Changing Systems Curriculum

How to be an Upper Level Resident

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Introduction

Being an upper level resident is often challenging. As an intern, you are likely anxious about it. You already have an idea what to do because you've watched your senior residents. Knowing and doing are two different things, however. This session is a chance to explore ways to be a great senior resident.

As a Family Medicine (FM) resident, you serve as a senior resident on FM inpatient service (including obstetrics), Pediatric ER and Cardiology services. You run an inpatient team and supervise an intern and a medical student. Family Medicine residents perform the same duties as internal medicine residents on cardiology. In the midst of a sub-specialty dominated hospital, are you intimidated by inpatient medicine?

In truth, FM residents have not had as much experience as internal medicine, pediatric, obstetric, and ER residents in many areas of inpatient medicine. The expectation that the senior resident will teach also adds anxiety. Starting on the wards, residents seem to have different ways of coping with their insecurity. Thankfully, most respond with honest assessments of where their knowledge ends and begins. However, some respond with machismo, extreme timidity, arrogance, or avoidance. This creates problems for patients, interns and medical students attached to a dysfunctional team. Even highly functional teams have trouble with setting expectations, teaching, giving feedback, and getting work done efficiently.

Anecdotal stories are easier to find than evaluations supporting a problem trend. A review of medical student of faculty evaluations of FM senior residents for two years showed that over 75% of the time medical students do not evaluate their senior resident. When they do, Family Medicine residents receive fairly good marks (7 out of 9 points) for overall teaching. Attending faculty grade our residents on average a grade 6 of 9 possible points for teaching, but write NA or "did not observe" 50% of the time. Yet a few comments ("Didn't make any attempt to teach … "resented my presence…") and low scores (2 out of 9 for overall teaching) stand out (see Table 1 below). How can we help these residents do better?

What would it take to achieve a reputation as a great teacher? Many think of teaching as the hierarchical transfer of medical knowledge from a knowledgeable senior to a less experienced subordinate. If you think you have to be an all-knowing expert, and if worried about your own knowledge, you may be somewhat alarmed at the idea of supervising students and interns. However, another way to think of a teacher is as a facilitator of the process of learning for another person. Maybe you don't have to know everything.

I believe you can teach and manage a team well if you do 4 things:

1. Negotiate expectations for what everyone is supposed to do.
2. Keep the medical student involved in ways that they learn.
3. Give feedback in a constructive way.

4. Create an environment where everyone is learning and teaching all the time.

Table 1. Medical Student Evaluations of Family Medicine Resident

	Average score	Range
Tried to teach me	7/9	(4 – 9)
Asked my thoughts on patients	7/9	(3 - 9)
Gave positive feedback	7/9	(5 - 9)
Gave negative feedback	5/9	(3 - 7)
Overall Teaching	7/9	(2 - 9)

Positive Comments: "Helped me with my presentations…", "got me involved…", "gave me articles…"
Negative Comments: "Resented my presence…", "Didn't make any attempt to teach…"

The goals of this session (Feb 1) are…

1. Reduce excessive anxiety about managing an inpatient medicine team.
2. Identify learning needs you have about medical knowledge or procedures.
3. Improve the way you interact with medical students
    a. Set expectations
    b. Include the medical student
    c. Give Feedback
4. Change your perception that ward teaching is the transfer of medical knowledge from a knowledgeable person to a subordinate learner to the idea that teaching is facilitation of self directed learning.

The next session (Feb 13) will cover "teaching on the fly". The goal for that session is to practice short one-on-one teaching that can be done during the course of a hectic day. We will discuss how to incorporate this teaching style into your inpatient team.

Each of you has been a medical student and intern on both well-run and poorly run services. Your collective experiences may be the most useful resource in developing successful strategies. Rather than give you a template for running a team, this course simply generates discussion around your areas of anxiety. Each of you will develop your own strategies to successfully meet the challenges of these rotations. This course uses a pre-course survey (sent by e-mail) to identify areas of anxiety and structured discussion sessions to raise issues of concern.

This course uses two pre-session surveys to guide the discussions as described below.

1. Pre course survey (see Attachment #1)

This survey measures interns' feeling of preparedness for managing a Cardiology/FM team in general, taking care of typical patients, performing typical procedures, overseeing an intern, and mentoring a medical student. Pre and post scores will be used to assess the effectiveness of the course. The information is also useful to assign more or less time to general areas of concern.

