Five Questions for Residency Leadership in the Time of COVID-19: Reflections of Chief Medical Residents From an Internal Medicine Program

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Abstract

The COVID-19 pandemic has drastically affected the traditional methods residency programs use to train their residents. Chief residents serve a unique role as part of the residency leadership to foster the education and development of the residents. Given the rapid shift in demands on physicians in the face of the pandemic, the responsibilities of the chief residents have also shifted to help prepare the residents to meet these demands as frontline providers. There is not a precedent for how residency programs respond to this crisis while maintaining their primary role to develop and train physicians. The authors have identified 5 questions chief residents can ask to guide their program's response to the demands of COVID-19 during this uncertain time in health care.

Residency programs share a common goal: educating and developing competent, compassionate physicians who are ready to independently practice medicine. Each program takes on this challenge in different ways; however, the themes are often the same: provide diverse exposure to a variety of clinical conditions, motivate educational inquiry, and cultivate an environment that fosters resilience. Another goal we all share is instilling and modeling courage in the face of uncertainty. And while many of us passed this final milestone slowly on an uneven arc that swept beyond residency, our residents have been catapulted into a crisis that will come to define their training and identities as physicians.

As chief residents, we serve a unique leadership role in the program: operating as a conduit between the program directors and the residents to help them meet the goals of the residency program. As we navigate this uncertain time in health care, we have identified the following questions as the most important in maintaining our identity while addressing these goals in response to the demands of COVID-19.

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1. What Are Our Program's Core Values and How Do We Maintain Them?

In considering this question, we have reflected on what makes our residency program "ours." What traditions are carried forward each year that form the foundation of our residents' shared experiences? What aspects of our curriculum and culture mold our residents into strong graduates of the program? Our reflections have highlighted several essential principles that together support our program's mission and exemplify our core values. When we took on the role as chief residents, we expected to focus on these questions as we moved through the year, with the comfort of modeling our responses after those of chiefs that came before us. However, as our programs have been thrust into a pandemic, we have had to acknowledge that the examples we followed are no longer applicable. Reviewing and reengaging with these questions has helped anchor us to our central purpose as we make large structural changes to our programs to adapt to this pandemic.

For example, we firmly believe that dedicated training informed by theories of medical education is a crucial part of residency training. To enhance our didactics under the guidance of adult learning theory, we flip our classrooms; use case-based teaching styles; and use interactive tools such as simulations and small-group learning to replicate realistic, probing clinical scenarios and to facilitate deep learning. Since we rely on group settings to implement many of these strategies, the isolation imposed by COVID-19 has presented an extraordinary physical challenge to our educational philosophy. We have quickly come to recognize that COVID-19 has created a learning environment of its own and has presented a unique opportunity for us as medical educators. Our learners are experiencing a pandemic, a rare event that in itself is stimulating the parts of the brain that facilitate deep learning. Our task has been to work with this material and provide our residents with an effective educational experience. To that end, we have manipulated the learning environment by using asynchronous learning and digital media. We have transitioned some of our conferences to remote learning and have used spaced learning tools to keep our learners actively engaged, including podcasts, email-based clinical vignettes with associated questions and clinical images, and "tweetorials" (tutorials composed of several linked tweets, available only on Twitter, which may include links to other sites and short videos). While we will gladly return to our in-person teaching sessions, some of these solutions will surely innovate the methods we use to implement adult learning theories for years to come.

We have also had to adapt to providing high-quality and pertinent education on the literature around this disease.

While our residents are comfortable with triaging hypotension and responding to chest pain, it is our job to make sure they understand how to apply these principles to a patient infected with COVID-19. Our goal of training well-rounded, competent physicians remains the same; however, this infectious disease will leave its mark on nearly every medical condition we learn to diagnose and treat.

2. How Do We Manage Communication?

In times of confusion and crisis, a unified message is essential to effectively help guide a team. Inconsistencies in messaging risk increasing fear and doubt and impairing physicians from maintaining a clear purpose. Our residents have been exposed to an overload of information from both within and outside of the hospital. In the face of daily, and sometimes hourly, changes in policies, recommendations, rules, and restrictions, we have had to think about how to distill communication for our residents who are uniquely vulnerable to this excess of information as they make up the majority of our frontline providers.

