



The Case of the Overwhelmed Senior Resident

Case by Dr. Shahbaz Syed

Case

Dr. Shahbaz Syed

Objectives / Questions:

Dr. Teresa Chan

Expert Commentaries

Dr. Gus Garmel

Dr. Eric Nadel

Curated Community Commentary

Dr. Sarah Lockett-Gatopoulos

MEiC Project Lead

Dr. Tamara McColl

Dr. Teresa Chan

ALiEM Editor-in-Chief

Dr. Michelle Lin

It had been hours since Mark had seen his supervising attending on his overnight shift. Mark was a senior Emergency Medicine resident, and as such, was tasked with "running the department." In addition to taking handover from the previous physician, dealing with acute resuscitations, and seeing new patients, Mark was also responsible for supervising the junior resident throughout the shift. While it was certainly not his first time 'running the department', Mark was finding tonight's shift particularly taxing. Several sick complex patients had come in and required extra attention and the charts of patients waiting to be seen were piling up.

"Have you seen Dr. Ezra?" Mark asked one of the nurses.

"Not in the last few hours. If he's not seeing patients then he must be taking a nap in his office. That's where he tends to disappear to," she replied.

At that moment, the EMS notification phone rang: an incoming code stroke in 10 minutes. Mark sat down with a sigh to collect his thoughts. He was only a few months from graduation. All he had to do was get through his exam and the final stretch of residency and he was home free. However, as he sat there - he couldn't help but feel despair; his department was falling apart around him, and he didn't know what to do.

He had multiple patients who required disposition, 2 cases still to review with his junior

resident, a number of patients with long wait times in urgent care, and now an incoming code stroke. How could he be ready to be a supervising physician himself if he couldn't keep the department in check during this overnight shift? Would he struggle like this when he was all alone with no backup?

Mark shook his head as he realized he was already living in that scenario, with his attending nowhere to be found. He debated, "Should I go and wake Dr. Ezra for help? Or would Dr. Ezra simply think that I am incapable of managing the department without his support?"

As Mark contemplated his best course of action, Dr. Ezra wandered into the department.

"How are you doing?" he asked, "seems like things are starting to slip away a little bit in here! You should have come and grabbed me sooner."

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Questions for Discussion

1. If you were Mark, how would you respond to or handle this situation?
2. How should Dr. Ezra have handled this situation as the staff person? Is it reasonable for attending physicians to leave the department for senior residents to manage?
3. What does it mean to "run the department" as a senior resident? What are the expectations and at what level of training would this be appropriate?
4. Why does it seem unacceptable to ask for help as a senior learner?

Competencies

ACGME	CanMEDS
Professional Values (PROF1) Team Management (ICS2)	Leader Professional Communicator Collaborator

Intended Objectives of Case

1. Discuss the role and nature of supervision in the resident-attending relationship.
2. Describe an approach to enlist additional help when patient care volumes are increased. Describe an emergency physician's role in assisting housestaff or other junior attendings.
3. List specific ways that we can prepare junior faculty members to best support and supervise senior trainees.

Autonomy vs Safety: Striking a Balance

by Gus M. Garmel MD, FACEP, FAAEM

This scenario presents challenges not only for Mark, the overwhelmed senior resident, but also for Dr. Ezra, his supervising attending. Mark's desire to "run the department" is noble. However, what "running the department" exactly means is subject to interpretation. While Dr. Ezra demonstrates confidence in Mark's ability by entrusting the department to him, Dr. Ezra's foremost consideration should be to balance patient safety with Mark's (or any provider's) skill level and preparedness for running a busy department. Dr. Ezra's extended disappearance during a shift (whether or not to take a nap) may jeopardize patient care, may cause Mark unnecessary or extreme stress, and is likely to influence the staff and patients. Although Dr. Ezra's intentions may be to challenge Mark, "toughen him up," expose him to challenging situations, or "prepare" him for the future, his absence from the ED does not give him the opportunity to provide Mark with direct observation, real-time feedback, or wisdom from teaching and supervision. As a learner, Mark should strive to seek and receive direct observation, feedback, and knowledge. As a teacher, Dr. Ezra is responsible for providing these.