2. Areas of concern for interns prior to being an upper level (Attachment #2).

This questionnaire asks interns to list medical topics, procedures, or specific concerns about having a medical student or intern on their inpatient team. Responses will be collected prior to the course and used to develop discussion sessions, scenarios, and role-plays. This information is also useful in allocating time to various discussion topics.

Changing Systems Curriculum

Schedule for Feb 1, 2012: 8:00-10:00 “How to be an Upper Level Resident”

RUNNING A TEAM

8:00 AM Introduction

The pre-course survey indicated that you are anxious about becoming a senior residents. The responses suggested you felt “somewhat prepared” to manage the patients but “not at all prepared” to oversee the students and interns. Mentioning procedures caused a noticeable handwriting tremor. Responses ranged from “Dreading” to “Very much” looking forward to being an upper level.

Your concerns about teaching the student included 6 main themes:

1. Your knowledge (teach something wrong; they will think I’m incompetent
2. Your inexperience
    a. Procedures
    b. Physical exam skills
    c. Answering their questions?
    d. Keeping things interesting
    e. Will I know the answers to the students’ questions
3. Time -> How to juggle everything
4. How to teach
    a. Not wanting to be perceived as pimping
    b. Not wanting to lecture too much
    c. Teaching at their level
    d. Student has a different learning style
5. Including them
    a. in the team (they don’t have enough to do)
    b. in patient care (What responsibilities can I give them? Trust)
6. Giving them negative feedback (suggest improvement)

Your concerns about working with intern

1. How to get things done ? (complicated systems and informatics)
2. Time management (teaching when it is busy)
3. The intern will know more than me
4. Supervising procedures
5. Designating roles-> What do I do? What to they do?
6. Knowledge: I’m supposed to make the plan, what if it’s a bad plan or wrong?
7. Dealing with frustration (not getting emotional?)
8. High expectations (what if I don’t live up to their hopes?)
9. Dealing with a stressed out intern
10. Overwhelming intern?
11. Intern says “not learning.”

Inpatient topics of concern you gave…

1. **V Tach/Arrythmias (#6, 52)**
2. **Septic Shock (#10, 15)**
3. **LVAD Complications**
4. **Pneumothorax**
5. **Seizures (#23)**
6. **Acute Pain**
7. **Angry Patients**
8. **L&D (38)**
9. **Renal: Glomerular/ RTA**
10. **Pancreatic Dz other than pancreatitis (#25, 9)**
11. **DTs (#17, 16)**
12. **DKA**
13. **GI Bleed (#16, 20)**

Procedures

1. **Chest tube**
2. **Needle thoracotomy**
3. **Central Line**
4. **Intubation**
5. **Laceration rep (perineal?)**
6. **Paracentesis**
7. **NG tube**
8. **ABGs**
9. **LP**
10. **Thoracentesis**
11. **Arterial Line**
12. **Operative Vaginal Delivery**

So help me understand what you are anxious about being a senior resident. This is a deeper, more thoughtful list than I've gotten previously. You capture the traditional themes that residents worry about such as medical knowledge and time management. But the ideas about how to include the student and teaching to their learning style is new. You also mention the roles of each team member and giving negative feedback. And, wow, are you worried about **procedures**.

Anxiety can be productive; but, like the Frank Starling Curve of cardiac output (pause for groan), there's a happy medium. Excessive anxiety can reduce performance like volume overload is bad for hearts. But under-anxiety can be a problem too. So let's use it. Perhaps collectively sharing the anxiety with your peers and seeing that everyone has the same concerns will reduce it to an optimal level. Or, for someone with no anxiety, sharing concerns may create a more optimal level of preparation. As a group you seem on the overload side of the anxiety curve.

For example, realizing "I don't know how to run a code" might lead to asking for help, reading, and seeking learning experiences. Destructive paths might start with a sense of shame and deciding to cover up knowledge gaps or avoiding some situations (you make sure you are never the first one at a code).

8:30 AM: Running a team: negotiating who does what

1. Read Attachment 9 and discuss. (Get a sense of who participates and who is quiet for next discussion) It's your 3rd day on cardiology.

2. Read Attachment 3 and discuss how interns would establish expectations for getting work done and involve medical students in patient care. Pair up and discuss (10 minutes), discuss in a

"fishbowl" group (10 minutes), and then with the whole group (10 minutes). The "fishbowl" method has a smaller group of people talking and the rest observing to demonstrate the usefulness of listening and reflection. (It's a way to bring out quiet people.)

