Residency Program Alert

INSIDE THIS ISSUE

Gauge applicants' non-cognitive attributes with multiple mini interviews format

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Most applicants put the best version of themselves forward during an interview to impress program directors and faculty. So, it's often surprising when an individual who was the epitome of professionalism in the interview process enters the training program and acts unprofessionally or lacks communication skills.

Screening for attitudes is a challenge for interviewers. The traditional structured interview style where the interviewer simply reviews a candidate's CV or test scores may confirm his or her medical knowledge, but it will not identify a candidate who isn't a team player.

"Really ask yourself, are the interviews you're conducting really getting you the residents that you want to be a part of your program? If not, multiple mini interviewing is a great way to seek out the people who are going to be a great fit with your culture," says **Ryan Zimmerman, DO,** internal medicine osteopathic program director at Tower Health System—Reading (Pennsylvania) Hospital.

Multiple mini interviews, or MMIs, involve a series of eight-minute interviews with five blinded interviewers who have not seen any information about the

candidate. The candidate reviews a patient scenario, ethical dilemma, or other situation directly before each meeting and then describes to the interviewer how he or she would handle the situation. Each scenario reflects character traits the ideal resident would possess. For example, "if we want to test somebody's humanism, we give them a scenario that requires application of humanistic principles of empathy," says Zimmerman.

In addition to professionalism, empathy, and communication skills, MMIs are great for assessing:

- Mindfulness and ability to self-reflect
- Capacity to handle stressful situations
- Flexibility and propensity to innovate
- Ability to work in teams
- Desire to learn and ability to incorporate feedback
- Cultural awareness

With some work, a strong team (program director, faculty, and program coordinator) can implement MMIs and enhance the quality of residents they select for their programs. To successfully implement MMIs, you must have:

- Thoughtful MMI scenarios
- A well-executed interview day, often managed by the program coordinator and other program administrators
- A candidate evaluation framework that accounts for the MMI results as well as traditional qualifications, such as test scores

Early preparation is key to successful implementation

Right now is the time to decide whether you want to use MMIs during next year's interview season. You will need several months to do the following:

- **Get faculty buy-in:** Understandably, some faculty will be apprehensive about changing the candidate selection process. MMI interviewers will not have any information about candidates, such as their medical school or test scores, until after the MMI is completed; this can be a hard sell to faculty members. In these cases, present the data published about the MMI format.
  MMIs have been shown to increase inter-rater reliability, Zimmerman says. Having five faculty observers results in a significant number of data

points and a fairly complete picture of a candidate's disposition, Zimmerman adds.

Evaluators are also less biased because they are blinded to the candidate's application file and only rate the candidate based on MMI performance. Bias is also further reduced because all candidates receive the same scenarios and are evaluated on the same scale.

The information produced by MMIs is more reliable for making the high-stakes decision about whether to bring a candidate into your program, Zimmerman says.

- **Identify the ideal residents for your program:** The program director and faculty members should start by identifying the non-cognitive traits they want to see in residents. Look at current issues you're experiencing with trainees in your program and think about the qualities an ideal resident would have.

  For example, residents in Zimmerman's program were not always receptive to feedback, so the program developed an MMI case to test openness to feedback.

  "We give them a situation about receiving feedback that they think may or may not be accurate and ask what their action plan would be with their mentor to implement that feedback," Zimmerman says.

  Also consider the initiatives residents will partake in throughout training and the traits successful residents have. For example, Reading Hospital has a program for providing care to homeless patients. As such, empathy is extremely important for trainees, so several of the hospital's MMIs evaluate empathy.

- **Develop MMI scenarios for each identified trait:** Ask faculty members who frequently participate in interviews to help develop scenarios. Use actual patient care interactions often faced by residents in the program as inspiration for the scenario—just ensure they reflect the attitudes and behaviors you want to evaluate.

  Make each case broad enough that there is no correct answer. "If the applicant thinks we have a right answer in mind, they force themselves

Prep interviews with mock MMIs during training

Faculty training on the multiple mini interviews (MMI) technique is crucial to identifying candidates who have the traits important to your program, says **Ryan Zimmerman, DO,** internal medicine osteopathic program director at Tower Health System—Reading (Pennsylvania) Hospital.

Train faculty a few months prior to the first interview day. Start the session by reviewing the scenarios with the faculty members. Explain the attitudes the scenario is designed to assess and what the interviewer should look for in successful and unsuccessful responses. Once everyone is on the same page, conduct mock MMIs.

"You have six to eight minutes with the applicant, so it moves quickly," Zimmerman says. "We practice the pace to make sure the faculty can cover what they need to cover."

Getting the tempo down ensures that faculty interviewers will have time to ask additional probing questions that delve deeper into candidates' responses to assess the desired characteristics. Instruct interviewers to ask follow-up questions that require candidates to:

- Defend their positions while remaining adaptable
- Demonstrate clear verbal communication
- Display their emotional quotient
- Explore the "why" behind their positions

Additionally, prepare interviewers to spot candidates who have rehearsed their answers. One drawback of MMIs is that after you use the technique for a year or two, applicants often share the cases online after their interviews. This is an issue because practiced answers are not indicative of the resident's true personality, so the interviewer needs to quickly move into the probing questions.

