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Stages of Change: Internal Medicine Schedule Post Duty Hours, a Chief's Perspective

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> *"A leader takes people where they want to go. A great leader takes people where they don't necessarily want to go, but ought to be."*
>
> —Eleanor Rosalynn Carter

Part of the challenge of being a chief medical resident is evolving from resident and learner to teacher and leader with a group that recently knew you as their colleague. We had the additional task of introducing a brand new medicine schedule that entailed fundamental changes to the structure of our medicine teams. Looking back, the journey felt similar to passing through the stages of grief, which we call our stages of change.

In 2011, the Accreditation Council for Graduate Medical Education (ACGME) established new regulations limiting PGY-1 work hours to 16 consecutive hours.[1] In response, our program implemented a progressive call schedule where interns rotated between day and night call every six days with nearly two days off in between. Two years into the schedule, it became clear that the continuity and quantity of patient care encounters were suboptimal. We needed a change.

Ultimately, we eliminated traditional call days and incorporated a drip system allowing for a steady stream of daily admissions instead of the previous bolus of admissions. This ensures an adequate number of admissions while maintaining the same educational schedule of morning report and noon conference. We also moved from two seniors to one senior per team to accommodate the expansion. To provide 24-hour resident coverage, we designed a separate day and night medicine schedule. Under the new day schedule, interns round on the same patients daily, except for their day off. Night coverage is a separate clinical rotation provided by two teams composed of one senior and one intern each that are on for two weeks with a day off covered by the alternate night team. The remaining two weeks are devoted to procedures, online modules, continuity clinic, and other specialty clinics.

The proposed schedule was met with concern and apprehension from nearly everyone involved. In planning and implementing the changes, we grew as leaders. We share our experience to aid those pursing similar endeavors.

Our stages of change included:

1. *Denial: Things are fine. We don't need to change*. We, the chiefs, were finally getting comfortable with our schedule since the 2011 duty hour changes. It was hard to accept changing again. Moreover, we were starting to realize the amount of work that goes into a chief year, which made the creation and implementation of a new medicine schedule feel overwhelming.

2. *Anger: This is not fair! This won't work! Why do we need to change?* There were some very unpleasant feelings. The angry response might have been taken differently if it had included recognition of the 100-plus hours spent planning. It was difficult to hear the many concerns voiced without recognition of all the time and thought invested. At the same time, we recognize how difficult it was for our residents and attendings to take on such significant change. The anger response can be counterproductive and is often misdirected.

3. *Bargaining: Well, if we have to change, could the admission cap be lower? Could we have more days off? Could we have fewer clinic days?* There was a lot of bargaining before we got to our end product. It was important to listen to all suggestions and compromise where possible. Ultimately, many needed to make sacrifices to ensure success, including us.

4. *Depression: This is hard. I don't like it. I am unhappy*. There were rough times in implementation as we worked through the kinks. For example, we previously had a two senior system, so it was hard to figure out planning for the "seniorless" day, such as who would hand out admissions and field intern questions. It was tempting to revert back to the comfort of the "good old days," but times had changed, and those systems no longer fit within the current work hour restrictions.

5. *Acceptance: OK, it's not too bad. In fact, there are a lot of*

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positives! Let's keep working to make it better. Hearing residents and attendings finally say "This isn't as bad as I had expected" or even "I actually like the new schedule" was satisfying and relieving. After a few months, we knew that we'd moved through the hardest part. The positivity of the senior residents and attendings involved was crucial to the success of the schedule.

Although the schedule has been achieving its goals, kinks still need to be worked out. Fortunately, our program's leadership is very supportive of continuing to work toward the most ideal schedule. Meanwhile, we walk away from the experience with some valuable lessons.

- Listen to everyone, and act on some suggestions. Write concerns down. Revisit them to identify what works best for everyone.
- Solicit feedback from quiet members of the group. They may have great insight.
- Find advocates and stakeholders. This is crucial.
- Work in groups, brainstorm, and debrief. Teams increase transparency and promote sanity.
- Recognize anger as a phase of change. Realize what's happening, and step back. Listen to feedback. Don't be blinded by defensiveness.
- Withhold judgement until after the trial period.
- Most importantly, take care of yourself! It's easy to get caught up in worrying about others. Your strength and perseverance are equally important for success.

Overall, it has been a unique and rewarding experience participating in a significant structure change to improve the education of our residents. Our hope is that in doing so we were able to make the transition from leader to great leader.

References

1. The Accreditation Council for Graduate Medical Education (ACGME) 2011 Standards. Accessed online November 7, 2013. Available at: http://www.acgme.org/acgmeweb/tabid/271/GraduateMedicalEducation/DutyHours.aspx.

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