9:00 AM: Help, I don't know what to do?

3. Read Attachment 8. Discuss what emotions these cases raise for you. What would be hard about managing these patients? Reverse fishbowl: Whoever did not sit on the inside before does now. Discuss 15 minutes in fishbowl and then 15 minutes as large group.

9:30 AM Ummm, you're doing great?

4. "Giving Feedback" (Attachment 4). Instructor reads the scenario. Role play or Fishbowl method. What you would say to the intern in the scenario? Discuss how to give useful feedback

5. Tips for giving feedback

Ask:	How are things going for you on this rotation?
Solicit:	Would it be okay if we talked about how you're doing?
Invite a self assessment:	What do you think you do well or not so well?
Timely:	We've still got 3 weeks to go on service together…
Objective:	Neutral team members are helpful
Specific:	Let the facts speak for themselves
Positive:	Remember to say good things if true
Negotiate:	What you will do/what they will do differently?
Help:	Is an outside intervention needed?
Follow up:	Set a time to check in again.

6. Discuss Attachments 6 and 7

   Compare the list of topics you are worried about with these lists. If they are similar then these are high yield topics. Prioritize your worrying. Complications of LVAD devices may not be something expected for a FM resident to know much about. And, all of these topics are the reason you are here in the first place. If you knew everything, we could just graduate you.

7. Homework Assignment: Review topics and procedures of concern that interns identified in the pre-course survey "Areas of Concern for Interns Prior to Being an Upper Level." Also present the list of 100 top reasons for community hospital admissions and top 100 reasons for admission to a medicine floor at UVA (Attachments 6 and 7). Ask each intern to prepare one 10 minute "chalk talk" on a topic or procedure at a level appropriate for a 3rd year medical student. Quick learning points are appropriate rather than broad reviews (e.g., DKA is too broad: insulin regimens for DKA). No power point slides, please. Preparation time should not exceed 1 hour (ideally 20 minutes). For procedures, use a procedure book or handout or bring equipment used for the procedure).

SESSION # 2 (Friday Feb 13th 3:00 – 5:00)

3:00 PM

Divide into groups of 2 and have each intern give their prepared "chalk talk" on the topic they chose for homework to the other intern. (10 minutes for two talks = 20 minutes). Then the interns will trade talks and rotate to teach the material they just learned to another intern and vice versa (20 minutes). Discuss how long it took to prepare, where did residents get the information, and what teaching techniques worked best. (1 hour)

1st 20 minutes

Intern	Talk↔	Intern	Talk
1	A	E	5
2	B	F	6
3	C	G	7
4	D	H	8

2nd 20 minutes

Intern	Talk↔	Intern	Talk
1	E	D	8
2	F	C	7
3	G	B	6
4	H	A	5

4:00 PM

8. Summary for the teaching session. You just had a teaching experience, not a lecture on the theory of teaching. Are you more motivated to do more, refine it, reflect on it, read about it? You just learned something about teaching and I didn't have to say a word. It was efficient use of my time and more fun. The point is, you learned and I only facilitated. I didn't have to be the world's expert about hyponatremia and atrial fibrillation (phew). <u>So get your teams teaching themselves.</u> You may need to prime the pump by giving a talk or two, and then turn your students and interns loose. For the exercise above, compare my role as "instructor" to your concerns from the pre course survey. You were mainly concerned about knowing enough. First of all, you know more than you think you do; secondly, getting others to prepare little talks removes your need to know

everything. It doesn't take much time if everyone does a 10 minute talk once or twice a week. When students prepare talks, you find out quickly what level of knowledge they have and how they think and learn; and, a student who is teaching feels important and engaged with the team.

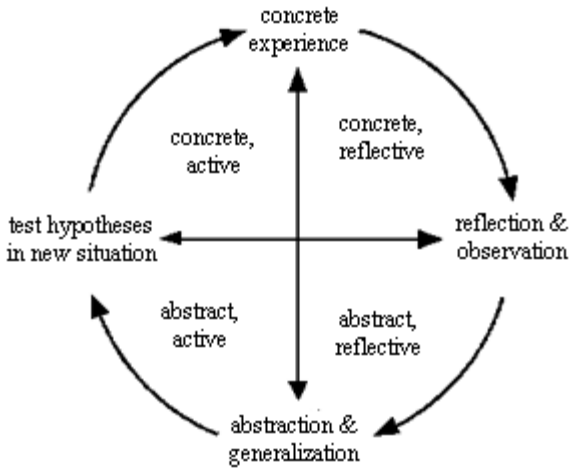
It is still important to be "the teacher" some of the time. Three benefits of sitting down with your student and giving your chalk talk are 1) they learn something 2) you send them a message that they matter 3) you learn something. (You probably learned more by preparing than you would have by hearing someone else give the talk.) So re-use your talk or steal one of the talks you heard; you now have a bunch of talks you can give.

