PERSPECTIVES

Middle Manager Role of the Chief Medical Resident: An Organizational Psychologist's Perspective

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The role of the chief resident in internal medicine is examined through the eyes of an organizational psychologist who, over a 3-year period, met with each of 6 groups of chief residents for an average of 1 hour a week over the 12 months of the job. Based on this experience, the chief resident job is conceptualized as a middle management role with 4 distinct types of tasks: up work, down work, lateral work, and internal work. Core challenges facing the chief residents at each stage of the chief resident year are also identified. The paper concludes with a description of "lessons" learned in 5 areas (sliding up or sliding down, losing contact, splitting, scapegoating, and losing sight of the system) for improving the effectiveness of the chief resident role.

KEY WORDS: chief resident; internal medicine; residency program; medical education.

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Chief residents play a critical role in the educational mission of residency programs. Administrative, educational, and clinical tasks of chief residents have been detailed,¹⁻⁷ and "leadership" and "teamwork" are readily identified by residency directors as important elements of the job.^{4,7,8} Many internal medicine chief residents participate in retreats to begin the process of learning their new roles before assuming this position.^{7,9,10} The administrative role of chief resident requires the analytic and practical skills of a good middle manager. Middle managers have organizational responsibilities in 4 different directions, up the hierarchy in relation to their "bosses," down the hierarchy in relation to those whose work they supervise, laterally in relation to other middle managers with the same level of formal authority, and internally in relation to the other chiefs who share the role.

A difficult aspect of this role is that these constituencies, members of which see the institutional world differently, send a variety of often conflicting messages about what the middle manager should be doing to best support their constituency. "Middles" live their organizational life pushed and pulled by

the demands and requirements of the groups above, below, and around them.

To teach middle management skills to our chief residents to help them address administrative issues over the course of the academic year, the Department of Medicine at Yale recruited an expert in organizational psychology (DB) who met with each chief resident cohort as a group weekly throughout the year. During the period June 2003 through June 2006, 6 groups of chief residents (25 individuals) in 2 Yale internal medicine residency programs met with the organizational psychologist for approximately 1 hour per week. During these meetings, the chief residents discussed actual problems and the organizational psychologist offered concepts, suggestions, and reflective questions¹¹ to help the chief residents clarify their role and develop approaches to addressing these problems.

We used an iterative, qualitative analysis of notes from these meetings¹²⁻¹⁴ to identify descriptive themes that are the basis for our conceptualization of the chief resident middle management role. We describe the chief resident middle management role as it evolves over the course of the academic year and offer lessons learned concerning foreseeable job hazards.

CHIEF RESIDENT: A JOB IN THE MIDDLE

Chief residents as middle managers have 4 kinds of work: (1) up work, (2) down work, (3) lateral work, and (4) internal work. None of these occur in isolation as many administrative tasks involve 2 or more of these kinds of work simultaneously, but each has a primary focus.

Up Work. One of the core functions of the chief resident administrative role is to satisfy the needs and requirements of the Residency Director and the institutions in which they work. This "up work" involves developing an understanding of these needs and finding ways to meet them. Up work can be stressful because these needs are sometimes in conflict with the chief residents' perception of the needs of those below them, the residents. For example, if changes in training requirements lead to the restructuring of an educational experience, chief residents may be in the position of implementing changes that may be unpopular with the affected residents. And from the other side, if the chief residents perceive that an individual resident will be disproportionately negatively affected by a change, they may feel the need to advocate for this person. When chief residents are advocating for the residents, they are talking to and negotiating with their bosses. Determining if and when to initiate such conversations is a critical skill for chief residents to develop to be successful in their middle manager role.

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Down Work. The bulk of the chief residents' work involves their relationships with residents. Some of this "down work" is done *on behalf* of the program or the hospital, but all of it is done *with* the residents. In addition to their teaching role, they provide counseling and support. Fatigue, work-load, difficult cases, personal demands, births, deaths, injuries, self-doubt, and failure will cause almost every resident to feel overwhelmed at some point over the course of the year. The chief residents are responsible for creating a space, both physical and psychological, where the house staff feels safe to express their neediness, fragility, doubt, fear, and anxiety while receiving encouragement and support. Learning the skills to provide this critical organizational role can be difficult for chief residents who are faced with similar challenges and are close in age and educational experience to those they supervise and lead.