According to Zimmerman, applicants who have reviewed the cases prior to the interview day will:

- Use terms that they should not be familiar with yet, such as lingo associated with hospital quality improvement projects
- Answer quickly without thinking through the scenarios or showing any signs of struggle or emotion
- Monologue for the entire time without having a two-way conversation with the interviewer

When it comes to selecting whom to train, include enough faculty to head off scheduling issues during interview season, says **Mary Lisney,** program manager for the internal medicine residency at Reading Hospital.

Consider including the chief residents and rising chief residents in the training and as interviewers. Not only do they add to your MMI-trained interviewer pool, but it's great for them to have input into the residents they will work with, says Lisney.

to answer in a certain way that may not reflect who they really are," Zimmerman says. As such, stay away from scenarios that test medical knowledge. Programs already cover that ground through CVs, test scores, and GPAs, Zimmerman says. (See the accompanying sidebar for a sample scenario.)

- **Schedule faculty and reserve rooms:** Every interview day will require the presence of five faculty members and the program director, plus space for each interview. Put those dates on faculty members' calendars as early as possible to reduce headaches, advises **Sharon DuAime,** the program director's administrative assistant at Reading Hospital.

"That's probably one of the biggest problems—we have limited faculty doing the MMI. If they went on vacation in November and didn't tell us, we were scrambling and had a hard time finding

back up," DuAime says.

The MMIs at Reading Hospital take about two-and-a-half hours, which includes the interviews and a post-interview meeting to score the applicants, Zimmerman says.

Map out MMI logistics

If you're not compulsively organized, a lot can go haywire on the day of the interview, says **Mary Lisney,** program manager for the internal medicine residency at Reading Hospital.

Prior to starting the MMIs, Zimmerman suggests briefly describing why the program uses MMIs and reassuring candidates that there is no right or wrong answer for each scenario. The goal is to put candidates at ease so that they will show their true colors during the MMI. Give them a quick review of the order of the stations as well.

Candidates at Reading Hospital rotate through the following eight stations:

- **MMI stations #1–#5.** Each MMI lasts about eight minutes. First, candidates review the case study outside of the interview room. This typically takes about two minutes. When they are finished, they enter the room and discuss the case with the interviewer for about six to six-and-a-half minutes.

- **Program director interview.** This is a traditional-style interview. Unlike the MMI interviewers, the program director is not blinded to the applicants' files. During this time, the program director asks candidates about their qualifications and clarifies any items of note within the application file. This is a "double session," lasting 16 minutes.

- **Break.** Applicants have one eight-minute round to catch their breath, use the restroom, etc.

Because there are eight stations, the program invites eight candidates to interview each day. They have 35 interview days, which are always Monday and Tuesday.

Lisney and DuAime tag-team logistics on interview days to ensure everything runs smoothly. "For the first session, we wait until everyone gets to their station.

Sample MMI scenario and scoring sheet

The following is a sample MMI scenario that evaluates the candidate's professionalism and ability to handle pressure, empathize with the patient experience, and disclose a medical error.

You are an upper-year resident rounding on a new admission of an 80-year-old woman from an assisted living center with moderate dementia and neuropathy. She was admitted last night by your night float for DM foot ulcer and to rule out osteomyelitis.

You interviewed and examined the patient on morning rounds, and the exam was consistent with your night float team's assessment. Reviewing her studies, you note that the MRI was completed on the wrong foot.

You are now summoned to the patient's room as her daughter is requesting an update on her mother's status and the results of the test so far.

The following are example probing questions faculty interviewers might ask the applicant:

1. How would you respond if the patient's daughter tells you her mother frequently sundowns when in the hospital, and she is angry that this mistake will extend her stay?

2. How would you respond if the patient's daughter asks, "We have a 20% copay. Who will pay for this mistake?"

3. How would you prevent this type of mistake from happening again?

Source: Ryan Zimmerman, DO internal medicine residency program director at Tower Health System—Reading (Pennsylvania) Hospital.

We tell them to open the folder and start reading. I walk to my desk and start the timer for six minutes. At that point, I give them a two-minute warning and set the timer for two minutes," DuAime says.

Communication between DuAime, Lisney, and MMI interviewers is critical to the MMIs running smoothly. Each room has a phone connected to a dedicated intercom. DuAime uses the system to announce the two-minute warning and the end of the session.

Meanwhile, Lisney remains in the hallway throughout the MMIs to ensure that candidates get to the correct room at the right time. She also manages candidates who lose interest, leave early, or finish the discussion quickly. Once time is up, she guides applicants to the next station.

"I keep them right on schedule so that nobody has too much time or looks ahead at the scenario before they're allowed to. It does take some careful policing to make sure it's fair," Lisney says.

