<th>Aspiration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not collect accurate historical data</td>
<td>Inconsistently able to acquire accurate historical information in an organized fashion</td>
<td>Consistently acquires accurate and relevant histories from patients.</td>
<td>Acquires accurate histories from patients in an efficient, prioritized, and hypothesis-driven fashion.</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>Does not perform an appropriately thorough physical exam or misses key physical exam findings.</td>
<td>Seeks and obtains data from secondary sources when needed.</td>
<td>Performs accurate physical exams that are targeted to the patient’s complaints.</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>Does not seek or is overly reliant on secondary data.</td>
<td>Consistently performs accurate and appropriately thorough physical exams.</td>
<td>Efficiently utilizes all sources of secondary data to inform differential diagnosis.</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 patient’s central clinical problems</td>
<td>Inconsistently recognizes patients’ central clinical problem or develops limited differential diagnoses.</td>
<td>Uses collected data to define a patient’s central clinical problem(s).</td>
<td>Effectively uses history and physical examination skills to minimize the need for further diagnostic testing.</td>
<td>R, I, M/E.</td>
</tr>
</tbody>
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REPORTER

Gather a history and perform a physical exam
Document a clinical encounter in the patient record
Provide an oral presentation of a clinical encounter
Collaborate as a member of an interprofessional team

INTERPRETER

Prioritize a differential diagnosis following a clinical encounter
Recognize a patient requiring urgent or emergent care
Recommend* and interpret common diagnostic and screening tests

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Are interns ready for roles as reporter and interpreter?

<table>
<thead>
<tr>
<th>EPA 1: Gather a history, perform physical examination</th>
<th>78</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPA 2: Develop a differential diagnosis</td>
<td>72</td>
</tr>
<tr>
<td>EPA 3: Recommend and interpret diagnostic and screening tests</td>
<td>70</td>
</tr>
<tr>
<td>EPA 4: Enter and discuss orders/prescriptions</td>
<td>69</td>
</tr>
<tr>
<td>EPA 5: Document a clinical encounter</td>
<td>98</td>
</tr>
<tr>
<td>EPA 6: Present orally a patient encounter</td>
<td>94</td>
</tr>
</tbody>
</table>
Beginners: Situational and Path-Goal Approaches

• Situational*: the balance of direction and support
  • With beginners coaching should BE EXPLICIT about what success looks like
  • On going partnering to have gradual improvement over time
  • Feedback, Stimulation, “Cortrosyn”

• What’s your assessment of how ready her current teachers are to support this?
  • What do you as chief need to do to create conditions for her progress?

*Blanchard, 2013
Beginners: Situational and Path-Goal Approaches

• Path-Goal:
  • GOAL: Can Dr MR tell you what readiness for PGY2 looks like?
    • Does this fit with her own wants and needs?
  • PATH: Can Dr MR describe the steps in patient care?
    • Does Dr MR feel confident about following these steps?

• What’s your assessment of current teachers are to support this? –
  • What do you as chief need to do to create conditions for MR’s progress?
The resident with problems in duty

- Dr JN, PGY2, has excellent procedural skills but publicly berates nurses, staff and junior members of the team.

- What might feedback and coaching look like?
Transformational Approach*

• Role modelling and inspiration
  • Not angry with Dr JN
• Considering the individual
  • What’s the need underneath
• High expectations
  • Duty = professional relationships
  • Stop this at once (suppression ,“dexamethasone”)

• What do you as chief need to do to create conditions for MR’s progress?

*Burns, 1978; Bass, 2006
The advanced resident

- Dr JJ, PGY2, shows proficiency in patient care and in directing junior house officers.
- Research oriented: publishing case reports and working with faculty
- Micromanages the late year PGY1s.
- Wants to be selected as Chief Resident.
Leading Residents for Adaptivity

- **Technical challenges**: what micromanagement can work for
  - known problems, known solutions
  - task emphasis; path-goal works

- **Adaptive challenges**: from manager to educator, “aspirational”
  - Unknowns – need for independent problem solving
  - Relationships and support

- **Your own Leadership behaviors:**
  - Identify the challenges – “How can I help?”
  - Get on the balcony and give the work back
  - Protect voices from below; regulate distress

Heifetz, 1997
Adaptivity Checklist for the Chief Resident

Communication/Interpersonal Skills:
• Addresses conflict diplomatically; conducts difficult conversations
• Is approachable, listens to others
• Facilitates discussions among residents; group decision-making
• Maintains confidentiality; recognizes boundaries

Advocacy Skills:
• Able to present viewpoints effectively
Adaptivity Checklist for the Chief Resident

**Ability to Develop Others:**
- Encourages and facilitates development in other residents

**Personal Skills That Support Leadership:**
- Manages one’s emotions (keep cool)
- Organizes well, keeps timelines
- Attends to details
- Demonstrates flexibility; adapts

Marvel, Family Med, 2018
Leadership as creativity, empowerment

Teaching = fostering independence = leadership
• With beginners - be explicit, help them visualize the path
• With others: “How can I help?”
• Thank you for your attention!

• Revise your own goals for the year!