SUMMARY: IM FOCUS GROUPS

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MORALE PROBLEMS:

There was widespread agreement that morale had declined last year. The shift was primarily attributed to the many changes that had occurred in the program (morning report, academy, call system) that led to residents feeling out of control. Residents pointed out that even positive change (such as the academy) were stressful. When change was perceived as not beneficial, just creating more work (eg., the call system changes) it was even more stressful. There was general agreement that the call system changes were responsible for the biggest drop in morale, and made residents feel stressed, upset, and unhappy. The call system was roundly criticized ("incredibly awful") and viewed by some as destroying team cohesion and bonding. For some residents, there was a sense of betrayal: the program seemed to have changed completely from the previous year – residents expected one thing, but got another. Call system changes resulted in "numerous changes to provide a new equilibrium and those subsequent changes" resulted in what felt like a completely different residency program.

The rapidity and quantity of changes made the residents feel experimented on, like guinea pigs. Residents lost structure, stability, and never knew what to expect. Some residents said they wouldn't choose this program again. The third year class seemed especially miserable: "Can't wait until it's done." "I'll never come back here again." While some residents believed that the intentions of the program were good, all agreed the results of the change process were stressful.

Even worse than the actual changes was the process by which change was introduced. Residents didn't feel they had a say in the call schedule change – it seemed inevitable, foreordained. In general, changes seemed to be made independent of what the residents wanted. Resident feedback sessions appeared unrelated to the actual change process, a kind of parallel universe that provided only the illusion of control, which led to a lack of trust in the change process. Residents didn't understand the decisions the program took – there was little transparency; and their own alternative ideas seemed to be consistently shot down or ignored. Many residents felt their voices weren't being heard, that people in authority only pretended to listen. Since residents weren't being listened to, they stopped proposing ideas.

Some residents felt the chiefs/administration were actively antagonistic and contemptuous of the alternate suggestions the residents proposed, and made it appear as though the residents didn't think things through well. Several residents felt resident feedback sessions were nothing more than a charade to make it appear that the proposed changes were what the residents themselves wanted; or that they had even been proposed by a resident. Regarding a vote that had been taken, one resident commented cynically, **"**Whether or not the vote actually counted for anything I'm not sure and I actually doubt it." Another labeled the voting process a "farce" because it occurred when no residents could attend and was then followed by an email saying that all the residents agreed with

the proposed change. At one meeting, one resident reported that residents were blamed for the changes because they had been honest about documenting their duty hours. One resident went on to comment that the overall process of introducing change was "insulting to the residents' intelligence;" another resident called it "disrespectful," while another used the term "disingenuous."

Such discrepancies between appearance and reality contributed to residents' feeling they were being manipulated and deceived. Overall, there seemed to be a significant lack of trust toward those in power – a feeling that the administration (and the chiefs) were not on the side of the residents. Lack of transparency and lack of respect produced apathy, helplessness, and anger.

Last year's chiefs came in for intense criticism. In the opinion of the majority of residents, the chiefs were often rude and dismissive, on the administration's "team" rather than on the side of the residents. The chiefs were not seen as trustworthy, and often their process toward other residents appeared "insulting." When residents approached them with issues, instead of hearing them, the chiefs implied the residents were deficient and had stupid ideas. The chiefs' constant refrain to their fellow residents was perceived to be "suck it up." Their other favored response to being approached about problems was telling residents to "improve themselves." When the patient census was high, one resident was told "I wasn't working hard enough, maybe I needed remediation because I wasn't discharging patients." During morning conference, the chiefs would "shoot down" differential diagnosis suggestions, and not put them up on the board. At times, feedback from the chiefs seemed almost threatening (e.g. "I was told to 'keep my nose clean,' what does that even mean?"). The chiefs were also criticized for lack of caring about the program or their fellow residents: It was their transition year to moonlight and to get to their GI fellowship.

