The results of the study by Garg and colleagues\(^1\) shine a light on a legacy practice of internal medicine (IM) residencies across the country: the honorific chief resident year, typically served after completion of the formal residency program. Although the majority of chief residents surveyed would repeat their chief residency year again, respondents reported serving as primary program schedulers, and substantial numbers reported little feedback on teaching, clinical skills, or leadership skills.\(^1\)

Although Garg et al\(^1\) focused primarily on chief residents from academic centers, the chief residency year is a recognition of exemplary performance and is often considered to be a stepping-stone to an academic career. The ambiguity of the role and lack of formal credentials for these future leaders is a lost opportunity both for the learners themselves and the institutions in which they work. Additionally, with medical school indebtedness steadily increasing, any year that delays entry into a position that is compensated as a practicing board-certified physician carries a high economic cost. Peers of chief residents are often hired into hospitalist positions with greater flexibility and compensation. Thus, ensuring that the types of exemplary physicians typically chosen for chief resident roles find the role to be value-added demands that we consider reengineering the year as a launching pad to leadership.

Chief Residents Are Not Really Residents

Despite the title, IM chief residents are not residents. Chief residents do not apply for a position through the National Residency Matching Program but instead are picked midway through their residency through an often opaque process. There is no formal curriculum and there are no milestone assessments, although the Garg et al\(^1\) study shows that many do receive feedback on elements of their role. No board certification opportunity exists for successful completion of the year.

Chief Residents Should Not Be Administrators

In many programs, the chief residency year is one designed at the completion of residency training but prior to any fellowship training or faculty appointment. For this reason, chief residents are often relied on to complete complex administrative scheduling for training programs, given their proximity to training and understanding of the staffing needs of the programs.\(^2\) This considerable reliance on chief residents for administrative tasks interferes with their ability to complete other important tasks, such as teaching and focusing on trainee well-being.

There is an opportunity cost to relying on chief residents for administrative tasks. Rather than harnessing the talent of these enthusiastic future leaders for other key roles that will further develop their skills and benefit the residents in their programs (such as teaching or coaching junior residents), saddling chief residents with administrative tasks takes away from these opportunities. Moreover, the frequent turnover of chief residents means the training programs must then reorient new chief residents to complete these important administrative tasks such as program scheduling. The Accreditation Council for Graduate Medical Education Common Program Requirements for the learning and working environment outline that the learning objectives of the training program must “be accomplished without excessive reliance on residents to fulfill non-physician obligations.”\(^3\) We
would argue that the same should be true for chief residents. Programs should offload these administrative responsibilities to other administrative team members.

Chief Residents Are Junior Faculty Leaders

Chief residents function much more like junior faculty or junior program leadership. Like faculty, chief residents are credentialed and bill for their patient care services. Their administrative role carries the responsibility of ensuring that there is an adequate patient care workforce for the hospitals and clinics. They are often privy to and expected to manage confidential performance issues, personal problems, and conflicts among postgraduate year 1 to 3 residents, medical students, and occasionally faculty. They oversee compliance with accreditation rules, develop and implement curriculum, provide wellness and health support for learners, and engage in continuous quality improvement for educational programs as well as clinical care delivery programs. Importantly, they train junior residents in clinical care delivery and often lead root cause analyses of medical errors in the residency programs. Unlike faculty, chief residents are often paid a postgraduate year 4 salary.

The Chief Resident Year Should Be Engineered to Launch Leadership Careers

In addition to developing academic skills in teaching and patient care, chief residents must learn to manage talent selection and support, institutional change, conflict management, regulatory compliance, and institutional accountability. Realizing the potential of the chief resident year to launch leadership careers in academia and beyond requires transparent selection as well as specific engineering of the role, the responsibilities, the training opportunities and the mentorship of the chiefs. Strategic selection of chief residents with an intent to populate the academic workforce of the future could include attention to the habits of mind of inquiry, social justice, continuous improvement, and well-being in addition to demonstrated prowess at morning report and in clinical team leadership and teaching.

Each chief resident should be assigned a mentorship committee to maximize the key elements for their desired future career as a researcher, educator, clinician, or other contributor to the profession of medicine. They should engage in leadership development activities and courses, meet and interview existing institutional leaders for advice and insight, participate in scholarly work to advance their academic portfolios, and receive ongoing feedback about their development.

The Chief Resident Role During the COVID-19 Pandemic

The study by Garg et al was conducted prior to the COVID-19 pandemic. The COVID-19 pandemic necessitated that many graduate medical education programs enact emergency accreditation status and interrupt residency and fellowship training experiences. The chief resident role was vital for many graduate medical education programs to adapt and respond to the needs of their trainees with all notions of the chief resident role as a middle manager being discarded. The chief resident role required substantial innovation in clinical service delivery and in the design of virtual teaching conferences and medical student education. Chief residents were also tasked with virtual resident onboarding and helping new trainees build community in the shadow of physical distancing and COVID precautions. Importantly, chief residents also bore vital responsibility in communicating institutional culture and ethos to applicants during a virtual recruitment season. These efforts further emphasize the fact that chief residents are a tremendous creative force for programs and institutions. Failure to provide adequate coaching and development in order to harness chief resident energy for the collective good is a loss to the medical education community.
The 3 authors of this commentary have served as IM chief residents across the 4 decades since Wortman and colleagues\(^9\) published a study describing the IM chief resident in 1982. Our experience and that described by Garg and colleagues\(^1\) suggests that transformation of the chief resident role to deliberately prepare the leadership workforce our nation needs is long overdue.

REFERENCES