The Case of the Shifting Expectations

Case by Dr. Teresa Chan

Case
Dr. Teresa Chan

Objectives / Questions:
Dr. Teresa Chan

Expert Commentaries
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Deborah had started as a new attending at St. Elsewhere Hospital and had initially found it difficult to transition to the new environment. The computer system was different from the one she had trained on, the layout of the department was new, it was busier with more patients and more consultants and although the people seemed nice, they were strangers. After three weeks, however, she was finally starting to hit her stride.

Until today.

Deb was finding her shift especially difficult today.

Deb had been assigned a senior resident for the first time. Supervising Donald was turning out to be a lot more difficult than she had expected.

During her training, Deb had been interested in learning to teach on shift. She had even set up teaching shifts in her final year of residency, hoping to perfect her skills. But in all of her shifts, she had only ever supervised junior residents at least two behind her in training. Donald was a confident senior resident, to put it mildly. At her faculty orientation, Deb had been given a primer on all the residents in the program, and she recalled the program director's description of Donald as confident, bordering on cocky. He performed well on shelf exams, and did a lot of moonlighting, and the PD recognized that he had racked up a lot of experience to back up his confident demeanor.

Deb had felt undermined throughout her whole shift. The nurses had looked to Donald for instruction, and had even overridden some of her orders based on his suggestions during a cardiac arrest case. Fortunately, everything had turned out well for the patient, and he was now safely in the intensive care unit (ICU). Still, Deb had noticed that Donald had discharged home a few patients without even telling her, and had once forgotten to order a second set of cardiac enzymes in a low risk chest pain patient. Deb had asked Donald to call the patient back; luck would have it that he was still in his car in the parking garage and happily obliged.

It was now nearly a half-hour to the end of their shift together, and Deb was feeling very uneasy about how things were going. She had asked Donald a few times to "run the board" with her and update her about his patient-care decisions. Inevitably, they had been interrupted every time they tried to complete this exercise and Deb was feeling like she had lost all control of the department. It was challenging to second the bulk of the patient care to someone else. Adding to that challenge, Donald was intent on making sure that he was "running a tight ship" and insisted that Deb just "sit back and relax" like the other attendings usually do.

"Oh, hey Debbie! How are things?" asked Josephine as she strolled into the department, coffee in hand. Josephine was Deb's relief, and she was a sight for sore eyes. Josephine also happened to be Deb's assigned faculty mentor, and they had met a few times recently to discuss how she was settling in to the new department.

Deb looked quickly around the room to make sure she and Josephine were alone.

"Um, it's been a rough shift," she whispered.

"Oh?" inquired Josephine with her eyebrows raised.

"How so?"

"Well, to be honest, I'm not used to working with senior residents, and I feel like I've sort of lost control of the department," she admitted sheepishly.

Josephine nodded sagely, taking a sip of her coffee. She remembered how she had felt when she had first started. As a new attending, it had been hard enough to finally start thinking independently, but supervising senior residents added a whole other layer of complexity.

Josephine pondered. What advice could she give Deborah to help her in her current situation?

Questions for discussion on page 2.

Questions for Discussion

For Residents:

1. How does working with junior faculty members differ from working with senior faculty members?
2. Can you identify things that junior faculty members have done well when supervising you?
3. How do you provide feedback to someone who is senior to you? (i.e. How do you tell a faculty member that you appreciated something that they did when they were supervising you? How do you tell a faculty member when they did something that made you uncomfortable?)

For Junior Clinician Educators:

1. Have you had any difficult situations while teaching senior residents? If so, what have been some problems have you encountered?
2. What advice have you received from senior educators about handling senior residents?

For Senior Clinician Educators:

1. If you were Josephine, what advice would you give Deborah?
2. Are there any unique approaches that you use with senior residents that are different ones you use when you teach junior ones?
3. What are some systems that you use to mitigate transitional problems like the ones highlighted in this case?

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Intended Objectives of Case

1. Discuss and identify factors that can lead to difficulties between supervisors and trainees.

2. Describe an approach to contextualizing and reflexively analyzing one's own feelings when dealing with trainees.

3. List ways in which senior residents and junior educators might mitigate the tensions in a supervisory situation where the teacher is still developing his/her skills.