Lateral Work. Chief residents work with other middle managers in various clinical units to make sure that clinical needs are met and educational experiences are provided. This "lateral work" involves tasks that require the input, authority, or participation of people outside the chief residents' residency program and authority domain. These may include faculty, nursing managers, pharmacists, information specialists, etc. Chief residents are often the first contact for these people when problems arise on the teaching clinical units. As they have no formal authority in many of these groups, their work involves searching for acceptable solutions among groups that may have conflicting or competing agenda. The chief residents' lateral work is almost always related to their up- and down work. It is often done *on behalf* of the people above or below the chief residents, either because these other parties delegate these tasks (those above) or do not have the knowledge and standing to address them (those below).

Internal Work. Internal work involves the chief group periodically stepping back from the daily tasks of the job to reflect on how the job is being done.¹¹ This reflection provides an opportunity to notice patterns, stress points, individuals, or relationships that need attention as well as longer term problems that need fixing.^{14,15}

This role is simultaneously aided and made more complicated when the chief job is done by a group. The division of labor among chief residents happens early in the Chief year. Periodically, the group may need to "rebalance" the workload assignments. Feelings attached to a workload imbalance can negatively affect the chief residents' relationships with each other and with others in their work environment, reducing the effectiveness of the chief residents.

THE ANNUAL CYCLE: THEMES IN THE CHIEF RESIDENT YEAR

As with any other time-bounded activity, the chief resident job has a life cycle. Specific times of the year bring with them an increased likelihood of facing certain, often predictable up, down, lateral, and internal issues.

The First 3 Months: Authorizing. The core task for the chief residents during these initial months is establishing some authority in their role.^{16,17} In some cases, authority is

established through medical expertise. In others, it comes from fair and humane decisions. In still other cases, legitimate authority is earned by holding firm in the face of heartfelt pressure from above or below.

New chief residents are faced with a host of situations that they have not previously dealt with and they are assumed by others to be expert administrators from day 1 despite their personal lack of such experience. One critical choice the chief residents face is how they will respond to this sharp increase in both responsibility and vulnerability as they tackle the "down work" of supervising residents. Will they demand or cajole? Will they listen or presume to know better? Will they be fair or play favorites? When will they hold firm and when will they give in?

This early period also presents opportunities to do important "up work." The chief residents need to learn about the extent and limits of their authority in relation to their "boss." Does the Program Director support their decisions? How are differences in approach dealt with? How do the chief residents avoid undermining the Program Director when they disagree? What about the reverse? When should the chief residents check in with the Program Director before making certain decisions? Can the chief residents count on the Program Director to follow through on commitments?

The Second 3 Months: Problem Solving. In the next phase, chief residents often find that they have energy for the job, have earned some level of authority, have the necessary perspective and expertise, and are now beset by a host of problems to be solved. In these months, the chief residents often find themselves engaged in a great deal of "lateral work." For example, the Department decides to institute multidisciplinary rounds on the medical wards involving residents, nurses, social workers, pharmacists, and case managers. The chief residents are asked to work with these other entities to identify the time and location of these rounds in a way that will optimize their impact and minimize disruption of the other teaching service activities.

The initial division of labor among the chief residents has also now played itself out by this time of the year and the implications for individual chiefs and the group are becoming clearer. Differences in style, approach and philosophy, relative strengths and weaknesses start to become apparent. A crucial piece of "internal work" during this problem-solving phase is to acknowledge and confront these differences. Most groups are reticent to risk upsetting the balance of relationships upon which the remainder of the year's work depends, but unacknowledged and unaddressed, these internal problems present the greatest risk to the effective functioning of the chief resident group.