MMI scoring and generating an overall score

There are as many ways to score applicants as there are residency programs, but Zimmerman's program has hit on a method that works for them. Immediately following an MMI, the interviewers complete an evaluation form that has two values, both scored with a seven-point Likert rating scale. The first value indicates how the candidate performed overall on the scenario (for example, whether he or she displayed empathy) with the following descriptors for scores of 1, 4, and 7:

- 1: Personality is difficult to work with; unable to empathize
- 4: Provides standard answers without good rationale; can handle basic conflicts
- 7: Top-level emotional quotient; obvious team player; unusually mature; strong conflict resolution skills

The second value denotes the candidate's interpersonal and communication skills, with the following descriptors:

- 1: Poor listening, nonverbal skills; unable to

clearly explain complex problems; poorly understands English
- 4: Average listening or nonverbal skills; clear but not comprehensive explanations of problems; moderately understands English but has difficulty with euphemisms and slang
- 7: Excellent listening or nonverbal skills; comprehensive, clear explanations; fluent in English

Once all MMIs are completed, the MMI interviewers and program director meet to discuss each candidate. The program director reveals the details of the applicants' files and gives a report of his conversations with them, highlighting their responses to anything outstanding or unusual on their applications, Zimmerman says.

Five tips for successfully using multiple mini interviews

After years of conducting and organizing multiple mini interviews (MMI), **Ryan Zimmerman, DO,** internal medicine osteopathic program director, **Mary Lisney,** program manager, and **Sharon DuAime,** program director administrative assistant at Tower Health—Reading (Pennsylvania) Hospital, share several tips for organizing and conducting them successfully:

1. Prepare MMI interviewers by holding a refresher training right before interview season starts. Remind the interviewers of the traits each scenario assesses and the types of follow-up questions that will help them dive deeply into candidates' responses.

2. Inform applicants that they will participate in MMIs. MMIs are an unfamiliar interview style for most candidates, especially international medical graduates, so it's important to set their expectations. In your interview invitation, include information about the MMI format and why the program uses it. Alternatively, you can direct applicants to your program's website for more information.

3. Stick to one area. If possible, keep the MMI stations in the same hallway or area. This minimizes candidates' travel time and makes it easier for administrators to keep track of and guide candidates between stations.

4. Do not start the day with MMIs. If a candidate is late, it will throw the entire MMI schedule off. Instead, start with morning rounds, a hospital tour, or program director for resident presentations. This ensures candidates arrive in plenty of time before MMIs begin.

5. Review the scenarios annually at the faculty retreat and discuss which are successful, dated, or topical. Decide which scenarios need updating for the following year.

Each MMI interviewer shares their scores and impressions for each case. "When multiple faculty members observe the same characteristic, we realize it's probably a consistent finding," Zimmerman says, adding that if raters' impressions are inconsistent, it's probably a red flag.

Taking both the traditional medical education record and MMI scores into consideration, the group then decides which quartile of the rank list they will place each candidate in.

Lisney and DuAime keep the MMI scores and the values the program leadership attaches to other qualifications, such as USMLE scores, in a massive spreadsheet. It calculates an overall score for each candidate based on all of this information. However, they review the formula annually.

"It comes down to identifying our mission as a residency and our priorities. The weight of the scores reflects the type of doctors we try to attract," Zimmerman says. "If we determine that clinical skills, humanism, and interest in the local community are more important than research and USMLE, we change the formula to reflect that."

Although MMIs are a lot of work, they provide a novel way to bring new residents into your program that reflect the characteristics of your ideal physician. ◼

An insider's look at the ACGME's Back to Bedside grant opportunity

This is the first in a two-part series on the ACGME's Back to Bedside program. This month, you'll learn about the program and how to apply. Next month, Residency Program Alert will bring you examples of Back to Bedside projects.

The ACGME is requesting proposals for the second cycle of Back to Bedside, a competitive grant awarded to residents and fellows who develop transformative projects that result in more time spent with patients.

Recipients of the Back to Bedside grant will identify barriers to spending time with patients (e.g., nonclinical and administrative tasks), develop and implement solutions to remove those barriers, and measure outcomes of the interventions. They will present findings at the 2021 ACGME Annual Educational Conference. The deadline for proposals is March 15, 2019.

"Residents are in many ways the front line. They can see what gets in the way of spending meaningful time with patients and find some really innovative solutions," says **Dinchen Jardine, MD,** chair of the ACGME's Back to Bedside Working and Advisory Group.

Recipients of the first round of funding have had incredible success, and Jardine expects even more exciting ideas to come out of the second round of awards. However, if the first cycle of Back to Bedside is any indication, competition for the grant is fierce.

"We anticipated getting a few dozen [proposals], and we got a couple hundred in our first round in 2016," Jardine says.

For this round of Back to Bedside, the ACGME will award $260,000 to up to 32 projects.

With the deadline for proposals fast approaching and the competition stiff, **Residency Program Alert** sat down with the ACGME and two Back to Bedside grant recipients from the first cycle to get an insider's look at the opportunity.

Why Back to Bedside?

With Back to Bedside, the ACGME acknowledges that residents find meaning and joy in their work when they directly engage with patients and their families. Experiencing joy regularly at work is key to avoiding burnout, which is a growing issue in the GME and larger physician community.

