TEACHING PRACTICE MANAGEMENT IN FELLOWSHIP

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Literature is limited for teaching practice management (PM) specifically in fellowship. The American Society of Anesthesiologists has practice guidelines focused on practice management information for residents moving on to private practice and academic careers. Personal PM advice received on the last day of critical care fellowship included:

1. Buy the least expensive house in the best neighborhood
2. Say yes to everything
3. Be punctual
4. Leave tracks
5. Do what you ask someone else to do.

This seemingly limited advice translated into a much larger spectrum covering much of what is professionalism in PM. 1. Save money, invest, contribute to a 401k; 2. Say yes meaning to academic projects for promotion, trades with colleagues, cover calls, be a good Departmental citizen; 3. Be punctual as it is a marker of dependability, turn work in on time, be early for work shifts already dressed in scrubs ready for signout by the time you are to assume care of the patient, be timely with compliance, billing, continuing medical education requirements; 5. Leave tracks means to document honestly and thoroughly, 5. Do what you ask of others- learn how to do what you are requesting from colleagues, nurses, other services and be a team player.

The outline for this talk includes:

1. Review basic tenets of PM published by the ASA
2. Discuss the role of the hidden curriculum
3. Explore how to teach leadership in fellowship
4. Know limitations to effectively teach PM
5. Assess where we are- how are we doing teaching PM?

The ASA PM guidelines offer practical advice on professionalism in addition to legal and regulatory information for anesthesiologists.[1] The guidelines address the strain put on physicians needing to be educated in negotiating contracts, running a business, and understanding legal implications to practice, while delivering patient care. Certain outcomes are expected, others we strive for. Legally clinicians need

to meet the minimum standard of care, medical care for a patient could be pass/fail (pass they live, fail is death), and for business, the goal is saving money. This might meet minimum standards, but does not address our moral and ethical obligation to do what is right, to have the best outcome for the patient with minimal morbidity, to exceed the standard of care legally, and to save money but not at the risk of patient safety.

Physicians face tremendous pressure including, as outlined in the ASA PM guidelines, managed care and regulations, shrinking resources, increased clinical volume, sicker patient population, lower compensation, often resulting in physician cynicism and burnout. This can affect professionalism that is defined as "a set of values, attitudes, and behaviors that focus on commitment to service". Attitudes and behaviors include integrity, availability, accountability, and altruism; honesty is a key value that is critical to an ethical and moral practice; respect and compassion need to be shown to patients, families, colleagues and coworkers; and effective communication requires active listening, closed loop communication, and confidentiality.

Physicians need to accept responsibility. This includes maintaining records that are accurate, legible, and temporally related to the timing of seeing the patient; embracing rules and regulations such as maintaining licensure, being compliant with a medical staff office, and completing continuing medical education; being a teacher instructing coworkers and patients; and being a role model to coworkers, students, and residents. Conduct is a component of responsibility that is evident in 1. appearance- you should dress for the job you want; 2. Clinical setting- being patient focused and present rather than distracted; 3. Being a good citizen by participating in hospital committees and medical societies; 4. And having a good attitude that is positive, "can do, will do" rather than obstructionist.

Components of medical education include the *formal curriculum*, which is stated, intended, required, the *informal curriculum* that is unscripted and interpersonal, and the *hidden curriculum* that is composed of values and influences reflecting the culture of the organization.[2] A formal curriculum may include set didactics on septic shock and acute lung injury, the informal curriculum can be the bedside teaching between faculty and resident discussing experiences managing septic shock, or more informal the discussion over dinner among the call team about the day's cases and co-worker interactions. The hidden curriculum however is the culture that is perceived and perpetuated among workers in an organization, whether positive or negative. For example, the cited article mentions an incident of a Chief resident saying to a medical student "why are you wasting my time? Just get to the important stuff". If this approach is tolerated, it suggests in a hierarchy it is acceptable to be rude if you are doing something important, it ignores the learning curve that the student would do better if the student knew better, and it negates that social aspects of medicine are important.

What is taught and what is learned may be very separate. Limitations to the informal and hidden curriculum include who the receiver is, their understanding, experience, and perceptions. For example, you can have emails sent and announcements at meetings stating the scrubs must be worn under a white coat, or you will risk suspension. Then you see a fellow in the garage in scrubs without a white coat. Did the fellow not read the email or attend the meetings (poor professionalism), did the fellow receive the information but not understand what was being said? Was the fellow's past experience that policies are not enforced so this won't affect him/her? Or is the fellow not agreeing with the policy and thinks he/she is above needing to follow the rules- the rules are for someone else. In this situation, a hidden curriculum

of demonstrating correct behavior by example (faculty wearing white coat with 3 buttons over scrubs) will not be sufficient to change the fellow's behavior. This "receiver" may need direct verbal correction of behavior since the subleties of the hidden curriculum may be ignored or not recognized as a teaching point by this fellow.

Leadership lessons from the military have been applied to postgraduate medical education for curricular development. Similarities between the military and medicine include fast decision-making, often in critical situations, advanced equipment, and changing team leadership/membership roles depending on dynamic situations. In both medicine and the military there is decision making that is proactive and collaborative.

Self-awareness has also been found to be critical in effective feedback during graduate medical education.[6] The Johari window separates feedback into 4 categories: 1. Behaviors known to self and others, 2. Behaviors unknown to self but known to others, 3. Behaviors known to self and unknown to others, 4. Behaviors unknown to self and others. Common to each window is how the self-awareness affects how the feedback is given and how it is received. A barrier in graduate medical education feedback is often the interpersonal relationships that develop on small teams, making it easy to provide compliments, but difficult to provide blinded or constructive criticism due to the close working environment. The learning environment becomes one that the faculty/fellow relationship can be friendly, but not friends.

Outside of financial and legal components to practice management, here is a top 10 list for graduates embarking on clinical practice:

1. Audition for your job everyday
2. Be a good citizen
3. If you don't know, say I don't know and figure it out
4. Talk when you have something to say
5. Learn names
6. Be willing
7. Say thank you
8. Be a patient teacher, and continue to learn yourself
9. Give your best
10. Have gratitude.

Character is "doing the right thing when nobody's looking". J.C. Watts.

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