

Essential Mediators of the Competency Process: Chief Residents as Assessors and Coaches

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Chief residents (CRs) are trainees who are either in their final year or have completed residency and take on specialized roles within the program, typically for 1 year. While the scope of responsibilities varies, CRs tend to serve as administrative leaders for the training program and advocates for residents.¹ Their tasks may include teaching, scheduling, clinical rotation monitoring, and sick call management.^{2,3} These activities place them at the front lines of the residency experience, where they may be the first to recognize a resident is having problems or the first to whom residents may confide when there are concerns about their peers.⁴⁻⁶ Managing scenarios with struggling learners is critical to the competency process. Because CRs are not simply novice faculty, we recommend training or guidance that expressly accommodates their position as trusted intermediaries.

Literature over the past 30 years on CRs consists of job descriptions,^{2,6-12} a personal narrative,¹³ surveys on CRs' confidence,^{1,14} and leadership training programs,¹⁵⁻¹⁷ illustrating an array of CR duties supporting program operations and resident education. Publications since the implementation of the Accreditation Council for Graduate Medical Education (ACGME) core competencies¹⁸ reference CRs' involvement with performance assessment of more junior residents; however, these articles do not focus on CRs' responsibilities with struggling residents. Thus, current scholarship has overlooked the opportunity to describe how CRs can make the most of their unique status as trainees and as faculty in supporting the competency process, a role that can have a deep impact on individuals. Therefore, we offer structured guidance for CRs and program directors to maximize their contribution to the competency process, both as assessors and coaches for struggling residents.

Chief Residents as Assessors: Identifying a Potential Area of Concern

When a resident is facing personal or professional struggles, there may be early behavioral changes. The in-depth awareness of the residency experience that CRs bring as near peers may allow them to recognize these subtle shifts in performance.

Investigate Further

Red flags for struggling residents can include arriving late for work or leaving early, unexcused absences, delayed paperwork, complaints from patients or other health professionals, or changes in social engagement within the program. It is important for the CR to reach out to the resident about concerning behavior early in the process. This conversation solicits the resident's point of view, as they may have limited awareness of potential issues others perceive.^{19,20} Data gathering may involve sensitively checking with peers who can offer additional perspectives about a colleague's work. Other members of the team can provide insight into its potential consequences on patient care.

Apply the "Competency Plus" Model

Once a CR has detected a pattern that may represent an area of concern, it is important to delineate the issues. Expanding on the ACGME core competencies and associated subcompetencies,^{21,22} the "Competency Plus" model²³ provides additional detail into "Patient Care" and, importantly, adds "Mental Well-Being," which can affect performance in any domain.^{24,25} By dividing "Patient Care" (a common concern relayed to CRs) into 3 more readily observable subskills (clinical skills, clinical reasoning, and personal organization/time management), the model provides a more specific roadmap to better identify root causes and formulate next steps. For instance, a resident thought to be "unprofessional" may actually have deficits in communication skills or be experiencing stressors outside of work, which are nuances described in the model that can help CRs

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conceptualize how they might gather information to help target the response.

Communicate and Collaborate

Some issues require urgent communication with program leadership before the CR gathers further background information, especially when there are acute concerns about resident wellness or patient safety. However, it can be challenging for CRs to find the balance between sharing the details of every conversation versus keeping leadership informed. In this respect, the model of clinical autonomy²⁶ is a useful frame: just as residents apply judgement in communicating patient changes to their supervisors, CRs can do the same in communicating resident changes to program leadership. Updates may be needed for significant new events (eg, a resident not responding to emails or requesting the rest of the week off) but not for minor developments (eg, requesting an hour off to attend an appointment). The threshold will vary by program culture and available resources, and expectations for CRs should be established in advance.

For programs with multiple CRs, the rest of the CR team should be kept informed; fellow CRs can serve as sounding boards and collaborators in competency assessment. Additionally, as CRs may rotate among different administrative roles, reliable mechanisms of relaying information (an educational “handoff”) will maintain consistency. Lastly, other CRs in the program may provide a complementary role in coaching, as below.

Chief Residents as Coaches: Taking Action Adhere to Coaching Principles

Key features of the coaching role^{27,28} include mutual orientation toward growth and development, shared reflection on performance and feedback, and a willingness to view failure as a catalyst for learning.^{29,30} Successful coaching entails (1) prompting reflection on performance informed by objective assessments; (2) partnering with learners to identify needs and incremental goals; (3) training learners in self-assessment and self-monitoring; and (4) jointly creating behaviorally based plans.³¹ Coaching is also iterative, and cycles of feedback and assessments should be aligned with milestone-based expectations for each year of training. Preparing struggling learners for this iterative process may help them maintain their sights on the goal of sustained high-level performance.¹² Normalizing the value of coaching for all learners, not just struggling learners, is an important strategy that may facilitate receptiveness to feedback.³² The TABLE describes example manifestations

of issues within each domain, linked to coaching strategies that CRs can rely on to address competency areas.

