Not Everyone Can be a Chief

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Introduction: In 2014, the residency program adopted a new chief resident model. Multiple other programs had adopted a similar style of having all final-year residents have a "chief" role. Chief residents are meant to be leaders in the residency, have a direct influence on the program, and serve as liaisons with other department chiefs.
Method: Prior to 2014, the program had three chief residents a year: one Admin, one Academic, and one Recruitment. They were chosen using a vote amongst residents/faculty, with the ultimate decision made by the residency leadership. Many other residents were interested, and often qualified, but were ultimately not chosen. In 2014, the all-chief model was adopted. Each PGY-3 would have a responsibility. The goal was to give each a leadership opportunity, and a tangible product as they transition to fellowships or new jobs. The residents were allowed to pick their position, with some influence by residency leadership. Residents were encouraged to create new roles which aligned with their personal interests or career goals. Examples included Medical Director Chief, U/S chief, PEM chief and Wellness Chief.
Results: Some residents thrived when given responsibility, while others did not. Some could not manage more responsibility: there was a clear disparity in the effort. At the start of this, all residents' total shifts/month decreased equally. This created some controversy when the workload was not equal. The alteration of details, requirements, and expectations occurred every year in an attempt to correct the failures.
Conclusion: Ultimately, the all-chief model was a failure. The program reverted to a traditional chief model, allowing only those the residency leadership felt could manage chief responsibilities to have a role. Those not doing a chief role were given additional shifts and those with less added work were given only a partial shift reduction.

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Organizational Resilience Among Health Organizations in Israel

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Introduction: Health Organizations (HOs) worldwide are vital to any nation's capacity to withstand crises. The COVID-19 pandemic increased the HOs' awareness of the importance of Organizational Resilience to ensure Operational Continuity during crises.

This study aimed to identify the main elements affecting HOs' resilience, to enable their application in long-term processes of capacity building.
Method: A cross-sectional study examining the level of organizational resilience in HOs was performed, in a general hospital (group A) and one region of Emergency Medical Services–EMS (group B). A structured questionnaire, consisting of 29 items, was developed, validated, and subsequently used to assess organizational resilience. The questionnaire encompassed: ethos, organizational culture, leadership and human capital, situational awareness, adaptability, organizational performance, and learning ability.
Results: The respondents included 225 participants from the hospital and 214 from the EMS. Both HOs presented a high level of organizational resilience (average score among hospital and EMS personnel was 3.79 versus 3.91 respectively).

In a multivariate linear regression test, the factors found to predict the organizational resilience (in both organizations) were education (academic/non-academic), gender (male/female), and two age groups (20-30 & 31-40).

These factors explained 11% of the organizational resilience. Other factors such as profession or seniority at work, were found to be non-significant.
Conclusion: As the operational continuity of health organizations is vital during crises, the developed evaluation tool contributes to the capacity of managers and policymakers to continuously monitor the level of organizational resilience. In line with the factors identified as predictors of organizational resilience, health managers should focus on educational interventions to increase their organization's resilience. It is recommended that follow-up studies be initiated to examine additional variables that may predict the level of organizational resilience.

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Evidence Mapping Survey on Professional Development Programs and Courses in Health Emergency and Disaster Risk Management

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Introduction: A prepared and well-trained workforce is essential to reducing the loss of lives from health emergencies. However, it is uncertain what should be included in the common set of core competencies for the health emergency and disaster risk management (Health EDRM) workforce. The objective of the study is to provide evidence mapping for the competencies in existing professional development programs and courses in Health EDRM.
Method: A survey conducted using an online platform (Survey Monkey) was conducted from October to November 2021. Experts in the Health EDRM Research Network including experts identified for the Delphi studies were invited to join the study. Participants should be ≥ 18 years of age, and had relevant experience in Health EDRM and in disaster education and training programs. A self designed questionnaire containing 28 questions in four domains including competencies; curriculum; evidence gaps; work and personal details were used.