Conflict often arises due to unclear and unmet expectations or needs.^{1,2} One important strategy to mitigate this conflict is to detail a plan for the shift in advance. Mark and Dr. Ezra should clearly express their goals, intentions, and plans of action to each other. If these plans do not match, they should further clarify or modify them until they reach a shared model. One key item to discuss would be how and when Mark would contact Dr. Ezra, and for what reasons. Perhaps having a clear understanding of when to call for help would have reduced Mark's stress. Dr. Ezra should have explicitly stated that asking for help is not failure. In fact, delegating and asking for help are essential skills that Mark needs to learn, employ, and be comfortable executing. Offering suggestions on how best to do this is only possible with direct observation, teaching, and feedback in the ED in real time.

Whether or not Dr. Ezra was monitoring the ED from his office or a nurse called to update him about the precarious situation, his assigning blame on arrival ("you should have come and grabbed me sooner") helps neither the situation nor the relationship. Blaming Mark neither develops nor strengthens his skill set. No one benefits in this situation. Staff and patients are left to suffer. Mark may lose confidence, doubt his abilities, and is at greater risk for burnout when this strategy is implemented. In fact, one particularly bad shift might be enough to cause Mark to leave the specialty. Most importantly, he gains little knowledge from his supervisor about useful strategies that might prevent a similar situation in the future.

Fostering positive relationships and a safe workplace are important to create an optimal learning environment. Learners need to be comfortable asking for help, and instructors need to be in a position to offer guidance and support. Any power dynamic inherent between these parties must be acknowledged and addressed. An offer of genuine concern by Dr. Ezra for Mark's learning, wellness, and safety (i.e., that he can come and get him at any time) might have encouraged Mark to seek help sooner.

Physicians commonly feel that they must be "perfect." This perfectionism contributes to physician burnout.^{3,4} Mark is being too hard on himself. He must learn to trust his instincts, which were correct - the department was busy, he was overwhelmed, and he needed help. The sooner he acts on these correct instincts, the better. Similarly, Dr. Ezra needs to jump in, help out, and guide Mark through this challenging situation. Although guidance or supervision can occasionally be done remotely, it is far better when supervisors are present, share ideas, assist with reflection (how did things get to this stage?), and offer support and encouragement.

The word "doctor" comes from the Latin *docere*, which means "to teach."^{5,6} A good instructor, coach, or mentor must be committed to his or her charge's success.^{7,8} Rather than placing blame or seeking secondary gain, instructors or mentors should have an altruistic approach that promotes success, wellness, and growth. Dr. Ezra's responsibilities as a supervisor should focus on preventing Mark from beating himself up, protecting him from losing his confidence or harming patients, and providing strategies for avoiding similar situations in the future. Especially important is that Dr. Ezra minimizes the negative impact that these challenges have on his learners, his staff, and his patients. On the other hand, rather than focus on Dr. Ezra's perception of him, it is more important that Mark focuses on patient safety and positive outcomes (for patients, for staff, and for his relationships), as well as his learning and development.⁹

Expert Response

Pearls & Recommendations

A. for Learners (Mark)

- 1) Set expectations, understand priorities, and have clear goals prior to the start of the shift
- 2) Don't be a hero – ask for help if needed (this includes delegating)
- 3) Seek real-time and specific feedback from supervisors
- 4) Know your limitations
- 5) Maintain wellness and keep a positive attitude despite the challenges facing you
- 6) Reflect and evaluate your efforts

B. for Faculty (Dr. Ezra)

- 1) Express your plan and your goals – clearly and in advance
- 2) Supervision is best done in person
- 3) Feedback is a gift to your learners – commit to providing specific and applicable feedback (it is your responsibility)
- 4) Monitor your learners' stress
- 5) Acknowledge that you are ultimately responsible for patient care outcomes – don't blame others when things go wrong
- 6) Adopt better coping strategies prior to your overnight shifts, so that you are able to stay awake, remain alert, and be present to supervise.