"Spending meaningful time with patients is how residents recharge, how faculty recharge. That's the reason we went into medicine in the first place," Jardine says. However, factors such as electronic

health record (EHR) requirements or system ineffi-ciencies curtail the amount of time residents can spend at the bedside. Back to Bedside addresses this issue by allowing residents and fellows to implement foundational changes, clinical practices, curricula, or policies that:

- Cultivate meaning in the residents' work
- Enhance residents' well-being
- Increase the time residents spend with patients

The ACGME intentionally kept the scope broad so that residents would not be limited in where or how they could affect change. The broad scope also ensures that trainees from all specialties can partici-pate in Back to Bedside, even those that do not have as many opportunities for immediate patient contact, Jardine explains.

"If they can tie [the idea] back to meaningful time with a patient, we will certainly consider it," Jardine says.

Ultimately, the ACGME intends residents' and fellows' Back to Bedside projects to serve as models and best practices for institutions around the country. The ACGME's website includes highlights from the first cycle of Back to Bedside as well as the grant application.

Project selection: Think patients and passion

Identifying a project is the first step in applying for Back to Bedside. In addition to meeting the param-eters set by the ACGME, residents must select a topic that will produce a foundational change in the pro-gram, says **Owen Kahn, MD,** a third-year pediatrics resident at Connecticut Children's Medical Center in Hartford and a Back to Bedside grant recipient.

Change often meets resistance, so ensure buy-in by involving many residents in the project selection. All of the residents in Kahn's program met to brainstorm and identify inefficiencies that keep them from spend-ing time with patients. They selected two interventions that would free up the most time:

- Automating the import of documentation in the EHR from the handoff into the progress notes, thereby eliminating duplicate documentation

- Eliminating pagers by putting residents on the same internal messaging application as nurses

Implementation is still underway, but the projects have gained the support of hospital leadership across multiple departments. Kahn has the support of health information management to update the format of the handoff and progress notes in the EHR. Furthermore, the hospital CEO decided to invest in a new commu-nication system across the hospital that would elimi-nate pagers for everyone, not just the residents.

"It's way out of the scope of what we were expecting, but it will lead to an even better communication ecosystem at our institution," Kahn says.

In addition to having buy-in, residents should pick a project they are passionate about, says **Kathryn Harold-son, MD, MPH,** a third-year internal medicine resident at University of North Carolina School of Medicine in Chapel Hill and a Back to Bedside grant recipient.

"It's a two-year grant, so you want to have something you're excited about," Haroldson says. "I've always been passionate about resident well-being, so that was the impetus to apply."

Developing and implementing these projects takes a lot of time and work, so the topic should be something that the residents are excited about and motivated to work on, she says.

Haroldson evolved the program's patient rounds from the traditional model that largely takes place outside of the patient's room to a patient-centered rounding model that occurs at the bedside.

"We get to spend more face time with patients talking to them. It makes everything more human," she explains.

Tips for completing the application

Jardine provides details on a few important sections of the grant application:

Evaluations: The ACGME asks applicants to detail a plan for evaluation of the project's progress. In the first round, the ACGME intended that all Back to Bedside recipients would use the same evaluation to assess the

outcomes of their projects. In the second cycle, participants will develop project-specific evaluations.

Jardine says including this question on the application will get residents and faculty members thinking about evaluation methodology early on in the process. Additionally, having a plan to evaluate project interventions will help facilitate IRB approval.

"Some groups had barriers to getting their IRBs [internal review boards] to approve the project, oftentimes because they were changing what the evaluation tool would be as time went on," Jardine says. "They had to go back and reapprove and change the protocol."

Succession planning: Applicants must include a succession plan that takes the project from the time the ACGME awards the grant through 2021. "We recognize that if a senior resident has taken on this project, we don't want it to go away if they graduate," Jardine says. "Someone still needs to carry on that work."

Include junior residents on the Back to Bedside project team so that they have ownership from the beginning and can finish the project after senior residents graduate, Haroldson suggests.

Jardine says many residents who participated in the first round stayed on at the institution after graduation and were able to complete the project.

Dissemination within the institution: One of the ACGME's goals is to disseminate the best practices and data that come out of the Back to Bedside Project. As such, the ACGME asks how the team will collaborate and spread the word about their projects within the team's home institution.

We're seeking experts

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– Son Hoang, Editor

Additionally, just like at Kahn's institution, many of the Back to Bedside projects were first implemented at the program level and later expanded to other programs or the entire institution. This question asks applicants to think outside of their immediate workspace early on so they are prepared for possible expansion once the project is underway, Jardine says.

What to expect if selected

Once selected, it will take some work to launch the project. From the start, the ACGME will ask awardees to complete many specific tasks that facilitate project development, Jardine says.

Information from the ACGME will include:

IRB protocol: The ACGME will ask residents earlier on in the process to explore how the institution's IRB process works ahead of time in hopes of reducing delays.

"Some [participants] were surprised by the amount of time it took for the individual institutions to approve this as an IRB protocol or to determine it wasn't human-subjects research," Jardine explains.

Faculty mentor: The ACGME will better define this role and provide information throughout the entire project regarding what faculty will need to do and think about so that they're better prepared to help the residents, Jardine explains.

