Changing Systems Curriculum

How to be an Upper Level Resident Part II

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August 2012

Introduction

This workshop continues last February's session about preparing you to manage people and teach on your inpatient rotations.

Are you finding that medicine is as much about teamwork as medical knowledge? Have you experienced a highly functional team? A dysfunctional one? Inpatient teams are just the beginning. Your future depends upon being part of great teams.

During your intern year, we discussed how to be a good senior resident on an Internal Medicine/Family Medicine team. We explored the qualities and strategies senior residents employ to manage a team well. Your collective experiences provided stories of both effective and ineffective leaders. My objective then was to optimize your level of anxiety about being a senior resident. Now, many of you have been the senior resident on medical teams. How did you do?

In February, I suggested that you will get high marks for team management if you see yourself as a facilitator rather than an expert. Accordingly, we talked about how to….

1. Negotiate expectations for what everyone is supposed to do.
2. Keep all team members engaged (e.g. the medical student)
3. Give feedback in a constructive way

As for teaching, we explored a similar idea of facilitating experiences instead of formally teaching; and, when you do "teach" …

4. "Teach on the fly"
5. Get everyone teaching (10 minute talks)

When I asked you during your intern year about being a senior resident, I mostly heard about worries about **time**. There are just to many things to juggle. One coping mechanism you talked about was "running the list". The "list" seemed to represent several fears: knowledge base of your intern, knowledge base of yourself, being sure the student had some role, setting a balance between being too lax or being a micromanager, and being efficient. How can you protect teaching time while meeting work duty hours, and doing a good job?

In Feb, I wanted to reduce destructively anxious feelings and yet create some expectation that you needed to prepare for leading a team. Did talking about these things ahead of time help you lead? Did you feel skilled at managing the team? Have you gotten any feedback as a teacher?

This session offers you a chance to discuss your progress. As second and third year residents, you will have more leadership roles and more formal teaching expectations. We will explore some principles

of effective teams that are simple to understand, but often hard to put into practice. We will also explore more formal conference teaching techniques.

- Peter Ham

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Session #1: Friday August 31, 8:00 – 10:00 AM

Exercise # 1: Appreciative Inquiry. What has been good thus far in 2nd year? (20 minutes)

Exercise # 2: Reflect on successes/problems. (30 minutes)

1) How have you performed as a teacher?
    a. Did your student learn something?
    b. Did teaching happen?
2) How have you performed as a team manager?
    a. Did you feel like a "micromanager"?
    b. How did you negotiate with your intern?
    c. How did you do in giving feedback?
    d. Did you engage everyone on the team?
3) What parts of your team did not function well?

Break: 10 minutes

Exercise # 3: Introduce Discussion of Principles of Effective Teams: why discuss principles instead of concrete examples?

Discussion: Present Lencioni: 5 dysfunctions of team below. (30 minutes)

Dysfunctions

What it looks like when it's not working.

Gloss over goals not met

Not giving feedback, venting to wrong people

Wishy washy

Artificial Harmony

Infallibility: not admitting knowledge gaps
Bullying: Shame

What it looks like when it's working.

Easy to admit mistakes

People speak up respectfully about what they want

Decisions are made and everyone accepts it

People praise and criticize each other constructively

Appreciate success, analyze failure

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Examples involving inpatient teams:

Absence of Trust/ Infalability. E.g., upper level knows a lot and pretends to know everything. To not know is "bad". Pimping is hurtful. Upper level wants team to "shine" in front of attending. Senior lets intern look bad on rounds for team decisions.
Successful example: Attending and senior model looking up information at the point of care. Senior admits to attending that they, not the intern, didn't think of something that was important.

Fear of conflict: Conflict is taboo. The team does not truly negotiate expectations, e.g., team does not discuss how many patients each member will pre-round on. Senior pre-rounds on many patients just to preserve harmony. Or, intern feels overwhelmed with more than 5 patients, but doesn't want to argue so just tries his best.
Successful example: Intern says "I can't handle more than 5 patients." Senior says "But I expect you to learn to handle 8 patients."
Caution: negotiation is hard among players of different rank. However, successful teams empower everyone to at least speak their needs even if they won't get their way. (All Toyota employees can stop assembly line if they feel something is wrong.)
Discussion idea: When should leaders be authoritative and when should they be collaborative? What are the advantages of each? Can both be integrated?

Lack of Commitment: Decisions aren't made or team doesn't accept decisions. E.g., Upper level wants bedside rounds because teaching and patient care are better. Intern hates bedside rounds because it takes longer. Every morning the same debate occurs, sit down or walk. No one wants to be "wrong" so no decision is made. Or, decision is made, but each day the argument is re-opened.
Successful example: Senior decides to do bedside rounds every day. Says "I know you like sit down, but I decided we would all learn more by walking." Everyone accepts the senior's authority.
Caution: Be sure you are listening to everyone who speaks up and deciding what is best for team. Transparent, rational decisions will be respected. Power plays or false listening may reduce trust. Say "I hear your need for ____; however, I've decided to do ____."

