

The Art of “Senioring”

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I stood huddled among my classmates, full of anticipation, gripping my Match Day envelope in my hand. Time came to a standstill as my neighbors' chatter faded and a distant voice counted down the final moments. The rustle of tearing paper filled the room, then cheers, a scream, and a crescendo of applause. Friends and family embraced in celebration.

Unlike my photographic memories of Match Day, the first weeks of internship were a blur—a whirl of electrocardiograms, chest radiographs, and blood gas reports. I lost myself in the ceaseless momentum of residency until, without warning, my last day as an intern drew to a close. While there was little pomp and circumstance, it represented a major milestone in my developing career as a physician.

With my mantle of experience came new responsibilities. During those first days of “seniorhood,” I came to understand that the knowledge and skills I developed over the past year were not sufficient to effectively guide my new team.

Looking for advice, I began a conversation with a medical school colleague who was also working his way through the experience of “senioring.” We found a number of leadership and teaching practices through our collective experience that served us well as emerging senior residents and, more generally, as physicians. Below we share excerpts of our conversations to highlight and provide context for those practices.

Building Trust

Christopher P. Kovach (C.P.K.): Entering my first month as a senior resident, I thought I was ready. I was quickly surprised by the new and imminent concerns of leading the team. Where did the interns wander off to? Did the medical student walk the pleural fluid down to the laboratory or send it (oh no!) by the tube system?

Matthew D. Ettleson (M.D.E.): You see the intern's empty chair and cannot help but wonder what is going on. Empty chair syndrome.

C.P.K.: Right. I struggled with not being “in the know” at all times. I needed to learn to trust my team

to get the job done without being involved in every detail. My level of comfort improved after I spent time getting to know the team and identified the strengths and weaknesses of each intern. I learned to probe their thought processes in the team room and observed their level of confidence during presentations and procedures. I made quiet suggestions to address areas needing improvement and reinforced positive behaviors. I found it was this process of “diagnosing the intern” that led to building trust.

M.D.E.: I definitely did some “helicopter senioring” early on, too. As my trust in the interns developed, I took the occasional opportunity to simply leave the room. This demonstrated my trust in the interns and gave them space to operate independently.

Find Your “Antibiotic Man”

C.P.K.: I *had* to teach antibiotics. My team was recommending a thick coating of vancomycin and piperacillin-tazobactam for every patient whether they had pneumonia, cellulitis, or a urinary tract infection. I experimented with different “off-the-cuff” approaches: a list of antibiotics and their uses, how to choose antibiotics for MRSA (*Methicillin-resistant Staphylococcus aureus*) or *Pseudomonas*. Both were helpful (I hope), but my lessons just did not seem to stick. I noticed we were reviewing the same concepts each morning on rounds.

M.D.E.: Off-the-cuff teaching can be tricky. One day, I asked the students about why we treat alcohol withdrawal with benzodiazepines and found myself fumbling through an explanation about GABA (gamma-aminobutyric acid) receptors and seizure thresholds. I got mired in unnecessary details and did not get my main point across concisely. The session came to a sputtering end with a couple of hand-wavy explanations—not my best teaching moment.

C.P.K.: But it probably taught you the importance of lesson preparation. With my antibiotic talk, I had better luck after I thought about a way to maintain their engagement with the material by highlighting the organ- and infection-specific nature of antibiotic choice. I prepared a diagram of an “antibiotic man” that focused their attention and generated a more enthusiastic response. The next time I was on service,

I taught the “antibiotic man” early on and found that the team was choosing antibiotic therapy more wisely.

Know Your Audience and Offer a Challenge

M.D.E.: I was starting a new rotation on the VA inpatient unit and had prepared a talk on implantable cardioverter defibrillator placement in ischemic heart disease; I had learned my lesson from my prior GABA receptor misadventure. I still had problems. For the interns, the lesson was not specifically applicable to their patients. For the students, it did not provide a broad enough context given their lack of clinical experience.

C.P.K.: Sounds like you were prepared, but for the wrong audience. It’s difficult when you have learners at different levels, like seasoned interns and third-year medical students.

M.D.E.: I found Lev Vygotsky’s theory on zones of proximal development helpful in addressing that problem. Simply put, the teacher strives to identify the environment in which each learner is forced to expand his or her knowledge while remaining supported. I applied this concept by moving away from scripted teaching, instead asking the students to list common triggers of heart failure exacerbation. After exhausting their ideas, I asked the interns to offer a few uncommon causes and posed follow-up questions. In this way, each tier of learners was challenged to expand their knowledge with the support of the teacher and each other.

C.P.K.: Another way to do that is through hypothetical scenarios. The interns, students, and I frequently engaged in impromptu learning experiences on rounds in the form of “what-if” scenarios. Name a disease and let’s talk about a relevant rapid response scenario. “How do we manage a patient with shortness of breath and a rapid irregular heart rate?” I looked to the students for the diagnosis and

initial management. With each Socratic iteration, I imposed rising clinical acuity to challenge the more experienced interns. “Why wouldn’t you use diltiazem to treat rapid A-fib in this patient with a large pleural effusion?” A good “what-if” scenario can help the team generate a shared model of clinical problem solving and teach learners to think through future possibilities and the consequences of their decisions.

Final Thoughts

We believe there is no replacement for the demands of intern year in facilitating the growth and development of a medical student into a successful resident. However, the skills of great senioring, in the forms of leadership, teaching, and mentorship, are those that foster the development of outstanding physicians. Knowing the strengths and weaknesses of your team members will add to the process of building trust within the team. Preparing a thoughtful teaching plan is key, but keep your target audience in mind. Try to recognize those moments when your experience as a senior is needed, and those when you can encourage independence by stepping away. We hope that these teaching pearls help those in the midst of internship (and beyond) and assist in the transition to supervisory roles. To those who have not yet opened their Match Day letters: enjoy the learning process and take note of the traits of your most successful mentors—you will be seniors before you know it!



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