Faculty mentors facilitated the successful implementation of many of the projects in the first cycle by helping residents navigate the IRB process, implement the intervention, get buy-in from faculty and hospital leadership, and select the appropriate evaluation tools. As such, experience with project management and/or research is helpful, but a faculty member without those qualifications should not be deterred from taking on the role. "We will support the faculty," Jardine says.

In addition, residents and faculty mentors will attend two collaborative meetings with other grant recipients. During these meetings, recipients will share experiences as well as how they overcame certain roadblocks.

"I didn't anticipate how helpful the meetings would

be," Haroldson says. "Working with residents doing projects at different institutions has helped us fine-tune a lot of things with our project."

The collaborative aspect among the residents was so important in driving individual projects that the ACGME will provide virtual collaboration opportunities in addition to the two in-person meetings.

Back to Bedside goes beyond meaning and joy

Improving the resident-patient relationship is the main goal of the Back to Bedside program, but there is no denying the incredible learning experience residents receive, either.

"We're building a cadre of residents who were able to implement a change successfully—more change than they thought they were able to," Jardine says. "Can you imagine what somebody coming out of training with that sort of confidence and ability to make those substantive culture changes can do in their careers moving forward as faculty?"

Friendly competition motivates residents to complete administrative tasks

"Reminder: Complete evaluations by Wednesday."

"Don't forget to sign and submit the form acknowledging you read the House Staff Manual."

"We're still looking for volunteers to host a recruitment dinner."

"It's Friday. Evaluations were due two days ago. Please submit them today."

Sound familiar? Residency and fellowship coordinators spend a lot of time asking and reminding residents to get things done. Repeating those requests over and over isn't pleasant for anyone in the program—residents or coordinators.

So, how can you make the mundane administrative tasks you ask residents to do every day fun? Turn them into a game or a competition, says **Amy Gaug,** senior pediatric residency program administrator at University of Minnesota Medical School in Minneapolis.

Gaug created the House Staff Cup, a competition in which teams of residents earn points when they complete tasks, such as submitting evaluations, giving a tour during interviews, or volunteering at community events. Quarterly and annually, Gaug awards prizes to the team with the most points. The competition gives residents the extra incentive they sometimes need to complete a task, she says.

The House Staff Cup not only helps motivate residents to submit paperwork, but builds morale as well, says **Scott Heflin,** pediatric residency program coordinator at Duke University School of Medicine in Durham, North Carolina, who introduced the House Staff Cup in his program last year. It gives coordinators, residents, and faculty a way to publicly acknowledge residents for things that often go unrecognized, such as covering for a colleague or organizing a social event for the trainees, Heflin says.

The House Staff Cup may sound like one more item for you to manage, but you can make it as big or small as you want, Gaug reassures. Get motivated by thinking about the end result. "It's part of a well-being and morale-boosting initiative," she says. "If your residents are happy, then it's well worth your time."

Bring the House Staff Cup to your program with the following tips from Gaug and Heflin.

Launch the House Staff Cup

The best time to launch the House Staff Cup is at the start of the academic year when new residents join the program, says Gaug.

Simply go down your roster and assign each resident to a team.

When you are ready to introduce the House Staff Cup, send an email to each team that:

- Describes the competition
- Explains how teams earn points
- Hints at the prizes that the winning team will receive
- Assigns their first task of coming up with a team name and emblem (with points awarded to the first team to submit their name and emblem—thus engaging them in the competition right away)

Send the email prior to orientation as a way to facilitate introductions and camaraderie between senior and new residents, Heflin says. For his program, "it broke the ice. The interns were initially apprehensive about making suggestions [for the team name], but as ideas rolled in, they contributed."

Publicize the House Staff Cup as often as possible for the first few months, suggests Gaug. To get the word out, share team standings during meetings and post information about the House Staff Cup on the program's bulletin board. Stoke residents' competitive spirit by periodically and publicly giving small prizes to the leading team, such as cookies or program pens.

You get a point, and you get a point, and …

What you award points for depends on how elaborate you want to make the House Staff Cup. The more activities you give points to, the more you can use the competition to motivate residents. Consider giving points for the following:

- **Administrative tasks:** This is the obvious place to start, and there is no shortage of options to include. Give points for completing or submitting evaluations, board reviews, and ACGME surveys or other program surveys. "We will say, 'The first 10 people to do this or the first 10 people to sign the form acknowledging that they read the program manual gets 20 points,' " Gaug says. "It really gets people in there looking at the policy or finishing surveys." Attending conferences and emptying out mailboxes are other point-getters to consider.
- **Recruitment activities.** This is a big points

earner in both Gaug's and Heflin's programs. "We award points for giving tours, hosting a dinner, and attending a dinner. We also have a program where residents can offer an applicant to stay at their house the night before the interview. That gets the most points," Heflin says.

- **Community and special events.** "We give points for being good community partners," Gaug says. For example, residents who supply a meal at the nearby crisis nursery receive points.
  There are also events inside the hospital that lend themselves to points. Gaug gives points for attending mock codes, being on time for guest lectures, and submitting ideas for community drives.
- **Photos and social media.** Coordinators are often responsible for keeping the program's website up to date. With new residents every year, finding fresh photos can be time-consuming, so give residents points every time they send you a photo, Gaug says. The photos are also useful to include in program newsletters, the program's Instagram feed, or slideshows.