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About the Expert

Dr. Gus Garmel is a Clinical Professor of EM, former Co-Director of the Stanford/Kaiser Residency Program and Clerkship Director for Stanford University School of Medicine. He is a passionate educator and mentor. He has authored 4 textbooks and published numerous articles and textbook chapters. He is a dedicated instructor for faculty, residents, medical students and nurses. Dr. Garmel serves as a senior EP for TPMG, KP Santa Clara, a senior editor for The Permanente Journal, an invited reviewer for several EM journals, and chairs the Kaiser National EM Conference. He is active with ABEM, ACEP, AAEM, SAEM, CORD and EMRA.

Gaining Independence in an Era of Patient Safety/Quality Improvement

by Eric Seth Nadel MD

The scenario described is that of Mark, a senior resident who is “running the department” on a busy overnight shift with high volume and acuity, while his attending is in the back room sleeping. Mark struggles with whether he can handle the department independently as a resident, and what it says about his own capabilities. He struggles with not knowing when to ask for help, or if asking for help might reflect poorly on him. The arrival of the attending on the scene seems to solve the immediate challenge related to patient care but leaves questions regarding progressive responsibility during training and attending responsibility within a training program in an era where patient safety and quality of care are paramount. How does a resident gain independence while also assuring the highest quality of care for every patient? Other issues which contribute to the discussion of this case are how we manage physician burnout, how feedback, evaluation, and mentorship influence our own professional development, and finally, how we navigate conflict in challenging situations.

Running the department/progressive responsibility

The idea that residents “run” the department is old school, and not consistent with how accreditation agencies and specialty boards understand the post graduate training process. The attending staff of the hospital and the department leadership “run” the department, and residents are attempting to complete their training successfully so that they can also “run” the department. We use the phrase “running the department” liberally which implies that we want to give the highest level of autonomy to a trainee while they are still in a supervised environment. At the level of senior resident practice there is enough variability in practice which is considered acceptable and safe, that faculty can offer some flexibility in decision making, which develops autonomous practice patterns for residents. There may exist clinical environments that slow down enough overnight making sleep a possibility for staff, but I don’t know of any in my part of the country. If the residents are awake, the staff should be awake, in my opinion.

Supervision policies/capacity management

In the case, an acute stroke is coming into an already busy department and the department is “falling apart”. The quality and safety movements over the past two decades support the notion that we are not willing to sacrifice quality of care in order to train the next generation. There is compelling data to suggest that physician safety profiles are most related to the safety profiles of the institutions where they trained.¹ The ACGME Next Accreditation System and the CLER (Clinical Learning

Environment) visits are focused on issues of patient safety within the institution, so that these safe practices can be handed down to the trainees.² One clear policy that every training program should have is a supervision policy. Such a policy should clarify the expectations of when a resident should seek attending back up, and to make it clear that the attending be available, and that it is not a sign of weakness to contact the attending, but rather an expectation. In addition to a supervision policy, every department should have a capacity management plan. Overflow of capacity requires additional resources. This takes the judgement out of calling for assistance without making trainees feel like a failure. We live in a culture where emergency physicians have a high threshold to call in sick, and an even higher threshold to call in back up. We need to overcome these old practices and focus on creating plans related to supervision and capacity management, so that Mark, and Dr. Ezra are clear as to how to function, without judgement.

Competence

Is Mark competent? It is easy for us to feel insecure in a busy emergency department given issues of volume, acuity and resources. While any trainee will have some insecurities in a stressful moment, we need to rely on our evaluation systems to determine whether they are meeting competency benchmarks. How do they compare to their peers? Who has provided Mark with feedback? Maybe he is behind the curve in clinical decision making, and efficient management, or maybe he is ahead of the curve and just getting slammed. This overnight shift should not be occurring in a vacuum, and Mark should be well aware of his strengths and weaknesses based on a robust evaluation system. If he is not aware, there should be strong consideration to improving the feedback and assessment of the trainees so they know how to put this overnight experience into context.