The best view was that the chiefs were trying to help, but were not approachable; and when approached, they were not effective. These residents said that the old chiefs just did not invest much effort in problem-solving. A minority view was that one particular chief was seen as intimidating, but in the opinion of at least a few residents, this individual was just straightforward and honest. One resident acknowledged that negative stories about the past chiefs might have become "amplified" beyond their reality.

The program director was criticized by several residents as well. One respondent accused him of playing games with the residents, not being transparent, having a hidden agenda, being sneaky; and as a consequence, creating distrust among the residents. Another resident expressed the view that the pd was more concerned with making the program work than with individual residents' wellbeing. The pd was also accused of being guilty himself of "retaliating" against residents who expressed concerns. Some saw him as intimidating, someone who would "freak out" and who created an atmosphere of fear. At morning report, "The pd… would single somebody out and kind of drill them." In terms of having a safe atmosphere in which to develop their clinical competency, residents sometimes felt "blindsided" in the sense that they would be pulled in with no warning, reprimanded, or even placed on probation.

However, other residents asserted that the pd was a good listener, on the side of the residents, and someone whom residents could rely on, who would fight for them. One resident attempted to justify difficulties with the pd last year by pointing out that he too "had his back against the wall" in terms of being under tremendous pressure to change the call system. Another resident noted that the pd was not always effective, but would always give residents a fair hearing. One resident noted s/he would rather go to pd w/ problems than to last year's chiefs.

Another contributing factor to lower morale was the lack of support from attendings generally. For example, in terms of interfacing with other departments, residents often felt they were left on their own, with insufficient support and back-up from attendings; or that they were caught between their own attendings and fellows/attendings from other services. In another instance, the duty hour issue, one resident pointed out that duty hours are supposed to be maximums, but were treated by attendings as minimums; so that if residents finished in less time, they were perceived as slackers. In these situations, it was the perception of this resident that some attendings "don't give a crap," they "don't care," and keep residents as late as possible, even if they've finished their work and could get home a little earlier. In yet another example, a couple of residents complained that attendings/hospitalists would show up at meetings and push their own agendas, even though the residents were the ones who would be most affected by the changes. In the view of one resident, the hospitalists expressed an attitude that residents didn't work hard and were lazy. This resident believed that hospitalists had their own motives for advocating for certain changes, but that these were not open to being explored.

Other contributory factors to lower morale were 1) Few social events (however, one resident noted that social events just "cover over" problems, rather than solve them). Many residents felt there was insufficient opportunity to hang out informally and create bonds in this way. 2) Poor interns (now improved). One resident observed that when others had to pick up the slack of poor residents, and then realized that there are no consequences for bad behavior, it was demoralizing. 3) Lack of respect, professionalism from other departments – "dumping" on Medicine (see below). 4) There was usually no feedback or action taken based on negative evaluations of attendings, or raising concerns about attendings with the pd or chiefs. The perception that residents' concerns and efforts to improve the program were routinely ignored led to demoralization.

A minority of residents rejected the view that the administration and chiefs were to blame for the deterioration in morale. These residents expressed the perspective that the intentions of the administration were good, but that the result was still stressful; or that changes had to do with site visits, issues above the program level, over which the program itself had no control. A couple of residents disputed that morale was a problem at all, and stated their perception that this was a good program, with concerned staff, helpful, sympathetic attendings on the side of the residents, a good balance of education/service, and enough days off.

Overall, although there was a general sense that the program had improved this year, the consensus seemed to be that there was a mixture of unique and ongoing problems – some have resolved, but there is still some carryover. One resident described the work environment as still "somewhat toxic."

ISSUES OF INTIMIDATION/RETALIATION:

Among the respondents, there was some confusion about reporting options, but this was not the prime contributor to feelings of intimidation. Rather, there appeared to be three main sources:

1) Previous chiefs (see above): The previous chiefs were widely perceived as indifferent or hostile. What residents wanted from their chiefs was help, someone to confide in. What they got, from their perspective, was intimidation and lack of caring. Residents commented that the chiefs would harass residents, insinuate they were slackers, not adequate, or hint that the resident needed remediation. Sometimes residents were told "you shouldn't report this" and this was seen as a form of intimidation. A couple of residents called them "tattle-tales," who broke residents' confidences by running to the administration, with the result that several residents were "called in" and, in their perception, retaliated against. They were sometimes described as intimidating and belligerent. One resident accused the chiefs of creating an atmosphere of fear, a "police state."

