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ETHICS CASE

# Balancing Supervision and Independence in Residency Training

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Chad is in his first year of residency in emergency medicine. He is working a night shift when a woman brings in her four-year-old daughter suffering from a high fever and ear pain. Chad decides to give the girl ibuprofen, start her on a course of antibiotics, and keep her under observation. Over the next couple of hours the toddler's condition seems to worsen, and Chad worries that she might have something more serious than a middle ear infection, such as meningitis, which would require a spinal tap to rule out. He considers phoning the physician on call, Dr. Gardner, but hesitates as he picks up the phone. It's late at night and he doesn't want to wake the doctor for what could be a trivial matter. "And I don't want to come across as incapable of making my own decisions," he thinks to himself.

A while later, he still feels unsure about what to do, so he calls Dr. Gardner. After hearing a summary of the situation, she tells him, "It's most likely a typical ear infection; sometimes they just take time to clear up. I would just wait and watch her."

After putting down the phone Chad feels more conflicted than before. His young patient looks worse than other patients he has seen with ear infections, and he has a strong suspicion she may have something more serious; however, doing a spinal tap now would be ignoring Dr. Gardner's advice. An hour later he decides to perform the spinal tap anyway, reasoning that, after all, this child is his patient and, ultimately, his responsibility. After reviewing the procedure briefly, he performs the tap with the help of a nurse and without complications. The results of the test come back negative, ruling out meningitis. Chad knows that he ought to feel relieved that the child is all right, but he is also disappointed to find that his instinct was wrong. He took a risk by going against Dr. Gardner's advice, and the results now indicate that it might have been better to have followed it.

When Dr. Gardner arrives in the morning she looks over the girl's chart and takes note of the negative spinal tap. She is aggravated that Chad chose to perform an invasive procedure, with its own set of risks, against her advice. "These young doctors always jump to rare and dire diagnoses, when most cases turn out to be as obvious and simple as they seem," she mutters to herself, wondering why, if Chad was still worried after their conversation, he didn't call again or ask for a consult from a doctor working last night. After the initial wave of annoyance passes, she considers another point: Chad needs to develop his own professional identity and she wants to encourage him to have confidence in his own clinical knowledge. She wonders how her reaction would have been different if the spinal tap had come back positive.

## Commentary

For any physician, the above scenario most likely sounds familiar. We can all recall moments during our training, either as a medical student or resident, in which our assessment of a clinical situation differed from that of our supervising attending physician. We understand the feelings of uneasiness and discontent that Chad, the resident in the case, must have felt, along with his desire to help his patient and exercise a bit of independence. Likewise, physicians who have chosen a career in academic medicine can easily empathize with Dr. Gardner, the attending physician, who is trying to balance patient care with resident education and maintaining control, all the while judiciously giving residents a bit of freedom. At the heart of this case is the struggle to maintain that balance, and we argue that the key to achieving it is mutual trust.

Educating future physicians is a daunting task, and attending physicians in academia need to fully understand the awesome gravity of the responsibility with which we have been charged. The Accreditation Council on Graduate Medical Education (ACGME) has much to say about how to do this in its 2011 publication on duty-hour standards [1]. Chapter 6 in particular offers commentary and guidance on resident supervision. In general, the ACGME asserts that faculty should provide enough supervision and oversight to ensure safe, effective patient care while giving residents increasing independence and authority. Do this, they imply, and we can turn fledgling, novice interns into confident and competent practitioners.

It may seem that proper supervision and independence of residents are mutually exclusive. For the anxious, overbearing attending physician or the overly confident, eager resident, this is most certainly the case. Neither wants to give the other their trust or cede control. With these two players, effective medical education hits a brick wall built of ego, fear, distrust, and frustration.

The ACGME's publication notes evidence that there are dire consequences if we fail to provide both supervision and independence [1]. Appropriate supervision of resident learners is absolutely critical to patient safety. The authors cite several cases of inadequately supervised residents associated with adverse outcomes in teaching hospitals, none more familiar to medical educators than the 1984 death of Libby Zion. Her untimely death under the care of unsupervised first- and second-year residents led to the establishment of regulations governing resident work hours and supervision standards.

On the other hand, excessive supervision leads to problems, too. Supervision without progressive independence may stunt residents' acquisition of knowledge and skills and ultimately hamper their progression to competency in their fields.

Luckily, supervision and independence of residents are not mutually exclusive. They can occur in harmony if residents and supervising physicians are willing to communicate openly, give frequent feedback, and allow trust and respect to guide their interactions.