Burnout/Wellness

Is the learning environment created for Mark one that promotes wellness and helps to prevent burnout? Probably not. In general, while residents move along the trajectory of progressive responsibility, increasing volume and acuity is essential. I tell my residents that 10% over capacity is not a bad thing, can create a little anxiety and a good learning environment. Fifty percent over capacity is over the top and off the cliff, much like a Starling curve. We know from recent studies that physician burnout is real and getting worse given the stress of our clinical environment and the expectations on physicians.³ There have been many Wellness efforts initiated at different programs and institutions around the country. Some of these focus on group social

Expert Response

activities and debriefing, and while I think that these are important, I believe that the focus should be on identifying and limiting the root causes of increased stress and burnout from both a systems and individual level perspective. I believe that we can train the next generation of emergency physicians to be outstanding clinicians and also mitigate stress and burnout. Our institution has initiated a Center for Professionalism and Peer Support⁴ and has also created a Resident Wellness Committee with a Faculty Advisor position to assist with these wellness efforts. Efforts such as these can help to change the culture of training to mitigate burnout and help to create learning environments which focus on resident learning and competency.

Conflict Resolution/Negotiation

Managing conflict is one of the most challenging skills to develop as a trainee. We work in complex environments with competing agendas, such as education and throughput, with people who have strong personalities often with individual priorities and agendas. I find it helpful to think of managing within these complex environments using certain frameworks. I would suggest to Mark that he read a few of these great resources. One is "Managing Your Boss" from the Harvard Business review⁵, a classic piece on managing up, and how to think about effective working relationships with those who supervise you. The other, "Getting to Yes", is a classic negotiation text and helps to create a framework for understanding negotiation and how to manage conflicts.⁶ I often recommend these texts to residents, and many have found them very useful. Mark could get a better understanding of Dr. Ezra, and how best to work with him so that these challenges could be anticipated and mitigated in advance.

If I was Mark, I would do my best to recognize that this was a close call, a near miss, a sentinel event, and one that would need to be managed when the dust settled, but not in the moment. In the moment all of the patients needed to be cared for as best as possible, regarding quality of care and efficiency of care. At the end of the shift I would recommend that Mark request feedback, thus creating the opportunity for a broader dialogue. In the light of day, it is important that Mark debrief with close colleagues or a mentor so he can better understand some of his own insecurities

and also plan for future situations where he is faced with similar conflicts. What would Mark's mentors do in the same situation? Hopefully Mark will have developed mentors by this time of training, and he should be encouraged to be open and honest with them and seek counsel. Mark should also know there are resources within the institution where he can seek help to think through a challenging situation. In the end, hopefully Mark will learn about how to manage a similar stressful situation and be better prepared should it happen again. As for Dr. Ezra, he should stay awake and be an active, responsible educator.

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About the Expert

Dr. Eric Nadel is an attending physician at the Massachusetts General Hospital Department of Emergency Medicine and is Associate Professor at Harvard Medical School. He is also the Program Director of the Brigham and Women's/Massachusetts General Hospital Harvard Affiliated EM residency training program.

Curated Community Commentary

By Sarah Lockett-Gatopoulos MD, FRCPC (candidate)

Our most recent case follows Mark, a senior emergency medicine resident nearing the end of his residency. Tasked with running the department - and supervised by an attending physician, Dr. Ezra, who is nowhere to be seen - Mark is overwhelmed and questions his ability to perform as a staff physician when he graduates. Just as Mark wonders how he will ever manage, Dr. Ezra reappears, only to remark that the department is out of control. He chastises Mark for not letting him know sooner.

The online discussion around this case generated three major themes: Respondents discussed resident autonomy and patient safety, the spectrum of teaching and supervisory styles, and the setting of expectations for senior learners.

Dr. Glenn Posner, an attending physician in Obstetrics and Gynecology and Director of Simulation at The Ottawa Hospital, described the delicate balance between resident autonomy and patient safety. In his Obstetrics department, the attending physician is expected to be present at each delivery and during the surgical brief and debrief. He acknowledges that this is 'great for patient safety, patient experience, and resident supervision, but not as good for resident 'independence', reinforcing what Dr. Mark Lipson, a PGY5 resident in General surgery describes as a 'delicate balance' between autonomy and supervision. Dr. Lipson notes that '[i]f trainees are too tightly supervised, they may struggle to develop...decision making skills and confidence' but also acknowledges that the balance between autonomy and supervision requires 'a good working relationship...between residents and their supervising preceptors'.