9. 4:30 AM Teaching on the fly

How do you learn best? You just did an exercise where a knowledgeable person transferred knowledge to a less knowledgeable person. Was it effective? Do you now want to go read more? Find a patient with that problem? How do you get motivated to learn something?

People will answer the above questions differently. How do you manage your team so people with different styles learn? Do you push learners to learn in ways they are not used to? Role play attachment 9.

Review the Kolb learning styles diagram below. Let's use the analogy of learning to ride a bike. Would you like to study the bike and read the manual before you get on? People who learn best this way start at the "abstract & generalization" spot on the Kolb wheel shown below. Or would you prefer to get on the bike and crash and get back on? If so, you may engage in learning best by "concrete experience." Every spot on the Kolb wheel is useful, but different people will move around the wheel in a different order. Recognizing this may free you from thinking all teaching is didactic.



Crash. (concrete experience)
Q: "Maybe you have to keep a minimum speed going?" (reflect/ask questions)
Q: "Why do rolling wheels tend to stay up but then fall when they stop?" (abstract theory)
Try again on a slight downhill to see if it's easier (test)

In the end, everyone crashes the bike, wonders why, thinks about it, and tries again. It's just a matter of recognizing what motivates the person to start the learning process.

The point is to help learners become hungry for teachable information. My advice: Make students do real work (orders, histories, notes, sign out, interpret tests, make a plan …CRASH) then encourage them to read and bring back questions.

10. Summary for the Course:
    a. Manage anxiety (don't let it manage you)
        i. Have the appropriate level of anxiety (worry about stuff you should)
        ii. Use anxiety constructively not destructively
        iii. Read about common inpatient diagnoses and procedures you don't know
    b. Create some strategies for managing your team
        1. Set expectations for who does what on your team.
        2. Involve the medical student in real patient care.
        3. Give and accept feedback (avoid artificial harmony)
        4. Facilitate teaching on the fly (you are a facilitator not a know it all).
    c. Are you a little bit reassured that you can do this?
    d. Follow up discussion with me in Sept of second year

11. Summary and feedback on this session (verbal and written). Interns fill out Post-Course Evaluations and Feedback. (Attachment 5)

Attachment 3

Discussion Questions for 1st Session

1. On your first day as an upper level resident on general medicine, you sit down with your intern to discuss expectations. Try to list 5 expectations for pre-rounding, rounding, writing notes, sign out, or getting work done?

2. What are the expectations for the medical student?

Attachment 4

Discussion Questions

1. You are the senior resident on the FM inpatient service. Your intern has been on service with you for one week and is having problems. The intern does not know overnight events on patients. He does not look up labs prior to rounds and blames nurses for forgetting things that were never ordered in the first place. He seems generally unprepared for rounds and sign out. Consults and discharges are not being done early in the day. The night float complains to you about too much follow up on radiology results, consult recommendations, and labs. Patients lack PRN orders, increasing the number of pages and work for them on call.

   Your service has been busy with 16 patients in total. Your patients don't seem to leave the hospital partially because of the delay in getting consults, tests, and procedures done. You've had two bounce-backs because patients did not go home on their usual diuretic dose and were readmitted for CHF exacerbations. What steps can you take to make your team work more effectively?

Attachment 5

Post Course Survey:

1. Overall, I feel prepared to become a senior resident on the Cardiology/FM services

   Not at all prepared Somewhat Prepared Well Prepared

2. I feel prepared to manage the patients admitted to the Cardiology/FM services.

   Not at all prepared Somewhat Prepared Well Prepared

3. I feel prepared to teach medical students rotating on the Cardiology/FM services.

   Not at all prepared Somewhat Prepared Well Prepared

4. I feel prepared to oversee a family medicine intern on the Cardiology/FM services.

   Not at all prepared Somewhat Prepared Well Prepared

5. I feel prepared to perform procedures a resident would be expected to perform on Cardiology/FM services.

   Not at all prepared Somewhat Prepared Well Prepared

6. As a senior resident, I will have the primary responsibility for teaching the medical student

   Disagree Somewhat agree Completely agree

7. I am looking forward to being a senior resident on Family Medicine and Cardiology

   Dreading Neutral Very much

Attachment 6

Top 100 Reasons for Admission to a Community Hospital and Procedures Done [1]
(Only those diagnoses and procedures likely to be encountered on a Medicine service are included)