Expert Response

One New Attending's Take

by Dr. James Kimo Takayesu MD, MS

As a relatively new attending and supervisor, Deborah is having difficulty finding the right way to provide feedback to her senior resident. It is further complicated by the fact that Donald is reticent to invite feedback on his performance, wanting to demonstrate his capacity for independent practice. However, it is well known that learners have great difficulty in understanding their areas of weakness, making feedback a critical part of training throughout residency. As residents advance through training, their needs, and perhaps initial desire, for feedback change.

Feedback can be divided into two categories: formative and summative feedback. Formative feedback has the explicit goal of making small adjustments in performance in real time and is very similar to what we would be commonly described as coaching. The goal of formative feedback is to provide "just-in-time" instruction, based on direct observation, to improve skills and knowledge at an individual's leading edge of performance or their zone of proximal development, as described by Vytgotsky. This immediate feedback is essential for deliberate practice and the pursuit of expertise.[1] Summative feedback has the goal of providing an appraisal of an observed episode of care or performance relative to a normative standard, thus allowing an individual to know where on the pathway from novice to expert performance they lie relative to their cohort.

Feedback can also be subdivided into different formats based on the duration of the feedback session: commentary (seconds), brief formal feedback (1-2 minutes), and major formal feedback (10-30minutes). Commentary during a clinical interaction or procedure may only take seconds and is at the heart of formative feedback, guiding the performance as it is happening. It minimizes disruption to the flow in the clinical environment and can provide a continuous feedback stream to the learner. A brief formal feedback session may be appropriate when clinical demands are not pressing and can be either formative or summative depending upon when in the care process it is given. For a senior resident in a busy clinical environment, this feedback may feel out of place when patient flow is at stake but extremely valuable during slower periods or post-shift. A major formal feedback session is much more in-depth and relies on a more substantial body of evidence and therefore is not typically used to provide feedback to residents during a shift. Post-shift debriefing around a critical incident or on the overall performance during the shift can be extremely valuable, but may be overwhelming to both resident and supervisor if expected after every shift.

There are many challenges to providing feedback[2] as exemplified by this vignette. In the emergency department setting, there are continual interruptions, variable patient flow, clinical metric goals, educational expectations, and a lack of continuity of exposure between individual supervisors and residents. Furthermore, there are several potential pitfalls of providing feedback that both supervisors and trainees fear.

1. Constructive criticism may be taken personally.
2. The trainee may not consider the feedback a perceived learning need.
3. The feedback may be taken more as a commentary on someone's personality rather than specific actions or skills.
4. If feedback is not provided promptly after the actual event, the trainee may feel unable to improve in real time.
5. The feedback may be unexpected by the trainee, potentially catching them off guard and leaving both supervisor and trainee unhappy with the outcome.

To combat these potential pitfalls, it is important for both teachers and learners to explicitly recognize that the goal of feedback is to understand where the resident's leading edge of performance is and how to teach to it.

While junior residents may feel comfortable being directly observed and guided, senior residents have an explicit need to establish their own practice pattern and demonstrate their ability to manage a department independently. For faculty, being a "silent observer", checking labs and orders in the background and peripherally overhearing or observing care interactions, can be effective in supporting the semi-independent practice of a senior resident while still maintaining a sense of control over the department. In addition, establishing a mutual understanding that the goal of supervision is to define the outer bounds of good and safe clinical practice3, rather than force the resident to apply themselves to the supervisor's practice pattern, can create a safe space for the senior resident to practice and learn.

As adult learners, residents need to perceive feedback as valuable prior to accepting it4. Therefore it is important to get a commitment for the desire to improve at the start of each shift and to set the expectation that direct observation and feedback ispart of the clinical learning environment. Rather than providing feedback immediately and without warning, asking an open-ended question to understand the learner's point of view can help to develop common understanding and clarify what is needed for improvement. Emphasis should be made on providing feedback that is of high quality, not quantity. The feedback should focus on correcting specific actions and knowledge deficits that are most important to address with the understanding that, over time, other deficits can be addressed.

Expert Response

We often speak of the "feedback sandwich": starting with something good, followed by something that needs improvement, finishing with something else positive2. Rather than this three-step approach, I recommend a five-step approach which, although slightly more complicated, establishes relevance to the learner as well as a specific direction for improvement:

1. Ask for a self-assessment (ask where the learner is coming from or about their understanding of the problem);
2. Ask permission to give the learner feedback
3. Provide a concrete specific positive about their performance
4. Provide a concrete specific area of improvement based on one's direct observation during the shift
5. Finish with a discussion on ways the trainee can improve moving forward and highlight how your feedback relates to your personal growth experience during training and in practice.