Take Advantage of System Resources During Remediation

When developing a plan with program leadership to address areas for resident development, resources outside of the program can be invaluable. Examples include professionals who specialize in addressing learning challenges (eg, neuropsychologists),³³ entities that support resident wellness (eg, resident mental health clinic or resiliency offices³⁴), or state-based physician health programs,³⁵ which may provide assessment, treatment (depending on the state), and monitoring for a range of physician issues. Many of these resources also support resident confidentiality with respect to reporting to licensing boards and future employers.

Navigate Potential Hazards

CRs may have concerns that their interactions with residents may be perceived as punitive, especially when constructive feedback is given. This can lead to internal conflict for CRs as they reconcile their roles as resident advocates versus program representatives. Further, it can be very challenging for CRs to cope with difficult program decisions, such as termination, especially when a CR has invested a significant amount working with a struggling learner. It is crucially important that programs engage early in the year with CRs to create a shared vision and establish mutual expectations to support them in these situations; CRs need guidance from their programs to identify situations that warrant detailed documentation and follow-up.

Conclusions

Chief residents can play a vital role in the competency process as assessors, both in the identification of struggling residents and systematic characterization of learner challenges, and as coaches with recent understanding of the trainee experience. These activities are enriched by the CRs’ unique proximity to residents and require special preparation. Accordingly, programs have an opportunity to add competency-based assessment and coaching to their CR preparation processes. This guide is intended to serve as a blueprint for CRs when identifying and assisting residents who may be struggling within a training program. These concepts should be adapted to align with one’s specialty, institutional culture and context, as well as the external entities that interface with

TABLE

Examples of Coaching Strategies Based on the “Competency Plus” Model

Competency	Potential Manifestations	Coaching Strategies
Medical knowledge	- Low scores on standardized examinations - Difficulty answering questions on rounds or in morning report - Difficulty with clinical reasoning	- Creation of a self-directed reading plan - Review of fact-based questions - Review of missed topics in the in-training examination, followed by having learners identify themes in their knowledge gaps - Promoting evidence-based learning strategies¹⁵ (eg, self-quizzing, retrieval), with reflection on how these techniques build knowledge - Iterative needs assessment on knowledge gaps
Patient care—clinical skills	- Missed diagnoses - Incomplete or missing historical elements or physical examination findings	- Direct observation of history taking and examination skills coupled with timely feedback - Simulation of complex care scenarios with use of critical action checklists
Patient care—clinical reasoning and judgment	- Missed diagnoses - Incomplete or overly broad differential diagnoses - Unfocused testing or consulting - Challenges with recognizing patients at risk for clinical deterioration	- Case-based discussion of differential diagnoses and questions that require application of knowledge - Soliciting problem representations (succinct synthesis of a patient's presentation) and modeling one's own thinking process - Changing key clinical scenario variables to practice other lines of clinical care (eg, what-if questions) - Prompting metacognition of the clinical reasoning process for potential cognitive biases
Patient care—time management and organization	- Incomplete patient care tasks - Signing out late - Delinquent clinic notes	- Review of organizational system - Setting of incremental time-based goals to monitor efficiency - Simulation of complex care scenarios with tracking of time to key actions
Communication	- Difficulty with oral presentations - Complaints from patients or allied health team members - Notes missing important content	- Role play verbal and phone communication scenarios, coupled with feedback and repeat practice - Review of audio and video recordings with standardized patients, with prompted self-assessment
Interpersonal skills	- Conflicts with staff - Complaints from patients or allied health team members	- Role play challenging situations with escalating difficulty of scenarios - Review of audio and video recordings with standardized patients, with prompted self-assessment
Professionalism	- Tardiness - Avoidance of work	- Comprehensive mental well-being assessment - Articulating professional norms - Training the learner to self-identify behaviors that may lead to a perception of being unprofessional
Systems-based practice	- Delayed or insufficient involvement of multidisciplinary team - Late consultation	- Stimulated chart review with feedback - Reminders to reach out to multidisciplinary team members to learn more about how best to include them
Practice-based learning and improvement	- Resistance to feedback - Making the same mistakes	- Iterative self-assessment - Observation of responsiveness to feedback in general and as part of the coaching process
Mental well-being	- Any of the manifestations above - Exhaustion and irritability - Withdrawal from social events - Unexplained absences	- Acknowledgement of burnout as a common and normal challenge - Frequent check-ins - Offering time and office space to talk - Early referral to professional mental health care with program assistance

programs in this domain, such as the local graduate medical education office, the ACGME, and specialty boards.

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