This balance between supervision and independence must be maintained throughout a resident's tenure but tends to look different at different points in time. It may seem obvious, but the ACGME points out that the interns, or first-year residents, require the

highest level of supervision, most often direct supervision from a faculty member who is physically present. This may seem suffocating to residents looking to stretch their wings. However, with time and experience, the balance evolves. If an intern is able to master relevant skills as well as demonstrate that he or she can responsibly recognize the limits and scope of his or her authority, the intern should be granted increasing independence. When mistakes or errors occur, as they inevitably will, that independence should be curbed for a time during which feedback and remediation, if necessary, are given.

This ebb and flow of control makes logical sense and, to the players, feels appropriate as well as judicious. It should reassure supervising physicians that no residents are left to their own devices until they have achieved some level of competence in clinical care. It should also appease eager residents because independence will be awarded to them if they work hard, follow the rules, and accept guidance from faculty.

As previously stated, trust is key to balancing these two tasks. Our residents need to trust that their supervising attending physicians will provide effective teaching, guidance, and feedback, as well as more independence once they display increasing mastery of concepts and skills. They also need to trust that their supervising physicians will welcome their questions, be happy to receive late-night calls, and be available in person to assist directly with patient care when appropriate.

We expect that Chad in our case was, to some degree, worried about getting exasperated or unhelpful feedback if he called Dr. Gardner back to voice his concerns about the young patient. Perhaps this expectation was a barrier to effective communication with his supervisor and thus led him to act alone and perform the lumbar puncture against instruction. Nonetheless, as an intern, Chad must understand his limits and recognize that he should respect the experienced opinion of his attending physician in this instance. Acting against her wishes represents a breach in the trust inherent in their relationship, and doing an invasive procedure without supervision could have put the patient at risk.

Supervising physicians certainly need to do their part. They need to teach, offer guidance, and give feedback happily, any time of day or night. They also need to encourage teamwork skills and remember that many decisions in medicine are not black and white. Allowing a resident to do things his or her own way, even if it is in contrast to the supervising physician's own preference—as long as it does not harm the patient—is valuable for the resident's emerging independence and leadership. In exchange, supervising physicians earn the right to feel reassured that their residents will honestly and effectively communicate clinical information, understand their limitations, and defer significant patient care decisions for the good of patient safety. In our case, Dr. Gardner has the right to be upset with Chad: he overstepped his bounds, acting against her directives. She would be wise to discuss this egregious misstep with him to ensure it does not happen again.

However, Dr. Gardner could have taken a different approach altogether. Even though she thought a lumbar puncture was unnecessary and the patient simply had an ear infection, she could have reassured Chad that he was welcome to call again should the situation change or he continue to have doubts regarding the diagnosis and plan, thereby keeping lines of communication and trust open. Additionally, she could have offered to come into

the hospital to evaluate the patient in person to alleviate Chad's worry and discuss appropriate indications for lumbar puncture. If they decided that a lumbar puncture might be useful, Dr. Gardner could have assisted and supervised Chad during this procedure.

This case poses an additional interesting question about whether Dr. Gardner's response would have been different if Chad's instinct had proved correct and the lumbar puncture was positive for meningitis. Although Dr. Gardner would have certainly felt relieved in this instance that the patient had been appropriately diagnosed, the same feedback regarding overstepped bounds, disobeying directives, and the need for trust would be relevant. Furthermore, for an open-minded instructor, this incident might just represent a turning point in Chad's evolution as a learner. If he had been correct about the meningitis, after all, he would have displayed competence in patient care and a spot-on sense of instinct. In that case, Dr. Gardner should consider recalibrating how much independent authority he merited in light of the skills he displayed.

In summary, effective resident education requires an appropriate balance of supervision for the sake of patient safety and progression towards independent authority and leadership for the sake of the resident's professional growth. This balance is difficult to achieve, should be individualized for each learner, recalibrated often, and is only possible when mutual trust exists between resident and supervising physician.

## References


1. ACGME Task Force on Quality Care and Professionalism. *The ACGME 2011 Duty Hour Standards: Enhancing Quality of Care, Supervision, and Resident Professional Development*. Chicago, IL: Accreditation Council for Graduate Medical Education; 2011. http://www.acgme.org/acgmeweb/Portals/0/PDFs/jgme-monograph%5B1%5D.pdf. Accessed December 17, 2014.



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