This last point ensures that the feedback dynamic is egalitarian, recognizing the universal and lifelong need to pursue practice improvement.

When the near miss occurs in the vignette, taking a time out free from interruption to provide brief formal feedback is essential to getting the resident and supervisor back on the same page regarding other patient plans to ensure that the goal of patient safety is equally valued to learning independent practice. Feedback can be particularly challenging when it deals with issues around professionalism and communication. Unlike medical knowledge, these issues can be uncomfortable to address as they can relate to one's personality, conduct, and respect within the department. When providing feedback on professionalism or communication issues, it is important to preface the feedback with the fact that it does not relate to a personal flaw but rather relates to skills that are essential for effective department management and patient care. Professionalism and communication skills are essential to enhance teamwork with nursing, encourage patient compliance, earn patient trust and satisfaction, reduce workplace conflict, and improve the morale of self and team. Focusing on the skills required to effectively manage a department can make the feedback relevant by highlighting the learning gap that many learners face.

References

1. Ericsson KA. Deliberate practice and acquisition of expert performance: A general overview. In: Academic Emergency Medicine.Vol 15.; 2008:988-994. doi:10.1111/j.1553-2712.2008.00227.x.
2. Ramani S, Krackov SK. Twelve tips for giving feedback effectively in the clinical environment. Med Teach. 2012;34(10):787-791. doi:10.3109/0142159X.2012.684916.
3. Kogan J, Conforti L, Iobst W. Reconceptualizing variable rater assessments as both an educational and clinical care problem. Academic. 2014. http://journals.lww.com/academicmedicine/Abstract/2014/05000/Reconceptualizing_Variable_Rater_Assessments_as.15.aspx. Accessed March 4, 2017.
4. Collins J. Education Techniques for Lifelong Learning. Radiographics. 2004;24:1483-1489. doi:10.1148/rg.245045020.

About the Expert

As the Assistant Residency Director of the Harvard-affiliated Emergency Medicine (EM) Residency at Brigham and Women's/Massachusetts General Hospitals, Dr. Takayesu (@kimotakayesu) designed a residency curriculum using a variety of teaching methods including mannequin simulation, partial task training, seminars, case conferences, and small-group evidence-based learning. He serves as the co-director of the EM clerkship for fourth year medical students, mentoring mentors senior medical students, exposing them to the practice of Emergency Medicine, and providing them with guidance through the application and interview process. As the EM Departmental Simulation Officer, he runs a program for individual resident formative assessment.

Expert Response

Clinical Supervision: To Trust or Not To Trust

by Dr. Warren J. Cheung MD, MMEd, FRCPC

At the heart of this scenario is an issue of appropriate clinical supervision. It highlights an important concept that the medical education literature has termed entrustment. Clinical supervisors are constantly making decisions about whether to trust a trainee to perform a task independently. These tasks may be relatively benign (e.g., asking a student to take a history from a patient) or may involve considerable risk (e.g., allowing the senior to perform a subclavian central line unsupervised). By entrusting a trainee with a clinical task, the supervisor is relying on the trainee to execute the task correctly, or to call for help when required.[1] This places the supervisor in a vulnerable position and implies a willingness to take on the responsibility for the trainee's actions, including his or her mistakes. While other supervisors had previously entrusted Donald to run the department, it appears that Deborah was struggling to figure out how much autonomy to give him.

Autonomy in learning and practice are valued in the culture of medicine.[2] This is not surprising since the ultimate goal of medical education is to produce doctors who are ready for independent practice. Therefore, graded responsibility must be permitted to push trainees toward their zone of proximal development (the gap between what they have mastered and the next level of proficiency to be attained).[3] However, incremental autonomy must be balanced with appropriate supervision, because medicine is, after all, about the patient first. But what factors come into play when making such entrustment decisions? The literature suggests five broad categories: the trainee, the supervisor, the task, the context, and the supervisor-trainee relationship.[1]

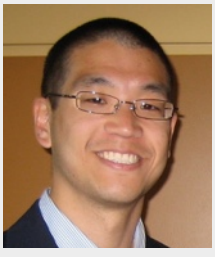
Let's focus on the interaction between a supervisor and trainee for a moment. Ten Cate and colleagues have proposed three modes of trust that evolve in the supervisor-trainee relationship. Presumptive trust is based solely on credentials. Initial trust is established upon first impressions. And grounded trust develops only after authentic and prolonged experience with the trainee.[1] In our scenario, the lack of an existing relationship between Deborah and Donald suggests that trust was based on Donald's credentials (he is a senior resident) and on Deborah's first impressions of Donald ("he is confident and borders on cocky"). While Donald may have expected Deborah to allow him to run the show as others have previously entrusted him to do, it's easy to understand why Deborah was hesitant and felt uncomfortable throughout the shift – her entrustment decisions weren't grounded in prior experiences. So what can supervisors and residents do to prevent this scenario from happening to them?