In a minority view, one resident offered the alternative suggestion that chiefs might have reported things out of concern for resident wellbeing; and that being called in to the pd's office could be conceptualized as an attempt to offer help and show concern.

2) Program culture: The perception of the culture of the program was quite variable. Some residents did not consider the atmosphere to be at all intimidating, and felt that while it is "always hard" to receive feedback, in this program feedback was generally delivered in a helpful, non-retaliatory manner. Others considered the program to be "somewhere in between" openness and retaliation. Individuals who endorsed this view stated there were good intentions; and good receptivity to some issues such as work hours; but that legitimate concerns about resident wellness and patient safety weren't always addressed. Others were more negative, stating that the program culture was not open, and in fact was often antagonistic, defensive, and resistant to feedback.

Some residents went further. From their vantage point, there was a pervasive atmosphere of fear and intimidation in the program. They had discovered their suggestions to improve the residency would be routinely shot down, not heard or acknowledged, which they experienced as a "slap in the face." These residents reported feelings of being dismissed, ignored, discounted, or not legitimized. They worried that they were perceived as complainers, or weak, whenever they tried to express legitimate concerns. These residents lacked a sense of safety – they expressed fear for their fellowships, their futures, and were persistently afraid of upsetting people in power. "When you've been open and been attacked, it makes you not speak up anymore." Fears of repercussions led to a

culture of silence – many residents were not comfortable bringing up issues with higher-ups. When faculty members were present, they felt unable to speak their minds freely. One resident stated that, with all the program changes, it seemed like the administration was "out to get them."

3) Lack of anonymous mechanisms: Fear of retaliation existed in part because of the lack of anonymity in registering complaints. All groups mentioned this concern. It was pointed out that evaluations were not really anonymous, and could easily be traced back to particular persons. Even anonymous feedback was considered to be risky, because it could make the whole group look weak. Some residents reported examples of "quid pro quo" evaluations – faculty would retaliate against an honest evaluation with a negative evaluation of their own. One resident stated s/he could not provide honest evaluations because of fear of retaliation and "this is a very big issue." Another resident stated that s/he had been much blunter originally on evaluations, but there was backlash, s/he got into trouble, so s/he stopped being honest. Another resident said that his/her peers gossiped about problems but were unwilling to step forward because of fear of "backlash."

4) Dishonesty among residents in reporting duty hours. Residents acknowledged that this practice was not encouraged by the program, but they feared honest reporting would make them look like slackers, and that the program's accreditation might be in jeopardy. One resident stated that the consensus among residents was not to report going over hours. A person-blame model existed in the program culture, so that nothing would ever change systemically; rather residents would simply be told to become more efficient, so that they felt intimidated into lying.

SUGGESTIONS FOR ENHANCING MORALE/IMPROVING COMMUNICATION, TRANSPARENCY WITHIN THE PROGRAM:

There were several suggestions for enhancing morale and improving communication within the program, which fell into the following categories:

1) **Better communication and transparency**. This included more explanatory discussion sessions between chiefs/residents; make it easier to attend ROC meetings, which actually provided good insight into what was going on and why changes were being made; make minutes from ROC & Curriculum meetings available a immediately after the meeting (not weeks later) so residents can keep on top of possible upcoming change; more updates on pending issues; pd should give a "State of the Program" address regularly to keep residents informed on what is happening in the residency and what to expect in the future; when proposing a change, come up with solutions, alternatives, and ways to implement those ideas … just as the residents are asked to do.