The House Staff Cup is also a great way to boost morale and recognize residents for their accomplishments. Gaug uses the competition to give recognition by including a "Shout Out" section in the weekly newsletter. Anyone—administrators, residents, faculty, the program director—can submit a form briefly explaining something great a resident did. There's no limit to what "Shout Outs" can be. Examples may include doing a great job with a difficult patient conversation, helping out with the morning report, or publishing a paper. Residents who receive a "Shout Out" earn points for their team.

"They see that someone recognized them for being a good colleague, or that they appreciated the help that they got. It makes people feel good," Gaug says.

Point pointers

Managing the points can be the most daunting task for coordinators who want to implement the House Staff Cup. However, there are ways to make it easy and quick:

- **Tally points automatically in a spreadsheet.** Create a spreadsheet with formulas that will automatically tally points when you add values. "I can go in and enter points for each resident, and it automatically updates all of the calculations for the quarter and the year," Heflin says. Setting up the spreadsheet may take some time initially, but it saves tons of time later on.

- **Leverage reports that you already pull.** When you run a report for conference attendance, for example, take a few minutes to copy and paste the data into your spreadsheet. It takes just a few seconds, and it keeps you on top of things.

- **Take advantage of online tools.** Online tools, such as Google Forms, SurveyMonkey, or SignUpGenius, are great for collecting signups for tasks with point awards. Use one so that you do not have to dig through emails or a stack of papers when updating your spreadsheet. For example, Gaug collects the "Shout Outs" using a Google Form, which is linked to her Google Sheet where she tallies the points. Every time a resident submits a "Shout Out," the recipient automatically receives points.

- **Make the standings public.** Frequently give residents an update on the team rankings to keep them engaged in the competition, Heflin says. Include the standings in emails that residents regularly receive, such as a program newsletter or a weekly email from the chief residents; post them in on-call rooms; or link to them on the program's internal website.

Most importantly, keep the House Staff Cup fun and light-hearted. The competition should build morale and camaraderie among the residents.

"It's supposed to be a carrot more than the stick," says Heflin. "Don't make it punitive."

For example, the residents in Heflin's program can see how each team compares to the others on conference attendance. However, they can only see the rolled-up score for each team rather than each resident's attendance. "We don't want them to call out the one or two people on the team who had really low attendance and make it look like they didn't pull their weight," Heflin explains.

And the winner is ...

You can't have a House Staff Cup without an awards ceremony. Determine how often you want to recognize the team with the most points. Gaug and Heflin suggest doing so quarterly as well as a "most overall points" award at the end of the year.

If you only present awards annually, residents will lose interest—but don't overdo it either. "I was very ambitious the first year and gave awards every block. Although they were small, it was too much," Gaug says.

Awards will vary based on the program's budget, but ideas include:

- T-shirts
- Local coffee
- Gourmet chocolates
- Breakfast or lunch
- A trophy that gets passed from winning team to winning team

No matter the prize, make winning teams feel special. "We make a big production of the team that wins. We put posters up and decorate. It drives the other teams crazy," Heflin says, adding that the extra attention helps residents feel like their compliance with administrative tasks was worth it.

Also consider recognizing MVPs from the losing teams. "I choose one or two people from the other teams who have been really involved, and I give them a prize, too. They see that people notice that they're involved and engaged," Gaug says.

If done right, the House Staff Cup will make both residents and coordinators a little happier about all those tiresome tasks.

"It's fun for them and it's fun for me," Gaug says. "It keeps me engaged." ◫

Coordinators: Emphasize your value as a leader to change the perception of your role

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During my eight years working in GME, I've noticed that many residency coordinators remain in the position for only two to three years even though it takes approximately three years to even learn the job. Why are coordinators leaving so early in their careers? I believe it is because the position of residency coordinator is perceived inaccurately and because coordinators are mistreated. Just as physicians, faculty, and directors of GME are considered leadership positions, so too should the residency coordinator position. Unfortunately, the coordinator position often is mistakenly categorized as clerical or secretarial. I would like to make an argument for why the coordinator is, in fact, a leader.

While program directors are ultimately responsible for their program's accreditation status, the majority of the responsibilities that maintain this status fall to the coordinator. Some of the important functions of this role include preparing for the site visits, self-studies, and special reviews. Coordinators write the clinical competency committee, program evaluation committee, and annual review reports as well as manage the corresponding meetings. Coordinators also complete the ACGME's annual updates and ensure that the required ACGME faculty and resident surveys are completed. It is also the coordinator who ensures that the specialty board requirements on behalf of each resident are complete, enabling all residents to sit for their boards. And most importantly, the coordinators hit the submit button for all these required elements of accreditation. The job description is ever-expanding for this role.

I have a saying: "It is the coordinator who makes or breaks the program." The variety of work elements in this job is extremely challenging. One must know human resources rules; master accreditation requirements; perform credentialing and licensing; process visas; plan small- and large-scale events; and understand how to effectively manage and offer guidance to staff and residents. The coordinator has to be an expert in many hospital functions, which is not the norm for most non-GME leaders.