It is important to make the implicit explicit. Regardless of whether a supervisor and trainee have previously worked together, every shift should begin with a discussion around expectations.[4] What does the supervisor expect the trainee to do? What does the trainee expect of the supervisor? Simply having the discussion, however, is not sufficient. It should result in an agreement on expectations and a mutual understanding of how much autonomy will be granted. In our scenario, Donald was expecting Deborah to "sit back and relax" while he acted as a junior staff, whereas it would appear that Deborah was expecting to be more hands-on. In this case, it would have been beneficial for Deborah to initiate a discussion with Donald about expectations in order to come to a compromise about an appropriate level of supervision that addressed both Donald's educational needs and Deborah's readiness to "let go of the reigns", while still ensuring that patient safety was preserved. It may also have been helpful to set some rules of engagement at the beginning of the shift, such as ensuring that patients were discussed before discharge. Then, as grounded trust becomes more established over the course of the shift, expectations can be mutually revised to reflect greater autonomy where appropriate.

Different people have different risk tolerance. This accounts for a lot of practice variation in medicine. In the same way, clinical supervisors will differ in how much autonomy they give to a particular trainee. Although not allowing trainees to act unsupervised until they are legally qualified will deprive them of important clinical experiences, appropriate clinical supervision is necessary to ensure patient safety.[1] Having a discussion that may necessarily involve compromise, but that ultimately leads to mutually aligned expectations, can help make entrustment decisions more explicit and quell some of the tension that faculty often feel when trying to juggle patient care and clinical supervision of their trainees.

References

1. ten Cate O, Hart D, Ankel F, Busari J, Englander R, Glasgow N, et al. Entrustment decision making in clinical training. Acad Med. 2015;91(2):1.
2. Watling C, LaDonna KA, Lingard L, Voyer S, Hatala R. "Sometimes the work just needs to be done": socio-cultural influences on direct observation in medical training. Med Educ. 2016;50(10):1054–64.
3. Vygotsky L. Thought and language. Cambridge: MIT press; 1986.
4. Sherbino J, Frank J, Lee C, Bandiera G. Evaluating "ED STAT!": a novel and effective faculty development program to improve emergency department teaching. Acad Emerg Med. 2006 Oct;13(10):1062–9.



About the Expert

Warren J. Cheung MD MMEd FRCPC (@wjcheungem) is an Assistant Professor and holds a Junior Clinical Research Chair in Medical Education in the Department of Emergency Medicine at the University of Ottawa. He is a Senior Clinician Investigator with the Ottawa Hospital Research Institute and a CanMEDS Clinician Educator at The Royal College of Physicians and Surgeons of Canada. His research focuses on improving the quality of trainee assessments within a competency-based framework, with a particular interest in studying workplace-based assessments. His greatest joy is spending time with his wife and son.

Curated Community Commentary

By Alkarim Velji BSc, BEd, MD, FRCPC (candidate), MHPE(candidate)

This month's case discussed the scenario of a new attending, Deborah, and her first experience having a senior resident, Donald, on shift. The attending-resident relationship is complicated by the proximity in level of training, the higher level of senior resident learning and particularly by Donald's [over]confidence. Throughout the shift, conflict inevitably arises. Deb feels that Donald is undermining her, overstepping boundaries, and dismissing her requests. He continues to exacerbate the scenario by insisting that Deb just "sit back and relax". When Deb is greeted by the incoming senior attending at the end of the shift, she is left feeling both lost and exhausted.

From a resident perspective, we are asked to discuss our experiences working with a junior and senior faculty and how residents can provide feedback to faculty. Junior attendings are asked to discuss strategies for working with senior residents and what advice they would offer to Deb. Finally, our senior attendings are asked to discuss what advice and strategies they could suggest to Deb.