2) **Anonymity in giving feedback** (anonymous reporting box; anonymous evaluation of chiefs; pooled evaluations to protect anonymity; making GME reporting phone line more accessible; meetings without faculty present; voicemail account that residents can call into; web forum)

3) **Better process for discussing issues**. This suggestion included creating an atmosphere where residents felt their voices were important (several residents' perception was that this was happening more now); not yelling at residents during curriculum meetings (again, there were several statements that now residents were not shot down, could bring up concerns, felt they're being listened to, even if not everything can be fixed); chiefs/administration avoiding defensiveness, "going ballistic," which was intimidating and discouraged people from saying anything (things were perceived to have gotten better this year on this score as well; there was acknowledgment that resident concerns are being heard and taken seriously).

4) Involve resident early when problems exist. For any concerns about resident performance, have an earlier intervention or acknowledgement of the problem.

5) A forum where residents could just vent, without fear of reprisal, without faculty, without tape recorders, late in the day, not at noon, to encourage informality.

6) More support from program and chiefs (this had also improved this year). For example, chiefs could go into rooms, ask residents if they needed help, troubleshoot for them, and be available just to talk. If they saw a resident struggling, they could offer assistance rather than ignoring the situation. Even if the chiefs couldn't solve a problem, their presence would "brighten the day," show that they cared and were concerned. Along similar lines, a few residents suggested having chiefs present at intern sign-outs so the interns could run things by them, share thinking, and make sure things went okay.

7) Create a more supportive, reinforcing culture that praises residents and acknowledges their positive efforts.

8) More opportunities for informal social interaction (to promote an atmosphere of friendliness)

9) More creature comforts (more social events; better lounge facilities; better, more food; cheaper parking).

10) Work out problems with other services. An alternative proposal was to be trained in more procedures, so residents could be more aggressive about taking care of their own patients and not depend so much on other services.

11) Efficacy. Make sure there are some concrete results from focus groups, other forums, otherwise morale will just take another dip. The academy and morning rounds were singled out as positive improvements that boosted morale.

RELATIONS WITH OTHER DEPARTMENTS/SERVICES:

a) Heme/onc – **There were varied opinions about heme/onc.** A few residents said heme/onc fellows were helpful, available, and that they were comfortable calling them anytime. Others felt they were hard to reach, provided no teaching, and treated IM residents like babysitters. One resident said sadly, "They could at least be nice." A

different resident said that his/her contacts with heme/onc made him/her angry and unhappy. This same individual said that for IM, heme/onc was a waste of time. Residents learned nothing about chemo regimens; were often caught between the IM attending and the heme/onc fellow; and that it was very demoralizing to try to address difficult issues such as end-of-life when the IM team and heme/onc disagreed. S/he also had complaints about routinely not being informed of the heme/onc treatment plan, and sometimes having to learn this information from the patients themselves. Heme/onc was criticized for having "too many drivers." **Problems with heme/onc were perceived to be more systems problems than person problems**.

b) ED – There was a lot of bad feeling toward ED. Residents accused fellows of dumping patients on IM and reported lots of inappropriate transfers. **The overall perception of many residents was that the ED did whatever it wanted**, and no one could stop them. Patients were already admitted by the ER before the IM team had even seen the patient. There was also concern that the ER uses a lot of unnecessary 23 hr. observation admits. One resident observed that ED admits were dumps due to "the shift work mentality" of its residents. Another called ER residents "inappropriate and unprofessional." Another accused the ER of inadequate work-ups and even "lying" in order to get pts admitted. Still another (successfully) urged a family to file an incident report, which s/he hoped gave them "some relief" from an inappropriate admission/ transfer that the resident felt had compromised patient care.

Arguing with ER attendings was perceived as useless by most IM residents. As one said, "I generally just give up the fight for the night," and wait till the morning and the arrival of the IM attending. However, one resident had a well-defined plan for presenting issues to the ER attendings, and felt they were more approachable than the fellows; and another said s/he respected the clinical judgment of the ER attendings, and was inclined to follow their recommendations.