This role, if not properly staffed, could adversely affect the program's accreditation status, even causing the closure of the program itself, and in some cases that means closure of other departments in the hospital. For example, surgery residency programs are a requirement if the hospital is a Level I trauma center; if that residency program closes, the hospital's trauma center designation could be in jeopardy. Ensuring program accreditation requires continued learning and expansion of one's knowledge and skills through education and training.

Coordinators, how do your program and institution see your role? Are you thought of as a leader or as a clerical worker? payscale.com defines the coordinator position as responsible for completing office and clerical tasks. A quick search for jobs in this sector will reveal that nearly all the advertised jobs are categorized as clerical/secretarial and not within management. It's evident that the perception of a coordinator in the GME sector does not align with the position's actual responsibilities related to accreditation, HR, credentialing, counseling, or management. While the title of a position may seem inconsequential, it ultimately affects the perception of the position, and, in this case, the reality of a coordinator's role.

I feel passionate about the misperception of this position. I am part of a small number of GME professionals who have been working to promote this role as one that should be respected and seen as a crucial position within the hospital. As I plead this case, I would like to discuss how the role of the coordinator is often disrespected and undervalued. My conversations with other GME professionals and program coordinators, as well as my own experiences, has inspired me to write a book that will be published next year. In my research, I found that while medical student and resident mistreatment and abuse are often discussed, coordinators, too, experience these things—yet the industry has not included them in the conversation. I've most commonly heard that coordinators feel diminished, both personally and professionally. This position needs to be represented properly so that others recognize its leadership and value. I believe this would greatly reduce the mistreatment and turnover we now see in the role.

Coordinators must value their role and expect the industry to hold their position in high esteem. It is difficult, however, to do this when the role is not considered a leadership position. My book will cover the topic of coordinator mistreatment in greater detail; however, I would like to get the conversation started now.

Types of mistreatment experienced by coordinators

From my research, these are the most frequent types of mistreatment:

Sexual harassment. Institutions have policies on such treatment, so I will keep this topic brief. It's important to know that sexual harassment doesn't necessarily involve physical contact or crude language. Unfortunately, these elements often do occur. I've been propositioned. I've had my breasts "accidentally" touched. I've had pictures taken of me without my consent when outside of work, such as at nighttime outings and at the beach. Those photos were then passed around. I've had a more serious incident of unwanted physical contact, as well. Although I am a woman, not all of these incidents were perpetrated by men. Fellow coordinators have shared their experiences with me, too. I am not alone in experiencing such treatment, and neither are you if you've experienced it. It's important to follow your institution's sexual harassment policy if any of these things have happened to you.

Physical mistreatment. Luckily, I have had only one direct incident involving this type of treatment. I was working with a resident to extend his contract. I had an assistant program director who was very upset with me for informing the resident that if he didn't make up all his hours, then I could not complete his information and thus send it to the board. He was upset by this and spoke to the assistant program director. Unbeknownst to me, the resident's time off was approved, but nobody told him that he would have to extend his contract. When the assistant program director and I went into an office to talk about it, the conversation quickly grew heated. In essence, she was going to allow the resident to graduate on track and act as if he wasn't missing any of his hours. I told her that in order for me to comply with the board's requirements, I had contacted the board to discuss their protocol. Her fist went up to face level, and she began to scream at me. I backed up quickly. She continued for about a minute and

then left the room. It was one of the scariest things I've ever had to endure. The entire office heard it, even the manager of the department. My direct boss was not there, but she heard about the incident from the manager. Yet nothing was ever done about it, and I had to continue to work with that assistant program director. When I spoke to my boss about the altercation, her response was, "I wasn't there." That was it. This situation was believed to be a gray area and therefore not taken seriously. It was also a doctor versus a coordinator, and I was seen as a clerical worker who could easily be replaced.

I suffered from that experience. I didn't feel that the assistant program director was safe to be around. I endured stress, anxiety, and ultimately financial hardship: I was not fired but was pushed to quit, which I did, even before I had lined up other employment. I was not seen as a high-ranking employee. My title was "program manager," but my job duties were perceived as coordinator functions. Any position with such functions is easy to replace in comparison to a department director or a financial director. Would the director of hospital accreditation be perceived as a position with coordinator functions and be so easily replaced?

I've witnessed other mistreatment situations, such as throwing textbooks and equipment and breaking things in the office. It can be very challenging to navigate such situations. Often there is no outlet for the coordinator, no ombudsman for the coordinators to speak with in the way that residents can.

Verbal mistreatment. No, this doesn't just include yelling or screaming. In one of the programs I worked for, the chair and a faculty member had nicknames for me and a coworker in their native language. It was a resident who informed us about these nicknames, and when I went to the chair's secretary to ask about the truth of what the resident had told me, her response was, "He has nicknames for just about everyone." My nickname was of a sexual nature (thus also constituting sexual mistreatment). My coworker's nickname was something that belittled her appearance. Any insult to your appearance or character is a form of verbal mistreatment.

