

A Personal Journey on the Sometimes Bumpy Road to Competence

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When I started my internal medicine residency training in 2010, the program I entered had yet to graduate its first cohort of residents. The program was accredited by a regional medical council that dictated the length of training, specified the required core rotations, and governed the board examinations. This council did not prescribe a robust educational structure or assessment framework, but I understood the program's limitations. In my heart, I used to feel that no matter what obstacles I would face, I would surely overcome them.

I spent most of my first year of training on general internal medicine inpatient rotations. A typical inpatient team consisted of an attending physician (consultant), 1 to 2 specialists (physicians who have completed their specialty training and examinations), and residents. Because of the program's relative newness and small size, there was neither a designated clinical teaching unit nor resident-led rounds. Consultants came from various international backgrounds. This created opportunities for exposure to diverse teaching styles; it also generated uncertainty about the roles of each member on the team. Ward rounds were service-focused, with education taking place mostly during daily morning reports and noon conferences. I used to compare our program to other international programs my colleagues joined. I longed for having a continuity clinic, being able to participate in more procedures, and scholarly activities.

During one of my early ward rotations, I was assigned to a new team. I did not know any of the 20 patients on the team's list. On the first day during rounds, I was assigned to discharge 3 patients. It was the norm then to assign discharges and the associated "scut work" to the most junior resident on the team. On this day I also had been assigned several other patients with active medical issues.

One patient I was assigned to discharge was an elderly gentleman who had been admitted with gastrointestinal bleeding. He was on warfarin for atrial fibrillation and on the day of discharge, I needed to confirm that he was on a therapeutic dose of this medication. I vividly recall the blank expression on

his face as I counseled him about his medications and gave him instructions on international normalized ratio (INR) monitoring. I had serious concerns that he did not comprehend the discharge instructions I provided. Yet I was worried about being perceived as a less than competent resident and hesitant to call my consultant who was busy in the clinic. I went ahead with the discharge.

Within a week, an elderly patient who was admitted with gastrointestinal bleeding and supra-therapeutic INR was presented at morning rounds. To my horror, this was the patient I had discharged a few days earlier. I felt an overwhelming sense of failure and shame, and I wished the earth would split and swallow me up! However, I did not disclose this to anyone. My defense mechanism was to pretend I had not been involved in the earlier discharge. I avoided all contact with the patient, although I closely followed the updates on his medical management by reviewing his chart every day. I waited for the program director or the attending to scold me for making a major error. That confrontation never happened. The patient was eventually discharged in stable condition. I very much hoped that the discharge counseling he received for this hospital stay was more effective than the one I had provided.

I remember the other cases in which I felt uncertain, especially during the first year of my training, and felt anguish for my patients' safety and my professional future. At that time, the concepts of graded and progressive responsibility and graded supervision were not well understood or universally implemented in our program. Any resident was expected to handle any case regardless of complexity. There was ambiguity regarding the resident's role on the team, what could be asked of him or her, and the level of difficulty of cases that could be assigned to a first-year resident.

In 2013, my program was accredited by the Accreditation Council for Graduate Medical Education International (ACGME-I). In the period leading up to ACGME-I accreditation, leadership significantly transformed the program. The introduction and implementation of core competencies and milestones helped create a mutual understanding and shared mental model between learners and faculty. To me,

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the concept of milestones has been the most important; it made me realize that as a trainee I was expected to grow professionally during training, to allow me to ultimately handle patients independently. After all, when I was a child, I wasn't expected to run before I could walk. Most important, I learned there is no shame in asking consultants and more senior residents for help when I need it.

I was the chief resident when my program became ACGME-I accredited. I witnessed and fully understood the many changes program leaders and faculty made to meet the accreditation requirements. Every person had a role in improving the structure of the program and homogenizing the approach to teaching. I used my chief resident year to integrate the competencies into the academic curriculum, and sought to ensure all residents understood and applied

the concepts of graded responsibility and supervision. This was my contribution to improving the program, and my way of ensuring that all future residents in this program would learn from my experiences as a first-year resident.



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