Learners may be hesitant to call their supervisors when they have been granted autonomy, and the reasons for this are many and varied. Dr. Posner relates - through his experience as a program director - that residents who call their attendings frequently are apt to be perceived as weak, may not be as well-liked, and may hurt their chances of being hired. There is an impetus for senior learners to try to do it all on their own, which Dr. Lipson asserts 'is a sure recipe for disaster'. In fact, Dr. Lipson told us that there were questions in his recent licensing exam that were contingent on the examinee's recognition that additional help was needed. He encouraged residents to be 'reflective and introspective' in knowing when they require extra guidance and supervision, and reminded us that 'a competent physician can assess the situation and recognize when they alone do not have the personal resources...to provide the necessary level of care'.

Dr. Posner additionally spoke about the differences in teaching and supervision styles amongst attending physicians, with some supervising more closely and others encouraging a greater level of autonomy. He emphasized that 'attendings who use independence as a teaching method must also create a safe

Contributors

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

Lisa Calder
Mark Lipson
Chau Pham
(@ChauPham_EM)
Glenn Posner
Ben Symon
Hans Rosenberg
(@hrosenberg33)
DocXology
(@dymonite69)

learning environment'. He aptly pointed out that the skill of the teacher and the techniques in question may have an impact on the level of independence allowed; confident teachers supervising a procedure where mistakes are unlikely to be serious and irreversible may allow more independence than those who are less confident or who are supervising high-stakes procedures. Dr. Lipson reminded us that there are often times when attending physicians are able to impart clinical pearls or wisdom gained through practice, and when learners do not take the opportunity to speak with their supervisors, they may lose out on these important opportunities to learn.

Given the differences in teaching and supervisory styles, it is important for attending physicians to set expectations and residents to understand these expectations. This is contingent upon a good working-relationship where the attending physician is aware of the learner's skill level and comfort. Dr. Lipson emphasized the attending physician's responsibility to know the resident with whom he is working prior to determining an appropriate level of autonomy. He argued that 'Dr. Ezra should have a good idea of Mark's skills and abilities before leaving him with minimal supervision'.

Dr. Posner espouses the mantra 'communication fixes everything' and believes that '[e]xplicit communication at the beginning of a shift regarding expectations for supervision and when to call for help can go a long way'. He tells senior residents tasked with running his service that they should 'call [him] as they would their second-call', and he believes that setting this expectation of a very senior resident allows them to approximate the imminent experience of being a staff physician. He reminds residents that he is 'paid handsomely to be on-call, not to sleep

Curated Community Commentary

through the night', and encourages them to call as needed, setting a clear expectation for residents that is then supported with his avoidance of expressing frustration when he is subsequently awoken by a learner or nurse. Dr. Rosenberg tweeted that some senior residents may suffer from a little too much confidence and pride, trying to portray themselves as junior attendings, and thus may not ask for help as it may be portrayed as incompetence or weakness. Setting clear expectations will certainly help mitigate these concerns. In Dr. Posner's experience in speaking with other physicians about resident supervision, even the attendings the residents were most concerned about 'bothering' overnight expressed that 'residents should always feel free to call...whenever they wanted'. Dr. Posner relates that he rarely encounters a situation that has gone wrong because a resident has not contacted him by 'making [himself] approachable', thereby reinforcing the expectation that the resident should call rather than compromising patient safety. Dr. Lipson provided important insight from a resident perspective. He argued that 'maybe Mark [the senior resident in our case] waited a bit too long to involve more of his team,' but acknowledged that it can be difficult to be sure whether that is the case as Dr. Ezra's expectations were not clear. Like Dr. Posner, Dr. Lipson emphasized the role of clear expectations about when the resident should check in with the staff physician and how the staff physician could be reached if needed. From an attending physician's perspective, Dr. Pham reminds us that, "for those privileged to be working with residents, we will have failed our learners if we breed the culture of fear for being asked to mentor while on a clinical shift."

In the discussion around this case, a few things were clear. First, patient safety must be carefully balanced with learner autonomy. Second, attending physicians must know their learners well, set expectations, and communicate these clearly

with learners. Third, learners must protect their patients' safety by calling on their attending physicians as needed, and by being acutely aware of the limits of their own skill and comfort. As we were reminded by Dr. Lipson, medicine is a team sport, and the idea that learners who call for help are 'weak' or 'incompetent' is inappropriate and a vestige of a culture of machismo that does nothing to protect our patients.

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