Most residents rarely considered calling their own IM attendings in the case of a transfer dispute. Several residents "felt bad" about disturbing their attendings at night because they didn't like to "bother" them. One resident complained that IM attendings were not good about call-backs, but this was disputed by several residents who stated that they were comfortable calling IM attendings at any time; and that attendings had indicated their openness to being called by giving out their personal cells. Another resident, who had had positive experiences with attending responsiveness, particularly appreciated attendings who set a specific night-time check-in. Residents who had contacted their attendings regarding perceived inappropriate admissions stated that they'd had both good and not so good experiences when they followed this procedure. One resident felt that involving IM attendings would not be helpful unless they actually came in to see the patient, because in most cases they wouldn't feel strongly enough to insist that the patient be admitted to another service. Another comment was that IM attendings

didn't have enough information to question admissions from outside hospitals. Yet another resident observed that involving IM attendings wouldn't really help anyway because they would end up in the same "grey zone" as the resident, where some of the ED admits made sense, and others were inappropriate. There was a sense from a few residents that attendings do not argue with ER because they "don't want to get involved in turf wars." Sense that attendings do not argue with ER because they "don't want to get involved in turf wars"; they play politics to keep good relations with other departments.

The policies governing admissions were perceived to be vague and open to interpretation. Residents had never seen the policies work.

c) <u>VA</u> – The VA also generated a fair amount of negative feelings. Residents rarely involved VA attendings, especially at night, because they were not perceived as dedicated or interested in education. Night float was seen as especially bad at the VA in terms of isolation and lack of supervision. One resident said, "I would've broken down," referring to another resident's experience there. Residents felt they often ended up doing dispo, not medicine; that they were more secretaries than doctors; and that they spent too much time on social issues ("not why I went into medicine"; "social admits are just disheartening, a waste of time"). One resident noted s/he often took care of surgery patients just because surgery was so resistant to accepting patients onto their own service. One resident mentioned lack of radiology services evenings and weekends. There was also concern expressed about the amount of time expended "begging "for patients to get vitals; getting lab collects (although better this year); and doing discharged summaries (also improved this year). **A dissenting opinion** praised the experience on the VA wards, with the fifth team providing the opportunity for literature research and thinking about patients. At the VA, spent a lot of time on the phone that wasn't related to patient care or wasn't educational.

d) <u>Memorial</u> – At Memorial, the pervasive opinion was that residents are the attendings' "consult monkeys" (they do the consults, attendings will do some teaching). Residents reported feeling like secretaries who spend all day on the phone trying to reach the intensivist who then tells them to call consults. There were also reports of some yelling and abuse of residents by attendings. One resident described Memorial attendings as "useless," only willing to give advice by phone. However, others noted that there was also some effort to make up for all the scut by teaching late into the day (a mixed blessing). A few residents expressed the view that, at this site, consults are done for "extra money … a kickback from their buddy."

e) <u>Interdepartmental relations.</u> In general, residents expressed the view that other services dump on IM and disrespect them (GI, vascular, ortho, general surgery, neurosurgery were frequently mentioned; pulm fellows were the exception, consistently praised as open to being called anytime day or night, and very helpful and supportive; however, there was a sense that admitting pulm patients had very little educational value). There were complaints that communication was poor with all these departments; and that surgery and ortho sometimes wouldn't even communicate plans for pts. Ortho

was singled out as especially bad, with residents who were both "lazy and arrogant." Many resident complaints had to do with the surgical teams. The residents felt that patients with stable medical issues awaiting a surgical procedure should be on the Surgery service.

One resident felt that other services "test" IM residents to see if they can get them to cave and accept inappropriate admissions. The policies governing relationships between IM and these departments seemed vague, not well understood or followed by other departments' fellows/attendings. Some residents felt consulting services routinely overstepped their bounds by interfering with medicine issues. Others felt consultants were very "black and white" in their recommendations ("bronch or no bronch"; "scope or no scope"). One resident mentioned feelings of learned helplessness, i.e., learning not to expect much from other services. Another resident noted that what was intended as an academic exchange with an attending from another department devolved into his/her being reprimanded. Residents felt that often there was not enough support from the IM program or the department in terms of resolving these conflicts. Many resident felt the best approach was to call the hospitalist to ensure that the patient is admitted to the proper service. However, many also complained that when they adopted this approach they did not get a positive response from the hospitalist. Consequently, they felt left hung out to dry: they had to fight their battles alone. **On the whole, there appeared to be mistrust and lack of good working relations among IM and other departments**. There was a perception of frequent miscommunications, differing recommendations, and time lost waiting for recommendations from consult teams. Residents didn't understand why other services can refuse patients, but not IM.