In a different situation, I was a manager and had employee dismissal privileges. I dealt a lot with the issue

of character assassination among coworkers and even from program directors speaking of their coordinators. Sometimes I dealt with program directors wanting another person as their coordinator. Other times I dealt with issues of envy and jealousy. I have also seen employees lie about other employees or about other people's work ethic. This type of behavior is more common than one might realize, and it can stem from peers as well as superiors, or from different departments.

Frozen income. Coordinators, how many of you have not been compensated for your actual number of work hours? Have you had to work events outside normal work hours without getting paid for those hours? Were these work activities included in the job description or explained to you when interviewing, therefore giving you the opportunity to negotiate a fair wage? If not, this could be considered unfair labor practices.

I have had two situations in which I suffered what I term "frozen income." In one, I was required to drive to participate in work events outside of the work location, and I wasn't able to be paid for the driving time because if I was working and somehow got injured, the company would be liable. Neither of these points were included in my job description.

In another, I would work overtime but not get paid for it. I was paid hourly, and I worked a lot, sometimes making revisions at night and on the weekends. I noticed that I was not getting overtime pay in my checks. I would put in requests to have payroll look into it, and I would get a couple of common excuses as to why I didn't receive overtime:

- **I didn't get my overtime approved by the GME manager.** Yet, what was I to do when my direct boss was asking me to do these things after hours: say no to my boss because I couldn't reach my GME manager, or say yes to my boss and have the GME manager get upset with me and possibly decline the overtime for not seeking prior approval?
- **The program director didn't expect me to complete such tasks after hours.** Again, though, what was I to do if I was asked to complete a task that was due the next morning? Another worker in my office who was experiencing this issue ended up quitting and con-

tacted the Department of Labor, which conducted an investigation. Although all wages were paid out as a result, working there during the investigation was stressful. All my emails regarding the situation were handed over to the auditor. In addition, even though that former employee was within her legal rights to act as she did, her reputation was damaged.

Being asked to participate in mistreatment of others. Coordinators, have you been asked to select prospective candidates to the residency program based on physical aspects? For example, I've encountered environments where healthy and fit candidates were considered ideal and overweight candidates were viewed as lacking the stamina needed to get through the hours of residency. Have you ever been asked to select a candidate based on his or her photo?

Demeaning work. I was working as a residency program coordinator alongside a residency program manager. She confided in me that the program director was giving us the same task simply to see who could do the job better. Coordinators have a busy schedule and must manage their calendars well—wasting their precious time like this is an insult. I was humiliated when I found out how the program director was treating the manager and me. A program director who values the coordinator's role would not devalue a coordinator's work or time.

I've been asked to stand right by the side of a site director as well as faculty while they were giving lectures. One time, at a large meeting attended by roughly 100 people, I was told by the site director to "stay right there," and I did, for the whole lecture. I thought maybe the director would need something else during the lecture, but I wasn't asked for anything else, so I just stood there. On another occasion, I had to deliver materials to a clinical competency committee meeting in which the manager was writing the notes. After the materials were delivered, I was asked to stay put in case anything else was needed. Again, nothing else was asked of me. The committee members were all sitting, but there was no space for me to sit down; I just stood there. This type of treatment is demeaning.

Some final thoughts

If you have been in the GME sector for a few years,

chances are that you have experienced or witnessed something similar to what I have. ACGME has a whole platform for resident wellness, but coordinators are facing many of the same challenges as residents, and they need assistance, too. Perhaps if the role was viewed as a leadership position, the administration would be inclined to spend more money on training and advancing coordinators' skill sets.

Based on all of the responsibilities fulfilled by a coordinator, institutions have a lot to lose if a coordinator leaves. Institutions should therefore have policies that can help coordinators who experience mistreatment. Speak with your GME director or the institution's HR department. Many program specialty associations also offer guidance. I recommend reaching out to your specialty association and seeing how they can help.

Speaking up is a personal choice. I've been in situations where speaking up worked for me, but also where it did not. But I am confident that if we all speak up and serve as agents of change for this profession, then the role—and the people serving in it—will be given the proper respect.

I would love it if you would lend your voice to this ongoing issue by answering a brief, anonymous survey. Please click here to participate. ⊞

How to help change the perception of your role

- Enlist the assistance of your program specialty association to help lead the change. For example, a few years ago, the American Association of Directors of Psychiatric Residency Training recognized the work that coordinators do and started to change the psychiatric program coordinator title to residency administrative director.

- Remember that there is strength in numbers. Gather your fellow coordinators in your institution. Talk about important changes that leadership could focus on. Transparency only works if it's two-sided. Hold a program coordinators' meeting with the GME director, DIO, and other important members of GME.

- Join the ACGME's coordinator advisory group. Coordinators can enlist the help of accreditation associations. This group helps with defining the role of the coordinator and work responsibilities.

- Continue to advocate through the Training Administrators of Graduate Medical Education (TAGME). TAGME has long been passionate about getting the role of the coordinator to be perceived as a manager/administrator position. Obtaining a TAGME certification strengthens the perception of what the coordinator position truly entails.

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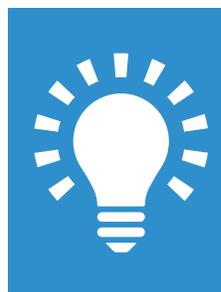
Questions
Comments & Ideas

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