IN TRAINING: PART I

# "The Ten Commandments for Transitioning from Intern to Junior": Foundation for a Clinical Team Management-Leadership Curriculum

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*A Challenge*. Despite the fact that residents play a critical role in clinical team management, there is very little literature that describes management (or leadership) curricula for residents. Although one qualitative study identified the descriptive themes of the hierarchical management skills necessary for chief residents,[1] beyond lists of roles and responsibilities distributed by professional societies and individual training programs, standalone workshops, and extensions of training parallel to or outside of residency training programs (i.e. MBA with a focus in medical management), there has been very little attention paid to determining and meeting the needs of resident clinical team managers. The need for team management training has been suggested as a means for reducing patient care errors in teaching hospitals,[2] and two articles[3,4] have broken ground in making the case for formal management and leadership training during residency. This scarcity of literature stands in direct contrast to the on-the-job managerial training deemed mandatory for young professionals outside of medicine, whose responsibilities may be considered far less critical than management of patient care teams. As articulated by Blumenthal et al., "For most [residency-level]...physicians, leadership responsibilities are new and unexpected in large part because medical school and residency training do not emphasize them."

*An Unexpected Solution*. To increase the impact of our two-day, System/Patient Care Orientation for new interns, our residency training program has held monthly "wrap-up" sessions in July through December of each academic year. The wrap-up sessions are mandatory one-hour sessions where interns come and share what is on their mind. Chiefs are excused so that interns can speak without reservation. Everything that is said is held as confidential. The session is facilitated by me, an education specialist with a professional license in coaching and experience in facilitation of teams.

Historically, wrap-up sessions in our program have had three primary objectives. One was to expedite interns' learning of the system they work in by providing a venue for them to share information about resources. This objective increased functional efficiency and also eased some of the uncertainty and stress of not knowing where to get what they need to accomplish quality patient care. Second was for new interns to begin to develop a sense of community and understand that they were all sharing a similar training experience. A noticeable calm permeates the room when interns understand that they are all experiencing similar challenges. Third was to collect information about interns' perceptions of the quality of education and supervision they were receiving so that feedback and best practices could be shared anonymously and implemented by junior and senior residents and faculty attendings and preceptors.

During the summer/fall of 2011, a fourth objective was added by our interns. They indicated a desire to compile a list of all the things that were "driving them crazy" about the ways their junior and senior residents managed clinical teams. Creating this list, they said, had two functions. First, it would allow them to vent and problem solve with each other in a confidential environment. Second, the list could be resurrected as they approached their own transition to resident so that they could remember the things they said they would never do and be intentional about the team management strategies they would implement with the new class of interns.

With our program's April transition, I resurrected the list our interns had produced earlier in the year. Residents' responses to what they had contributed to months ago were somewhat surprising. Initial comments included: "This is great....Where did you get this list?" and "This is funny; who wrote it?" I was instantly reminded of the short memory span of beginning interns! Here is the list, now deemed the "Ten Commandments":

1. *Thou shalt know that the best way to motivate interns is to enhance our ownership of patients by telling us when you make changes or add something to our orders*. We hate coming in and not knowing what is going on. Consultants come in and do the same thing, and it is frustrating. As residents you tell us to "own our patients," but your actions don't allow this. Don't act like a dictator. Involve us.
2. *Thou shalt know that when the census is high, you should take the lower learning-point patients and leave us the complex patients*.
3. *Thou shalt not tell interns to "step it up"!* This is not helpful. As the resident you should actually show us what you mean and give specific modeling for increasing efficiency.
4. *Thou shalt not just tell interns*

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*that our notes are bad*. Residents should give us a good example of notes and dictations so we can see what the difference is. This makes a huge positive impact.

5. *Thou shalt not get so stressed out!* Working with a stressed out resident is the worst thing possible for interns. Residents have to manage their stress and not let it show. You have to give us the confidence that you know how to triage tasks and manage the team. Freaking out and acting like the sky is falling over every little thing that comes up only creates anxiety for the team. When residents are all over the place, it's just awful for the intern.
6. *Thou shalt always pre-round and go through the plans for patients with interns*. Residents have to ask us how we interpret tests and what our management plan is. You also have to ask questions to help us get our management zipped up for the presentation with the attending. We need residents to check our thinking and share their thinking. Residents want us to improve. We want to improve. So help us improve.
7. *Thou shalt set the expectations and tone of the team by requiring attendance at attending rounds rather than having one intern off getting something else done*. The resident has to set and enforce this expectation to maximize our learning and make the team funtion well.
8. *Thou shalt role model when something needs to be looked up*. Residents should go through the process with us to make sure we know how to access all available resources. You should never say: "Just do this because this is what I've seen done, and I am the resident."
9. *Thou shalt provide specific and immediate feedback when you think we don't know our patients*. We probably *can* share what is going on and tell you why we don't know some information. The reason for "not knowing our patient" will always be context dependent, and we would like to be able to ask how we can get the information we need. Residents should not spread general gossip that "this intern never knows his/her patients." That's not the way to motivate us or to promote our learning.
10. *On the first day of a rotation, thou shalt organize days off and make sure that responsibilities and expectations for clinical work and teaching are clearly communicated*. Residents who do this half way through the rotation (or not at all) are the worst to work with. Residents who make room for planning and regular meetings are the best to work with.

Subsequent conversations about the commandments with interns-about-to-be-residents have been insightful. They asked, "How about using the commandments as a starting point to create a curriculum for resident team management skills?"

Hence, a new curriculum is under development with a team of new residents providing the vision for what the curricular objectives should be and how the curriculum will be taught. They feel that learning how to manage through role modeling or reading through a list of responsibilities is largely ineffective. In the words of one intern, "Let's face it...that kind of training tends to produce two kinds of team managers...either hands-on micromanagers who stifle the initiative, creativity, and motivation of their interns...or hands-off managers who are perceived as uninvolved and uninterested in the development of interns. Very few residents are able to find a management approach that encourages interns to move forward into the best that they can be."

The vision our new interns have articulated is to create a curriculum that will provide opportunities for them to learn to lead teams and manage patient care in a coach-like way.[5] Although the upcoming residents expect to have some positional influence in the upcoming year by virtue of completing the training year, they by no means expect to be the team expert given the broad experience base and skill level of incoming interns. The specific skills they would like to learn include how to:

- Create high-functioning teams that gel quickly;
- Work collaboratively with nurses, case managers, and other care providers;
- Demonstrate behaviors that build trust and credibility as a team manager and patient advocate;
- Integrate a state of well-being into teams;
- Create a learning and success expectation for the team so that everybody is motivated, developing, and shining in their abilities;
- Give real-time, constructive feedback to members of the team and coach them as they implement the feedback;

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- Foster interdependence and mutual accountability among team members;
- Serve as a team advocate with the faculty attendings and other teams;
- Effectively manage sign out procedures; and
- Facilitate the discussion of team errors and implement constructive changes.

Transitions between academic years are periods of opportunity for making needed changes within educational systems. Stay tuned for a new addition to the scant literature on managerial/leadership skills training curricula for residents—one designed to develop individual and team potential grounded in the foundations of positive psychology and coaching.

## References


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