Changing Systems Curriculum

Transition from Senior Resident to Physician Leader

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October 2012

Introduction

True teamwork is rare in the work environment. Yet, I believe effective teams almost always outperform individual heroics.

In February of your intern year and Sept of your 2nd year, we discussed how to be a good senior resident on an Internal Medicine/Family Medicine team. Your collective experiences provided examples of both effective and ineffective teams. We reflected on those experiences and discussed some scenarios to develop leadership and teaching skills.

At this point, all of you have been the senior resident on medical teams. This session offers a chance to consider how to join effective teams for the next steps of your career.

In our past sessions, we explored what makes a successful senior resident leader of an inpatient team. Here are 4 principles developed during those sessions:

1. Anxiety can be useful.
2. Effective teachers and leaders can be facilitators rather than experts.
3. There are strategies to running effective teams.
    a. Build trust
    b. Negotiate
    c. Make decisions
    d. Hold people accountable
    e. Look at results that matter
4. Lead with positive energy (appreciate what is working vs dwelling on problems).

During this session, I hope to identify principles you learned during residency that will be useful in your job search and next job.

I've heard and experienced a lot of success stories about your group. You have helped your interns without being micromanagers. Students have learned a lot while with you. Faculty have rated you highly as team leaders. So this session is simply a chance to discuss your progress and individual style of leadership, develop some productive anxiety about the next steps, and discuss strategies for making productive teams work for you in the future..

- Peter Ham

Exercise # 1: If you were interviewing people in a practice, what questions could you ask that would tell you whether they operated as a good team?

Pair up and come up with one or two questions. Of whom would you ask it? What kind of answer would reassure you that this was a functional team?

Exercise # 2: Compare your questions to the model we have used previously.

1) Lencioni claims there are 5 things teams must do well (in order). Do you agree? Recall examples from your experience with inpatient or outpatient teams?

    a. Trust
    b. Negotiate
    c. Decide
    d. Hold each other accountable
    e. Assess results

2) During an interview with a practice/dept., how would you determine whether they do these things?

Feedback on this session (10 minutes)

Review: Lencioni: 5 dysfunctions of team below.

Dysfunctions

What it looks like when it's not working.

Gloss over goals not met

Not giving feedback

Wishy washy

Artificial Harmony

Infalability. Shame is used to enforce.

What it looks like when it's working.

Easy to admit mistakes

People speak up and argue about what they want

Decisions are made and everyone accepts it

People praise and criticize each other constructively

Appreciate success, analyze failure

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.)

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."
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 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."

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.

Is this a useful model to discuss leadership for your future?

Think about the relationship between what works on an inpatient team and what works in an outpatient clinic. How would you size up a practice? Is this a team you want to join?

	IN-PATIENT	INTERVIEW	Look for…
TRUST	How did you make everyone feel they could admit mistakes?	Does this practice accept input from everyone? What might you notice if this practice did not value trust?	Honesty Beware: infalability, don't let you talk to staff
NEGOTIATE	How did you negotiate who did what?	Does this practice negotiate decisions? What might you notice if conflict was taboo?	Constructive arguments Beware: tranquility (false harmony)
DECIDE	How did you make decisions? Did you make decisions?	Who makes decisions? What might you notice if important decisions weren't being made? Do decisions stick?	Policies, the practice makes changes Beware: practices that aren't adopting new ideas (e.g.,EMR)
HOLD ACCOUNTABLE	When people didn't do what you decided, what happened?	Does this practice give positive and negative feedback? What might you notice if people weren't held accountable?	Anyone can talk to anyone Beware: people above the law, prima donnas, tolerating bad behavior
ASSESS RESULTS	How do you know your inpatient team did a good job?	How does this practice measure success? How would you recognize a practice that didn't measure success?	Talk about more than money; but, has a easily understood business model Beware: only money focus; no business model

Remember that Lencioni's ideas are laid out as a pyramid not a table. The top of the pyramid relies on the other layers. Therefore, maybe you only have to ask about attention to results to get a sense of the overall team function.

Q1: How do you measure success around here?

Money:	Look for a balanced answer. Too much focus may be bad. No focus may be bad.
Satisfaction:	Staff turnover. People tend to vote with their feet.
Patient satisfaction:	Practices should be assessing this somehow.
Quality of Care:	There should be some systematic approach to knowing whether health screening recommendations are being met,
Everyone knows their job:	Protocols, good flow, people look busy and engaged
Innovation:	EMRs, Plans for EMRs, some new initiative is happening that people feel excited about
Service:	Medical students, volunteer work, advocacy,

So you get some red flags or are not sure…

Q2: Does everyone here feel they can say when there are problems? Any examples?

Remember a healthy team has individuals giving feedback to individuals, not water cooler griping or policy manuals for every problem.

If you see people up and down the power ladder constructively saying how they think the practice could do better in the areas for Q1, then you can feel reassured the practice functions as a team and has a chance at success.

Still not reassured?

Q3: Has the practice made decisions about what to do about <the stuff in question 1>?

Should get a sense of how decisions are made? Openly negotiated? Someone seems to be in charge?

If the practice seems like an place where everyone can have a say, and someone is clearly vested in making some change, then there's hope.

Okay now you're worried but want to find the dead bodies to be sure.