Avoidance of Accountability: Confrontation is taboo. E.g., The night float does not put an H&P on the chart of a patient who is admitted at 10:00 PM. At 10:00 AM intern finds no note on the chart. And intern says…. nothing to the night float, but talks about how mad they are with other team members.
Successful example: Intern tells night float about the missing H&P and clarifies that night float needs to put H&P on chart when patient gets to floor.
Caution: Remember rules of feedback- be specific, be timely, avoid making it personal (let the problem be the problem), and say positive things also if you can. Remember how disheartening it is to do 99 things right but only hear about the 1 thing you missed. Venting is not the same thing as holding others accountable. THIS IS WHERE YOU FIND OUT IF THE TRUST LEVEL IS REAL.

This is a hard one to discuss. Perhaps the team broke down on another level- the night float couldn't admit they were overwhelmed (absence of trust), the night float and team did not negotiate who puts the H&P on the chart because that conversation would seem bossy (fear of conflict). Or, the team never really decided on whose job it is… "just try to get H&P's on the chart when you can, if you're not busy…" (lack of commitment).

For this to work, everyone needs to be accountable and empowered to hold others accountable. One could tell the attending and expect her to talk to the night float about the problem. This is inefficient and creates "policies" where 1 conversation could have done the job. Beware of a tempting, non productive side step… See a problem and expect the "system" (chiefs, residency director, …etc.) to fix it. Accountability is different from complaining to no one in particular or peripheral players. This is not easy. It is hard to say "you didn't do what we agreed" especially when rank of players is different. This cannot be done without the first layer of the pyramid, trust.

Inattention to results: Success or failure goes unnoticed. E.g., discharge by noon goals met but no teaching sessions happened. No one talks about it. Or we rationalize failures: "We didn't do much teaching, but we were busy and they learned from the patients."

Successful example: Honest assessment … "we succeeded at getting discharges out by noon, but we failed to have 11:30 teaching sessions every day. Why?"
Caution: Tail can wag the dog. Only things that can be measured become important. No one likes a failing grade even if the measure is less important. Does discharge by noon take priority over other important considerations? Would length of stay or cost per stay be a better measure?
Discussion ideas: #1 Many practices measure success by number of visits, RVUs, $, profit, overhead, or salary. How would you measure the success of your practice? #2 Insurance companies, hospitals and practice groups are measuring quality in various ways. Disease or organ specific quality measures may not reflect patient oriented measures. #3 How would you measure success for an inpatient team?
Is this a useful model to discuss leadership?

Summary:

Everyone struggles with managing team relationships. You understand why it is important to communicate well. Managing the relationships on the team involves creating an environment of trust, negotiating expectations, listening and then being decisive, giving feedback, and talking about failures and successes. This is easier said than done. In a stressful inpatient setting, you find team communication a hard skill to develop. Yet, it is worth learning to do well. Stress and teamwork are both in your future; and, better team leaders make better doctors. You are getting better at communicating with patients; similarly, getting better at communicating with teams is part of medical education.

Read more: Lencioni, P. The Five Dysfunctions of A Team.

Feedback on this session. (10 minutes)

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Case Studies:

1. Senior resident does not show up for rounds and does not answer pages. The team copes with being undermanned. He contacts the chief resident later on that day to say he is sick. This has happened before. But no one seems to be telling this resident that their lack of professionalism is a problem. Everyone just covers the work. But people are really angry. Discuss how lack of accountability damages teams.

2. The senior resident tells everyone on the first day "it is okay to say 'I don't know'" but then proceeds to pimp the intern with questions like "What is the most important thing I want to hear about this patient?" The senior acts like a know-it-all. She berates people for not knowing answers. And the student and intern say they feel embarrassed and "set up to look bad" on rounds. Discuss how to establish trust on teams.

3. The attending presents a chart showing inpatient billable charges and collections for the past year. It shows that inpatient does not cover departmental expenses. And he proposes increasing the time that the residents and faculty on inpatient teams spend in clinic. Discuss how to measure the success of an inpatient team.

4. The residents are invited to a faculty retreat to shape new directions and changes for the department and residency program. Several faculty present plans to make the clinical practices more patient centered. It is mostly a presentation with little discussion. There seems to be a leadership group that is going to decide whether to create more satellite practices. Residents say they found the presentations a little dry. Some residents are unsure what real changes will occur. Discuss how to have meaningful, open negotiation with teams.

5. The hospital sets goals of >50% patients discharged by noon with final discharge orders placed before 9:00 AM. Rounds start at 9:00 AM and mostly decisions are made about discharge during rounds. When reports circulate stating that the FM inpatient service is not meeting those targets, most people shrug. "The most important thing is that we take great care of our patients" we say. Should we "commit" to the discharge by noon goals?