A minority opinion was that the fellows from other services were almost uniformly helpful. One resident described residents/fellows/attendings from other services as "good people trying to do the good thing," and identified the problems as more systemic, out of individuals' personal control.

f) <u>Attending support</u>. When residents did receive support from attendings, it was greatly valued. Residents expressed feelings of relief and gratitude as they recounted instances where IM attendings backed them up. It meant a great deal to resident when attendings got involved in problematic issues between departments.

<u>PRIORITIZING SERVICE OVER EDUCATION:</u>

The prioritizing of service over education was related both to morale problems and to problematic relations with other services. It seemed to be a particular problem at certain sites (VA, Memorial, UCI hem/onc, UCI wards to some extent, nightfloat, dayfloat intern; SWaT team seems focused on getting patients in and out, not so much on education.**).** Especially at these sites, residents expressed a sense of babysitting patients, being used as secretaries, being exploited, relegated to scut work, with very little feeling of being part of a team. Getting medical records, setting up post-hospital follow ups, getting prescriptions for discharge, getting transfer forms took a great deal of time away from education. At UCI, high patient load and rapid turnover leads to significant

pressure to discharge patients with consequent less emphasis on actually learning what is actually wrong with the patient. Residents sometimes felt they were just an admitting service for other specialties ("lots of surgery dumps"), with attendings from other services just telling them what to do

Dissatisfaction regarding the educational mission was exacerbated by fellows/ attendings who were hard/impossible to get a hold of; and by their lack of interest in teaching (at one site, as put by a resident, "Most attendings don't give a crap about education"). On the wards, attendings sometimes seemed more interested in having residents fill in their note – vitals, labs – than in teaching. IM attendings at different sites were also of variable quality, with some criticized for just wanting residents to generate problem lists, rather than being interested in teaching differential diagnosis. In the UCI MICU, attendings would just change orders without involving housestaff. Consultants did not always provide education, rather telling residents "look it up yourself…" Residents also expressed some sense of not being sufficiently backed-up, being too alone, with too much responsibility resting entirely on seniors, so that there were too few opportunities for learning.

These perceptions of lack of opportunities for learning in turn led to anger and frustration. A few residents believed that at more prestigious institutions (e.g., Johns Hopkins) they wouldn't be doing so much scut work. There was a sense that UCI had significantly more social work aspects than other institutions.

A minority view was presented that the educational experience was pretty good overall, and that it was impossible to separate patient care from education, so that taking care of patients *was* education. In a similar vein, from this perspective, consults were also seen as opportunities for learning. These residents felt they were engaged in "real-world" learning.

RECOMMENDATIONS TO IMPROVE INTERDEPARTMENTAL RELATIONS/EDUCATIONAL PRIORITIES:

Two different types of recommendations emerged regarding improving interdepartmental relations:

Suggestions from the majority of groups were primarily instrumental:

1) ED

a) Make transfer/admission guidelines widely known; and create culture change that truly supports adherence to these guidelines

b) Have ER attending contact IM attending regarding admissions 3

c) More support/backup from IM attendings

d) Allow internal medicine residents decide *whether* to admit a patient to their service or not

e) Confront ER about not misrepresenting patients to obtain an admission ("ER should be scolded") Mandate that other services (surgery or anesthesia) come to all code blues and offer to place lines while medicine runs the codes