Q4: How are decisions made? Does everyone have input? What are meetings like?

Should get a sense of whether everyone is afraid or too apathetic to negotiate.

If the practice has lively meetings of people who care about success, then there's hope.

You're ready to catch the plane home. You're not even sure you want to identify the lesion.

Q5: What would you change about this practice if you could?

If they say “nothing, we’re perfect” just run.

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 teams make better doctors.

I've noticed that my job satisfaction depends much more on my team than myself. While I can control my attitude, I'm a happier, better doctor working with nurses, staff and doctors who work well together.

Remember Lencioni's pyramid. If you see great attention to results, the other parts of the team are probably working pretty well. Work down the pyramid to find out more about team function. Remember most teams aren't perfect. A solid foundation of trust, negotiating, and commitment to make positive change is pretty good.

Medicine has given a large portion of its mission over to people concerned with money. When I get my paycheck, I'm reminded that this is not always a bad thing. However, when medical teams are judged and managed top to bottom with a money-focus, some of the reasons you went to medical school can take a back seat.

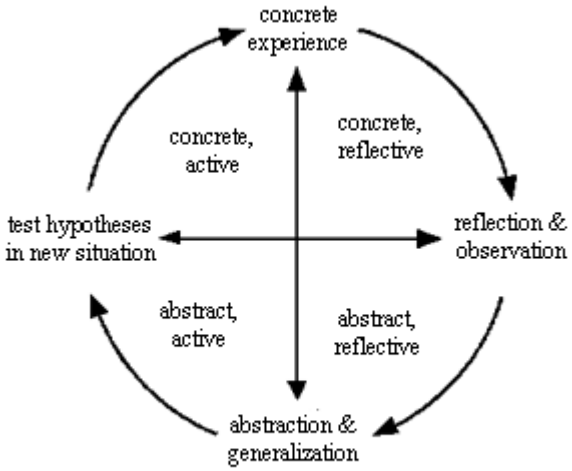
In interviewing for your next job, get the people to tell stories about successes and failures of the practice. You should get a sense whether people are collaborating. The more the people you interview can articulate a clear sense of mission and what it means to be successful, the more you can rest assured that there is a team behind it.

Feedback on this session. (10 minutes)

Other useful reminders from first session.

1. "Giving Feedback" Tips
    a. Inquire or Ask: How are things going for you on this rotation?
    b. Needs: What are you hoping to get out of this rotation?
    c. Specific Feedback: pos/neg/pos. but don't sugar coat it so much that you miss it.
    d. Interchange or Negotiate: The patients need to get taken care of well and you need to get home on time. How can we all get what we need?
    e. Help: Is an outside intervention needed.
    f. Timing of Follow up: set a time to check in again.

2. Kolb learning styles. You never would have tolerated a discussion about Lencioni's 5 dysfunctions of a team if you hadn't had the experience of running an inpatient team first. Keep learning medicine and leadership by meshing your experiences with reflections, experiments and theory.



Examples of dysfunction

	IN-PATIENT	INTERVIEW	PRACTICE
TRUST	INFALLIBILITY Senior res/attending can do no wrong, know it all, … Not knowing = shame	Infallible people everywhere. No one makes mistakes here. We are perfect.	Nurses don't speak easily to doctors.
NEGOTIATE	FEAR No one says anything about what they want. Senior/attend interpret silence as smooth sailing	Everyone seems afraid of the boss.	Water cooler complaining, boring meetings. Only money-people have input.
DECIDE	WISHY WASHY Try to make everyone happy.	"We've been kicking that idea around for years"	Confusion about protocols, rules, … Only money-people make decisions
HOLD ACCOUNTABLE	AVOIDANCE Let it slide. I'm sure it won't happen again. Only negatives discussed.	Might see prima donna behavior	Unprofessional behavior goes unchecked. Profitable people have different rules.
ASSESS RESULTS	INATTENTION "I survived, what else matters?"	Can't answer "What matters at the end of the day at this practice?" No clear goals or mission?	All anyone talks about it money. Don't have any metrics about the practice.

Examples of functional teams

	IN-PATIENT	INTERVIEW	PRACTICE
TRUST	People admit mistakes, knowledge and skill gaps.	Open about problems. They want a good fit with you. Seem to value staff, nurses input. Interview staff and nurses.	Dare to be imperfect- admit mistakes.
NEGOTIATE	People speak up about what they want to the decision makers.	Nurses and staff say doctors listen to them.	Staff meetings are lively.
DECIDE	Decisions are made and everyone accepts them.	Protocols seem clear and understood.	People understand and support decisions even if they lost the argument.
HOLD ACCOUNTABLE	Real feedback is given, especially from those of lower rank to upper.	"We had a problem with doctors coming in late, but we talked about it."	Feedback goes up and down rank. Feedback is constructive. Feedback contains both praise and criticism.
ASSESS RESULTS	Length of stay. Patient satisfaction. Evals for and by everyone. Discharge by noon. Teaching happens. Good team vibe.	Patient satisfaction scores Quality measures (patients getting great care) $/profit/RVUs Employee satisfaction A rotation at the practice felt like a good fit.	Your values match the practice values. Not everything that can be counted counts, and not everything that counts can be counted. – Albert Einstein