The Third 3 Months: Surviving. December through February is a time during which mental and physical fatigue catches up with everyone. The effect of fatigue, illness, darkness, and cold is to isolate people from each other. Finding ways to keep people in touch with each other is an important management strategy during this period. In a symbolic sense, social contact can provide the light and warmth that is missing from the physical environment. Rounding with teams, encouraging advisors to have coffee with their advisees, and sponsoring a social gathering are examples of ways that chief residents can create opportunities for maintaining supportive contact.

The Last 3 Months: Transitioning. The challenge for the chief residents in the final months is to continue in their roles when they are psychologically leaving the institution. The routine tasks becoming increasingly mundane, the complaints from residents less compelling, and the energy to address issues can wane. The core task during these months is to maintain the enhancements that the chief residents have helped establish and provide a smooth and effective transition to the rising chiefs ("down-work") while beginning the process of moving on ("internal work"). Establishing a "transition plan" that will allow the outgoing chiefs to pass on their wisdom and lessons learned through collaboration and sharing of experiences (e.g., taking "chief on call" questions, running morning report, and chief resident mentoring) is critical. This helps outgoing chiefs maintain their sense of "generativity" and helps them appreciate the skills they have acquired. It also facilitates a successful start for the new group and makes possible the transmission of institutional memory from 1 group of chief residents to the next.

LESSONS LEARNED

Lesson #1: Avoid Sliding Up or Sliding Down. Chief residents may seek to reduce the stress of "middleness" by sliding up (the tendency to identify with those above) or sliding down (the tendency to identify with those below).^{18,19} When the chief residents describe residents as constant complainers or as increasingly "soft" in light of the "pampering" they receive, this may be evidence of sliding up. Sliding up reduces the stress associated with the chief resident role by merging the chief residents with those higher up. When the chief residents describe proposed changes to an educational experience as "completely inappropriate" or "I wouldn't ever agree to that if I were a resident" without weighing the recommendation and alternatives, this may be evidence of "sliding down." Sliding down allows the chief residents to find explanations for *their* frustration in the actions of those in authority. By merging their perspective with those above or below them chief residents move out of the middle, leaving behind the stressful responsibility of being in the middle. A strategy that chief residents can employ in these situations is to facilitate *direct*, face-to-face conversation with the involved parties and help identify potential solutions and opportunities.¹⁵ If the chief residents can avoid sliding up or sliding down, they are in a better position to recognize a problem that requires direct problem solving between groups, especially those groups above and below them.

Lesson #2: Do not Lose Contact. At the beginning of the year, chief residents usually vow to meet regularly with each other and with their Program Director. These commitments come under pressure as work demands increase. Meeting times are postponed, shortened, or cancelled. E-mail correspondence begins to substitute for face-to-face conversation. Partial attendance becomes the norm and soon the whole group is rarely together and consequently rarely able to discuss issues or coordinate actions. Losing contact with each other and with their boss means that much of the internal work described above does not get done and consequently the entire chief group is less effective.

Chief residents need to establish protected time for 2 regular, standing meetings, 1 as a chief group, and 1 for the group with the Program Director and Associate Program Directors. The boundary around these meetings will need to be shored up repeatedly. The chief residents will need to remind each other as well as the Program Director that this time is a necessary component of their job. The chief residents and the Program Director occupy different roles in the organization. With these roles come different experiences, different tasks, and different expectations from different sets of people. The regular meetings between the chief residents and the Program Director provide the opportunity to discuss current issues *from the 2 different perspectives represented by the 2 different roles*. Regular, frequent meetings provide opportunities for this cross-hierarchical group to learn to work together, to become comfortable with disagreement and confident in their ability as a group to manage the residency program.

Lesson #3: Splitting. When 2 or more individuals share a job, there is a risk that the interests of those around them will split the group. Many people in the chief residents' work world are seeking to reduce some kind of distress, either personal or organizational. These parties will search for the chief residents who they think will most likely be able to relate to their issue and to help. The individual differences inside the chief resident group (history, identity, experience, career aspirations, and personality) provide the diversity of perspective that enriches discussions, but they also make each chief resident differentially susceptible to distress calls. For every sympathetic ear within the chief resident group, there must be a (relatively) unsympathetic ear.