2) Heme/onc

a) Have their own service

b) Do more of their own work

c) Do more education of IM residents

d) Have admissions/NPs notify heme/onc fellow when a heme/onc patient is admitted, schedule follow-up appts

e) Have heme/onc stop admitting scheduled chemo pts late at night

f) Have a senior or intern rounding with the heme/onc attending

g) IM residents round with the heme-onc team.

h) Heme/onc team should talk to IM after the patient has been admitted and review plan, go over what IM should be worried about

3) **General:**

a) Have open meetings with various departments, a healthy airing of grievances

b) Have a program director to program director discussion. Start at the top and trickle it down to chief residents and residents.

c) Specialty consultants should be more open to being questioned, not get mad at IM residents.

d) Require that all admissions to ICU or CCU be called in to the fellow so residents feel they have added support and guidance when they admit critically ill patients. The purpose is to allow residents to "run the case by a fellow."

e) Compile a list of contact information for outside PMDs for residents to access so they can notify PMDs of pt's admission

f) Surgery should admit to surgery and use Medicine as a consult team

g) Have consultants page IM resident when they put their note in the chart.

h) Have Pulm fellow come to all MICU admissions

4) VA:

a) Hire more social work/case management support at LBVA

b) Create a VA Chest pain unit, similar to UCI's

5) Memorial:

a) Create a list of subspecialists by preference for each intensivist at Memorial so residents do not have to call each to find out which specialist is preferred by a particular intensivist

b) Allow for more opportunities to perform procedures at Memorial

Suggestions from other groups emphasized the interpersonal and social: 1) Have an interdepartmental resident lounge so residents from different services could interact informally, not just in the work setting 2) Physician dining area, another way for people to mingle 3) Social mingling (interdepartmental parties).

Educational suggestions were sometimes mentioned in connection as morale boosters, and sometimes discussed independently. They focused primarily on intradepartmental issues:

1) **Focus and tighten educational sessions**:
   - **a)** Decrease frequency/duration of noon conferences
   - **b)** Improve quality of Grand Rounds

c) Decrease frequency of morning report
d) Keep board review series, conferences that are either directly relevant to boards or to practice
e) Review of NEJM cases
f) Introduce interactive, medical jeopardy type sessions
g) Mandate truly protected time for educational conferences; enforce that attending rounds MUST be over for noon conference)

2) **Limit and focus patient care**
   a) Put patient caps on teams; use PAs for scutwork; more clerical support to help with discharges; cut down on number of consults, or filter them
   b) Consider some "down time" in the UCI admissions cycle such that a team is on-call, post-call, nonadmitting, day-call, nonadmitting so residents do not feel they are there only to provide a service
3) **More support from attendings**
   a) Get 2-way pagers, to make it easier to reach IM attendings.
   b) Have an attending available at night, like at Memorial MICU, to give added teaching
   c) Have a specific night time check in with on-call attending by phone
4) **More systematic procedural training**
   a) More education, to include the basics of the procedure such as who qualifies for them (e.g. indications for a subclavian).
   b) Practice with the theory and manual aspects of a procedure before attempting on a patient.
   c) Create an anesthesia elective where residents can go to the OR to learn airway management (intubation) in a controlled setting or let residents go to OR with anesthesia during elective time to practice intubations
   d) Two-week Procedures Rotation
   e) Procedures rotation at Memorial that would perform procedures on non-teaching service patients.
   f) Intermittent reinforcement through the year, maybe through procedures workshops
   g) Use a simulator to learn a procedure.
5) **Hire more interns**

PATIENT SAFETY - ASKING FOR HELP:

In the eyes of the great majority of residents, the program culture supports asking for help (especially regarding procedures). The program expects its residents not to go out on a limb in terms of either their comfort level or their competence. It expects that residents will make sure they know how to do a specific procedure before attempting it independently. The consensus was that most IM residents are not "cowboys" – they know when to stop, and also when not to start. No one admitted to ever doing a procedure where they did not feel competent, although a couple of residents owned to doing procedures where they didn't feel fully competent, but needed to learn, and felt they would not be putting the patient at any significant risk. One resident recognized that you shouldn't keep trying a procedure "for pride's sake." According to the residents, reaching out for help (especially procedures) was usually well-received; people from other

services were seen as “pretty nice” about helping out. The general consensus was that IM attendings were always approachable, supportive, nice, “not rude” about being asked to supervise or help with a procedure, and “never called a resident out” for not being able to do something. Especially at UCI, residents felt there were always plenty of people around to ask for help.

