

Transition to Practice: From Resident to Faculty at the Same Institution

BRANDON R. ALLEN, MD

From the first day of residency I knew I wanted to enter an academic career. As an emergency physician, I felt that being a clinical faculty member was my calling. To be able to impart knowledge, to assist in training the next generation of emergency medicine physicians, was an opportunity I could not pass up.

In retrospect, the transition from resident to faculty member was as seamless as one could hope for, yet there still were many challenges. I went from chief resident of my residency program on June 30 to assistant professor on July 1. From the standpoint of logistics and knowing the emergency department, having done my residency in the department gave me an advantage over faculty recruited from other institutions. I had the firsthand knowledge of every faculty member's practice patterns, and knew the ones I would consider models for "best practice" for my management of patients. Yet there was 1 aspect of my new position that gave me angst and trepidation—my relationship with the residents who very recently had been my peers.

I went from making the schedule for the residents in the program to being the physician in charge for their 8-hour shift. How would I be received? How would I handle a conflict or a resident who did not follow my suggestions for patient management? Would senior residents who had recently been my peers embrace my teaching style? I would drive to work with butterflies in my stomach, and I started my shift with sweaty palms. I was very afraid of failing. Nobody wants to be the faculty member residents do not want to work with.

What did I do? I kept it simple. I asked myself, "What would I have wanted from junior faculty?" With this mantra I chose to see patients on my own, called consultants, and admitted patients to the hospital—all to decrease resident workloads. I defended residents in times of conflict. Even so, there were not many "perfect" shifts in our busy emergency department and I found myself continually applying the retrospectroscope on myself, rethinking decisions and actions. Whether it was multiple septic patients or trauma alert activations, often it seemed

like I was always just keeping my head above water. Trying to let residents grow as leaders during resuscitations without sacrificing the patient's well-being is a tough balance. I was so used to being the proceduralist and "doer" that I had to restrain myself from jumping in for that central line or intubation. In one of my first shifts after becoming faculty, I took over an intubation from a senior resident after he or she failed on his or her attempt. I felt terrible. Rather than advising with a new technique or different plan, I had revealed my own insecurities with the situation. I had a lot to learn about myself, and being an attending.

One area I focused on was giving feedback. I remember the "empty" feeling I experienced when my supervisor had little to nothing in the way of formative feedback at the end of a shift. Common but ultimately unhelpful feedback I received included, "Keep working on your efficiency and patient flow," "You should keep reading," and "Great job." Initially, I was no different than the other faculty members when asked for feedback. The customary, "Strong work. Can I help you with anything?" had become a feature of my parting words at the end of a shift.

Then I decided to make a commitment to consistently provide more effective feedback. I sent each resident an e-mail within 24 hours with my thoughts on the previous shift. My feedback was from the heart, with little censorship. At first, when I told postgraduate year-3 residents to correct their note or expand their differential diagnosis, I expected them to be taken aback. To my surprise, the residents thanked me for my candor and willingness to provide uninhibited evaluations.

I came to the quick realization that residents crave feedback with an insatiable appetite. The days when hearing nothing from your program director was considered a good thing apparently are gone. The current generation of learners expect a report on their progress in a timely manner. If a resident who is known to have shortcomings in his or her knowledge base or management of patients does not receive this feedback, how will he or she know the areas that need to be addressed?

During a faculty meeting a few months after I started sending feedback e-mails, my department chair said, "I'd like to share with the group what one of your colleagues has been doing for resident feedback. Brandon has done something that should be a model for all of us." Those butterflies and sweaty palms from my first several shifts as

Brandon R. Allen, MD, is Assistant Professor and Assistant Medical Director, Department of Emergency Medicine, University of Florida College of Medicine.

Corresponding author: Brandon R. Allen, MD, University of Florida, 1515 SW Archer Road, Gainesville, FL 32610, brandonrallen@ufl.edu

DOI: <http://dx.doi.org/10.4300/JGME-D-14-00266.1>

an attending were back. I squirmed in my chair and looked straight down at the paper I was taking notes on, trying not to make eye contact with anyone. I could feel the heat rising from my face as I began to turn red with embarrassment. Would any of them take this as a personal attack on their teaching style? Fortunately, I was met with questions about “how” rather than “why.” For the first time, I felt that I was truly viewed as a colleague.

At the start of my journey as a new faculty member, I asked myself whether it was more important to be popular or to be effective. I initially chose popular, but I think I

have moved to effective in terms of providing frank feedback. Coming from an athletics background, some of the most respected and effective coaches were not interested in being my friend but did want to be my mentor, and all had a gift of translating athletics into life lessons. When it comes to wins and losses the stakes are higher in emergency medicine, but the message still rings true. Years after my playing days were over, I called one of my coaches to thank him for his contribution to my growth. I hope I can have a similar effect on the residents I supervise. I think my transition to practice is moving in the right direction.