1.	Heart Disease			
2.	Pneumonia	Intubation (3%)		
3.	CHF Exacerbation	Intubation (2.7%)	**Thoracentesis (1.8%)**	
4.	**Myocardial Infarction**			
5.	Stroke	Intubation (3%)		
6.	Dysrythmias	Cardioversion (7%)		
7.	COPD	Intubation (3%)	ABG (1.4%)	
8.	Fluid/Electrolyte disorder			
9.	Biliary Disease			
10.	**Septicemia**	Lumbar Puncture (3.2%)	**Central Line (3.7%)**	Wound Care (2.4%)
11.	Asthma	Intubation (2.5%)	ABG (1.5%)	
12.	UTI	Lumbar Puncture (1.9%)		
13.	**Diabetes**	Wound Debridement		
14.	Hip Fracture			
15.	Skin Infection	Wound Debridement		
16.	GI Bleed			
17.	Alcohol Detox	Intubation (0.4%)		
18.	Small Bowel Obstruction	NG Tube (4.3%)		
19.	Malignancy	**Thoracentesis (7.8%)**		
20.	Hypertension			
21.	Overdose	Lumbar Puncture (0.34%)		
22.	Diverticulitis			
23.	Seizure	Lumbar Puncture (6.5%)	Intubation (3.5%)	
24.	Respiratory Distress	Intubation (43%)		
25.	Pancreatitis			
26.	TIA			
27.	Syncope			
28.	Altered Mental Status/Dementia			
29.	Gastroenteritis			
30.	HIV	Lumbar Puncture (6.8%)		
31.	Poisoning	Intubation (1		

[1] AHCPR, Most Common Diagnoses and Procedures in U.S. Community Hospitals, 1996. AHCPR Pub No. 99-0046. September 1999.

Attachment 7
Top 100 Reasons for Admission to a Medicine Floor (3 West, 3 Central, 8 West) at UVA