When splitting occurs, it can produce conflict within the chief group that is actually rooted in a tension existing outside it. The challenge for the chief residents is to (a) reduce the occurrence of splitting and (b) increase their capacity to diagnose splitting when it occurs. Some chief resident groups, for example, respond to all questions except those involving emergencies with the phrase "I'll bring it up at our Chiefs' meeting and get back to you." This approach tells the questioner that the chief residents meet regularly and develop commonly agreed upon responses. It also reduces the likelihood that the questioner will seek out a different chief resident. Chief residents can also reduce the incidence of splitting by making sure that any specific role (whether "positive" like a counseling, support role, or "negative" like an enforcing, unyielding role) does not become the purview of only 1 chief resident.

Lesson #4: Scapegoating. When the chief resident group is in distress, it too may look for relief. One way for members of a group to regain their sense of equilibrium is to identify someone who is in greater distress than everyone else. The "scapegoat" serves to reassure the other members of the group that they are competent, agreeable, fair, humane, and hard-working when this is precisely what worries each of them. The scapegoat role succeeds in relieving the distress because the other members of the group do not notice their own distress, but see it clearly in the scapegoat.²⁰ The process of scapegoating can result in serious damage to the person cast in the scapegoat role, for on top of the distress of the job and the middle role, the scapegoat is also carrying the disdain of his or her colleagues. As important,

the scapegoating process makes the group less likely to recognize, examine, and alleviate the sources of its own collective distress.

In complex social systems like hospitals and residency programs, nothing is as simple as "good-bad," "responsible-irresponsible," "professional-unprofessional." The simplification process that produces a scapegoat ("he's the only incompetent one in the group") is an indication of the group's desire to reduce the complexity and distress in their organizational experience.

The person in the scapegoat role cannot undo the process of scapegoating. The process can only be examined if at least 1 other person in the chief resident group expresses something in common with the scapegoat. If 1 chief consistently favors "giving the residents a break" and has become increasingly isolated by taking this position in the group, the willingness of another chief to acknowledge a similar impulse can begin to bring the scapegoat back into the group while encouraging the group to examine the issue of "leniency" anew.

Lesson #5: Look for System Level Explanations. Most people are prone to understand what happens around them in personal or interpersonal terms, rather than in system terms. When a resident talks to the chief residents about feeling overwhelmed, the first explanations that come to mind involve the individual (e.g., she has been struggling all along, he is having personal problems, she is depressed). The second set of explanations often involves an interpersonal relationship (e.g., he is on a team with a difficult attending, she has some weak interns working with her, his wife has been sick). The power of these explanations is rooted in their familiarity and the relative ease with which they can be acted upon.^{18,20} A depressed resident can be referred to a mental health professional. A resident with personal problems can be given an adjusted schedule. A struggling resident needs a remediation plan.

Always seek to generate *systemic* explanations to complement individual or interpersonal ones. Look beyond the individual by asking questions like: (1) What else is going on in the program or hospital that might shed light on why this is happening? (2) What purpose is served by this occurring now? (3) Who else or what other parts of the system might have a stake in this event? (4) Who or what parts of the system are allowing this situation to continue and why might that be the case? The answers to these kinds of questions can help the chief residents address both the manifestations of systemic issues and the issues themselves.

CONCLUSION

Drawing on organizational theory, we conceptualized the role of chief resident as a "middle" job in a complex organization involving 4 different kinds of work: *up work* with those above the chief residents in the medical and academic hierarchies; *down work* with residents and interns below them in the these hierarchies; *lateral work* with medical and administrative staff outside the formal hierarchy in which chief residents work; and the *internal work* the chief residents do with each other to maintain their capacity to function as individuals and as a

group. Middle roles bring with them the stress of being in between multiple and often competing needs, demands, and concerns. This paper offers a description of the work of the middle management role for Chief Residents along with lessons learned for improving the effectiveness of this role.

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