Key themes that came up this week included:

- The importance of residents setting expectations for attendings and for attendings to set expectations for residents
- As part of those expectation at the beginning of the shift, ensuring there is a balance between resident autonomy and appropriate supervision to ensure patient safety
- Frankly discussing shortcomings with senior residents
- With time and experience, junior clinicians will learn a style and comfort that will allow them to facilitate senior residents

Clear expectations for each other and open communication

Had Deb and Donald attempted to set expectations at the beginning of the shift, much of their conflict would have been avoided. Dr. Luckett-Gatopoulos, a resident at McMaster University, highlighted that one of the challenges (and benefits) of being an EM resident is that residents work with a variety of different attendings. She has found that successful shifts with a new attending start by setting one's goals for the shift and outlining one's strengths and limitations. With subsequent shifts, attendings and residents learn each other's style and learn to trust each other.

Similarly, along with having a clear conversation about expectations at the beginning of the shift, Deb and Donald would have benefited from checking in mid-shift. Dr. Brazil suggests that Donald may have been trying to be keen and manage the department entirely himself. However, conflict may have been mitigated had Deb spoken up and checked with Donald and had Donald shown the insight to listen to his attendings attempt at regaining control of the floor.

As Dr. Symon pointed out, Donald may not know that he struggles with communication and may lack insight. He seems to have made several critical errors including discharging patients without reviewing with his attending, overriding her orders, and ignoring his attending's requests. He may be unconsciously incompetent of his shortcomings. Dr. Cooney goes so far as to suggest that Donald is performing far below expectations for this competency.

To approach this issue, Dr. Brazil suggested that Deb focus on specific cases and safety incidents to highlight teachable moments. If Deb is unsure how to lead this debrief, Dr. Cooney suggested the senior attending who is coming on shift coach Deb on how to have crucial conversation. Dr. Rosenberg tweeted that it would be worthwhile to discuss with Donald the line between confidence and arrogance and give him specific strategies to improve in the future.

From the resident perspective, Dr. Luckett-Gatapolous astutely points out that providing constructive feedback to faculty can be challenging. She suggested that reinforcing an attending's positive skills or techniques is simple. However, while providing constructive feedback can be met with defense initially, the task becomes easier as one develops long term relationships with their attendings.

Allowing the residents enough leash to play (while ensuring safety)

Attendings "lend" residents their patients and department. While residents are learning to function autonomously, they are by definition still trainees. Therefore, an attending ought to clearly outline what they

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Thanks to the participants (in alphabetical order) for all of their input:

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Dr. H. Rosenberg
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Dr. L. Swisher
Dr. B. Symon
Dr. L. Thurgur
Dr. S. Yiu

are comfortable allowing residents to do in their department.

Dr. Luckett-Gatopoulos and many of our attendings pointed out that junior faculty frequently prefer to be more involved with patient care. However, attendings who helicopter over a resident's shoulder hamper learning and perpetuate an air of mistrust. Dr. Yiu frames her expectations around what her own comfort levels are rather than the resident's ability. Her rule is that she sees patients and looks at diagnostic tests regardless of level of training. As Dr. Swisher states, the supervision should be to the level that will let you comfortably sleep at night.

Dr. Symon equates supervising a resident with raising a teenager. The educator must harness the learner's passion while fostering independent, critical thinking. However, allowing this independence inherently brings risk. Unlike in teenagers the risk is not just personal, but might lead to patient harm if allowed to run unchecked.

With time comes wisdom and comfort

Many junior attendings may feel consciously incompetent and struggle with self-doubt and the weight of their new responsibility. When paired with an overconfident senior learner, many junior faculty experience a negative countertransference toward overly confident residents. Just as in psychiatry, being aware of and reflecting on the countertransference helps to alleviate conflict and minimize error. Our participating senior faculty suggested that much of this discomfort disappears with time as the attending sees more presentations, learns to make mistakes, and becomes more comfortable in their own skin. Dr. Swisher emphasizes the importance of normalizing Deb's feelings of conscious incompetence and highlighting that things will improve.

Junior attendings should be encouraged to reflect on their expectations of themselves and of their learners. Senior faculty faced with supporting a junior attending should focus on listening to their junior colleague's concerns and normalizing their experience.

Many of our senior faculty reiterated the idea that with experience comes comfort with oneself and one's practice. Dr, Rahall and Dr. Brazil both point out that as faculty shift from the "consciously incompetent" junior attending to the well-hardened experienced physician, they learn to be okay with residents performing actions that they may not do, so long as these actions are evidence-based and safe.

Dr. Brazil cleverly pointed out that for both the junior attending and the senior resident, "Transitions are called transitions for a reason. It's a process, and it takes time and a few bumps in the road".

About

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