Rank	Diagnosis	Percent
1	PNEUMONIA ORGANISM NOS	7.9
2	DIABETES MELLITUS	5.1
3	OTH URINARY TRACT DISORD	3.4
4	CHRONIC BRONCHITIS	3.2
5	HEART FAILURE	2.9
6	ACUTE RENAL FAILURE	2.8
7	CELLULITIS & ABSCESS NEC	2.6
8	FLUID/ELECTROLYTE DISORD	2.3
9	DISEASES OF PANCREAS	2.2
10	ASTHMA	2.2
11	GENERAL SYMPTOMS	2.0
12	REPLACEMENT & GRAFT COMP	2.0
13	CHR LIVER DIS/CIRRHOSIS	1.8
14	ACUTE PULMONARY HRT DIS	1.7
15	SEPTICEMIA	1.7
16	ALCOHOLIC PSYCHOSES	1.7
17	OTHER LUNG DISEASES	1.6
18	SOLID/LIQ PNEUMONITIS	1.4
19	RESP SYST/OTH CHEST SX	1.3
20	GASTROINTESTINAL HEMOR	1.1
21	OTHER BACT PNEUMONIA	1.0
22	POIS-ANALGESIC/ANTIPYR	0.9
23	TRACHEA/BRONCHUS/LUNG CA	0.9
24	OTH ABDOMEN/PELVIS SX	0.9
25	INTEST INF D/T ORG NEC	0.8
26	HIV DISEASE	0.8
27	OTHER SECONDARY CA	0.8
28	KIDNEY INFECTION	0.7
29	OTH VENOUS THROMBOSIS	0.7
30	DIVERTICULA OF INTESTINE	0.7
31	INTESTINAL OBSTRUCTION	0.7
32	POIS-PSYCHOTROPIC AGENT	0.6
33	PLEURISY	0.6
34	OSTEOMYELITIS	0.6
35	SEQUELA OF CHR LIVER DIS	0.6
36	HYPERTENSIVE RENAL DIS	0.6
37	SECONDARY RESP/DIGEST CA	0.6
38	SINGLE LIVEBORN	0.6
39	SURG COMP-BODY SYST NEC	0.5
40	ABNORMAL BLOOD FINDINGS	0.5
41	FUNCT DIGESTIVE DIS NEC	0.5
42	AMI	0.5
43	DISEASES OF ESOPHAGUS	0.5
44	GI SYSTEM SYMPTOMS	0.5
45	PANCREAS CA	0.5
46	CHOLELITHIASIS	0.5
47	OTH DISORD BILIARY TRACT	0.5
48	OTH SURGICAL COMP NEC	0.4
49	GASTRIC ULCER	0.4
50	CEREBRAL ARTERY OCCLUS	0.4
51	OSTEOARTHROSIS ET AL	0.4
52	CARDIAC DYSRHYTHMIAS	0.4
53	000	0.4
54	OTH BONE/CART DISORDER	0.4
55	OTH ALVEO PNEUMONOPATHY	0.4
56	STOMACH FUNCTION DISORD	0.4
57	FRACTURE NECK OF FEMUR	0.4
58	ALCOHOL DEPENDENCE SYND	0.4
59	OTH INTESTINAL DISORDERS	0.4
60	PITUITARY GLAND DISORD	0.4
61	ESSENTIAL HYPERTENSION	0.3
62	HYPOTENSION	0.3
63	DRUG PSYCHOSES	0.3
64	ENTEROVIRAL MENINGITIS	0.3
65	CHRONIC ULCER OF SKIN	0.3
66	VERT FX W/O CORD INJ	0.3
67	CANDIDIASIS	0.3
68	OTHER/UNSPEC BACK DISORD	0.3
69	OTH GASTRODUODENAL DIS	0.3
70	OTH NONINF GASTROENT	0.3
71	CERTAIN ADVERSE EFF NEC	0.3
72	GASTRITIS & DUODENITIS	0.3
73	CHRONIC AIRWAY OBSTR NEC	0.3
74	OTH CURRENT COND IN PREG	0.3
75	METABOL DISORD NEC & NOS	0.3
76	DUODENAL ULCER	0.3
77	DIF CONNECTIVE TISS DIS	0.3
78	RENAL/URETERAL CALCULUS	0.3
79	TOX EFF NONMED SUBSTANCE	0.3
80	POSTINFLAM PULM FIBROSIS	0.2
81	CHR PULMONARY HEART DIS	0.2
82	IRON DEFICIENCY ANEMIAS	0.2
83	DISORD MINERAL METABOL	0.2
84	PNEUMOCOCCAL PNEUMONIA	0.2
85	ANEMIA NEC & NOS	0.2
86	NUTRIT/METABOL/DEVEL SX	0.2
87	FINGER & TOE CELLULITIS	0.2
88	BRONCHIECTASIS	0.2
89	AC/SUBAC ENDOCARDITIS	0.2
90	VASC INSUFF INTESTINE	0.2
91	DISORD SOFT TISS NEC	0.2
92	OTH MAL LYMPH/HIST NEOPL	0.2
93	VIRAL HEPATITIS	0.2
94	CHRONIC RENAL FAILURE	0.2
95	PNEUMONIA ORGANISM NEC	0.2
96	HERED HEMOLYTIC ANEMIA	0.2
97	PNEUMOTHORAX	0.2
98	STOMACH CA	0.2

99	OTH CIRCULATORY DISORDER	0.2	100	SX INVOLVING HEAD/NECK	0.2

Attachment 8

Case 1: You admit a patient with Wilson's disease and cirrhosis. The medical student knows a lot of biochemistry, physical exam findings, and patho-physiology about this disease. The patient needs a paracentesis and your intern has done 12. You have done none. And all you can remember about Wilson's disease is the word copper.

Case 2: You admit a patient with cellulitis and are worried about compartment syndrome. You consult surgery. The patient has poor vascular access and does not have any IV access. The surgery resident scoffs " I can't believe that you didn't put a central line in a patient that you were worried about compartment syndrome" and tells you to put one in. You agree with the need for a central line; however, you have never placed a central line.

Attachment 9

Role Play 1: Your student tells you he would like to take the afternoon to go read. There is a delivery going on and he has done his OB rotation already and knows he doesn't want to do OB. There is a circumcision to do and a patient being admitted from clinic with DKA. (The intern has these covered and just wants to get them done –i.e. not help the student do the circ for an hour) He says he is finding it hard to learn by pre-rounding, presenting, writing notes, and following the team around and watching everyone else put in orders. He says he really learns best by reading.

The student is actually kind of a know it all and you find having him around is annoying.