There are some concerns about getting help. In certain settings, residents felt isolated, and would prefer more senior people to be available, so they could run a patient by them or ask an opinion. In these cases (especially at night at certain sites), it seemed consistently hard to find someone to ask, even if the resident would like help. The VA was singled out as an environment where the residents were very much on their own, and it was hard to get help. One resident commented that since VA attendings sometimes didn’t even return pages during the day, s/he felt it was useless to contact them at night. Several agreed that getting help at the VA was very attending-dependent. However one resident asserted that’s/he always had very pleasant, helpful experiences with VA attendings, better than at UCI.

Some residents noted that if they had a rule that they had to ask for help in certain situations, they would be more likely to ask earlier, suggesting that there may be some hesitancy about requesting assistance. Some residents expressed no hesitation at calling an attending; but particularly at night, a few worried that the attending would be annoyed, and think they were “stupid,” not performing at an appropriate level, more like a medical student than a resident. It was also pointed out that if the resident knew a particular fellow or attending would chew him/her out, it discouraged asking for help. One resident reported having been told by fellows, “Don’t wake me up about this next time.”

Another resident commented that if there was a “culture problem,” it was with the residents themselves, in that they tried to be independent, strong, and do things on their own. From one focus group, there seemed to be a tendency favoring asking for help horizontally, from peers, rather than turning to fellows or attendings. Residents defended this practice as stimulating learning (from each other) and as safeguarded by the fact that they could always go up the food chain if they couldn’t solve problems themselves. Most residents reported a mechanism of working their way upwards regarding requests for help that was influenced by the complexity of the procedure/situation, patient acuity, and availability.

In terms of **procedures** specifically, one resident acknowledged that sometimes there was a feeling that you should be able to do again what you’ve already achieved, which can lead to more attempts than are necessarily in the best interest of the patient. Another resident noted the tendency to keep pushing once you’ve have started something. Several residents did admit to trying a procedure more times than they thought was appropriate, but only because they had no good options – attendings were too busy and, in one case, “IR is an incredible hassle here.” This resident went on to express his/her “shock” at the attitude of IR residents and fellows toward providing assistance. Residents seemed to have an arbitrary number in their head regarding the number of procedure attempts. beyond which they would not go or let an intern go before getting help or intervening. Others weighed factors such as whether the patient was awake/sedated or in a lot of pain

in determining how long to persist in a procedure. Yet another resident commented that if you've done a procedure or are a senior, the assumption is you're comfortable with all procedures; while this is not necessarily the case, it makes it harder to ask for help. A couple of residents acknowledged feelings of embarrassment at asking for help, but recognizing that patient wellbeing trumped their personal feelings.

In a distinctly **minority view**, one resident asserted that this program did not emphasize manual dexterity, and there were a lot of residents here with inadequate skills. This individual felt that the culture of the department was to go out on a limb, rather than play it safe (a distinctly outlier view). In his/her view, many residents attempted procedures they weren't comfortable with, or were not skilled at, particularly at night when they were afraid of angering an attending or being perceived as incompetent. Another resident similarly observed that "a lot of residents" were afraid to ask for help, because it might make them look bad in the eyes of other residents. In someone else's words, "a lot of R2s and R3s" were uncomfortable asking for help, and either tried on their own and failed, or stalled, hoping they would not have to do the procedure. Another resident criticized his/her fellow residents for not being more "gung-ho" about pursuing procedures they weren't comfortable with. Yet another comment was that seniors were too busy to teach interns procedures so they just do the procedure themselves, which creates a self-perpetuating cycle where interns don't get enough procedures by the time they are seniors.

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