In response to these communication difficulties, we have found the following principles to be important:

- Expectations: Things will change frequently.
- Reassurance: We will be a source of truth and distill the deluge of information into concise and pertinent updates.
- Predictability: The timing and location of our communications will be predictable.
- Availability: We are available to address persisting questions or concerns.

Our initial response to managing communication in adherence with these principles has included sending a daily scheduled email with updates on staffing, residency changes, and hospital policies; holding small-group Q&A sessions with floor teams; and hosting digital discussion forums. While there has still been confusion and distress, these communications have been essential in maintaining a sense of well-being and confidence among the residents.

3. How Do We Maintain Community?

A large part of the residency experience is defined by the community that residents build with their peers. Debriefing about an emotional patient encounter, sharing an interesting clinical case, or sitting together for lunch are all necessary and formative experiences for a developing physician. To foster community within our program, we divide the house staff into 4 smaller firms to facilitate mentorship; we lead multiple daily conferences; and we support activities outside of the hospital, including annual dinners and brunches hosted by our leadership. Closeness is an integral part of residency training and has been challenged by the current efforts to minimize the spread of the virus. We know implementing policies related to social distancing is critical, but this necessary regulation of physical separation can also inadvertently result in feelings of isolation. Redefining the concept of social distancing to mere physical separation and finding ways to enable emotional connection between us have been critical to maintaining a sense of community within our program.

Similar to how we addressed our learning environment, we have had to modify the setting for community building and embrace virtual domains to do this important work. To meet this goal of maintaining community and bringing residents "together" regardless of physical location, we have looked to ways we can provide support for one another. We have encouraged teams in the hospital to spend time sharing stories and coping strategies, acknowledging the impact of small acts of kindness. We are also implementing online discussion forums and videoconferencing to meet these goals. While we look forward to returning to the old way of building and maintaining community, we might have stumbled on a solution to help our residents remain engaged and unified regardless of their clinical rotation.

4. How Have Our Roles as Chief Residents Evolved?

As chief residents, our identity was previously defined by the rigor and diversity of our teaching sessions and our ability to provide mentorship to our residents. Since the spread of the pandemic to our hospitals, we have had to shift our teaching material toward less cerebral topics such as the logistics of donning personal protective equipment (PPE), implementing and understanding triage algorithms, and teaching topics that require us to learn new information as we prepare to teach. We have had to redefine our roles as sources of excellence in clinical knowledge and teaching strategy to become leaders in preparing physicians to practice medicine on the front lines of a crisis. Our time and efforts have been refocused to intensive training and preparation of our residents for the work ahead. We have spent a significant amount of our time revising the structure of our wards; augmenting our sick call pool to meet the increasing demands of the hospital; and developing meticulous accounting systems for preservation of PPE, while trying to maintain a sense of calm and remain available to support the residents. When we accepted this role, we never could have imagined the change that would occur in our responsibilities in the setting of COVID-19. We are gaining leadership skills rapidly and testing them in an environment that forces us to quickly learn from our missteps. What impact will our current efforts have for the next group of chiefs? What will our class legacy be?

5. How Do We Create a Sense of "Normalcy"?

This is the hardest question to address as we are currently operating in unprecedented times. The world is far from normal, with nationwide anxiety and insecurity, and nowhere are these feelings experienced more acutely than in the hospital. As frontline providers for COVID-19 patients, we are asking our residents to adapt to changes in policy and management and forcing them into leadership roles while they are still learners. We acknowledge it is naive to think we can make the hospital environment "normal" for our residents. We hope that by focusing on answering the above questions, we can lead our residency program through this pandemic. We are optimistic about finding some positive unintended consequences, such as innovation in our teaching strategies, development of novel methods to build community, elevation of the role of the chief resident, and

the acquisition of leadership skills that could not have been gained elsewhere. This is a natural experiment in medicine, human behavior, and—for us—medical education. We will forge ahead with what we have outlined above and update you as the crisis abates.

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