

The Case of Unseasoned Senior

Case

Dr. Rebecca Wood
Dr. Sarah Luckett-Gatopoulos

Objectives / Questions:

Dr. Teresa Chan

Expert Responses

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Curated Community Commentary

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Mrs. Smith was a 50-year-old mother of three and had been admitted to hospital under the surgical service for the past 3 days. Debbie, a first-year resident, had been rounding on her every morning and was growing increasingly concerned with her clinical status. She had originally presented to hospital with diffuse abdominal pain, fever, and a high white count. The team had initially scheduled her to go to the operating theatre for a possible complicated diverticulitis. Since her admission, however, her management plan had been changed several times by the new Chief Resident.

This morning, Debbie had noticed that Mrs. Smith was somnolent, pale and running a high fever despite 3 days of intravenous antibiotics. Debbie knew she was growing increasingly ill, and was concerned that she might crash at any moment.

The new Chief Resident seemed unsure of himself and had not created a definitive treatment plan for Mrs. Smith. The usual half-hour morning rounds were now taking the team over two hours. Decisions were made and changed on a daily basis and the past few weeks seemed to become a ritual of constant interruptions, poor planning, and indecision. Debbie had voiced her concerns regarding Mrs. Smith to the Chief but he had opted to watch and wait for one more day.

As Debbie sat at the nursing station writing a progress report in Mrs. Smith's chart, she was approached by Dave, a highly-reliable floor nurse.

"Debbie," he began in a stern tone, "Mrs. Smith's family would like to speak with you. They are really upset that nobody has explained what is going. Frankly, I'm not sure what the plan is either."

At that moment, Dr. Singh, Debbie's surgical attending, strode onto the ward.

"Dr. Singh!" Dave called, "Debbie and I were just discussing the plan for Mrs. Smith. She's not responding to the antibiotics. Someone needs to make a decision."

Dr. Singh looked at Debbie, surprised.

"Mrs. Smith has been under our care for three days," he said. "No one told me she wasn't improving. Why don't we have a plan for her yet?"

Debbie hesitated. She knew that the new Chief Resident was sinking, not swimming, and she knew patient care was suffering as a result. But should she really throw him under the bus?

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Questions for Discussion

1. What is Debbie's responsibility as a junior resident in this situation? Is there a way to ensure good patient care without sacrificing her relationship with her senior?
2. Imagine you are Dr. Singh. How would you deal with the faltering chief resident?
3. What is Dave's role in dealing with the struggling senior? As a nurse, is there a role he can play in the chief's education and ensuring adequate patient care? Who should he speak to and how?

Competencies

ACGME	CanMEDS
Professional Values (PROF1) Interpersonal skills and Communication (IPCS)	Professional Collaborator Communicator

Intended Objectives of Case

1. Discuss and identify factors that are under Debbie's immediate locus of control.
2. Describe an approach for clinical supervision.
3. List specific things that should and should not be done by teams when a member seems to be not performing as expected.

Expert Response

Between a Rock and a Hard Place

by Brent Thoma MA, MD, FRCPC

This case places Rebecca, Dr. Singh, and Dave in a very difficult situation. For the sake of patient care it is clear that something must be done, but how and by whom are more challenging questions. Having only recently completed residency, I empathize most strongly with Rebecca and Dr. Singh and will approach the issue from their perspectives.

While it is clear that if patient care is being compromised it is important to speak up, the realities of a modern academic institution can make this a challenging thing to do [1,2]. Residents are placed in the unenviable position of having multiple supervisors, each of whom are at various levels of a complicated (and occasionally contradictory) clinical and social hierarchy [3].

Beyond the obvious implications for the patient, how Rebecca addresses this situation may affect her relationship with her colleagues, her reputation within the hospital, and potentially even her future job prospects [1]. I suspect that, unfortunately, some aspect of these realities and fears are what prevented her (and others) from speaking up sooner.

Fortunately, the dire situation and Dave's actions have made the correct course of action more clear. If Rebecca believes one of her patients may crash, she needs to inform Sam, Dr. Singh, and perhaps the pre-code team. The endorsement of her fears by senior nursing colleagues like Dave give her concerns substantial legitimacy. Dr. Singh's surprise at hearing about his patient suggests that he will review the case carefully and almost certainly identify the problems with the process of care. By responding to his inquiries diplomatically she can meet her responsibilities to Dr. Singh and the patient without necessarily throwing Sam under the bus.

If a critical incident like this had not occurred, the situation on the ward would have been even more difficult. I would encourage residents in situations like Rebecca's to begin by speaking to their seniors using the stages of graded assertiveness [4]. The mnemonic 'OSCE' is familiar to most medical learners but, beyond the assessment tool, the letters

represent the 4 stages of graded assertiveness: Observation, Suggestion, and Emergency.



If the acuity of the situation allows, prior to reaching the fourth stage I would suggest that Rebecca get advice from a trusted mentor.

A difficult conversation

Having identified a potential issue with patient care, Dr. Singh's first step should begin by addressing the concerns of Mrs. Smith's family and objectively assess the ward to ensure that his patients are receiving appropriate management. While doing so, it would be helpful to gather concrete examples (such as the case of Mrs. Smith) to gain insight into the possible source of the problem.



About the Expert

Dr. Thoma (@Brent_Thoma) completed his residency in Emergency Medicine at the University of Saskatchewan. He has also completed a Simulation Fellowship at Harvard University. Presently, Brent is a Staff Emergency Physician at the Saskatoon Regional Health. He is the research director of the University of Saskatchewan's Royal College training program in emergency medicine. Brent is the Editor-in-Chief of BoringEM, and an associate editor for the ALiEM MEdIC Series. His interests include medical education, social media quality and impact, and simulation.

Expert Response

Dr. Singh should then meet with Sam. This has the potential to be a difficult conversation [5]. As a result of my training in simulation, much of my approach to these situations is informed by the simulation literature. I have found that approaching them with genuine curiosity, rather than jumping to a conclusion (e.g. Sam is an incompetent Chief Resident), can dramatically decrease the defensiveness of the other party [6]. This may create space for Sam to open up about any personal struggles that may be affecting his performance.

The first goal of the discussion should be to determine whether Sam has insight into the issues. If he acknowledges his struggles it could lead nicely into a productive discussion of the underlying problem(s). On the other hand, if Sam thinks he is doing well it may be helpful to outline some of the specific concerns and get his perspective. If Dr. Singh can lay out an example, share his frank thoughts about it [7], and give Sam room to share his rationale, he might be surprised by what he learns (e.g. perhaps Sam was struggling because he had not felt comfortable asking Dr. Singh for help). Regardless of Sam's responses, it is appropriate to discuss his struggles with his Program Director so that an appropriate plan can be developed to address them.

While I can appreciate that Dr. Singh may not have been informed about how poorly the ward was being managed, an attending physician at an academic institution has a duty to ensure that the patients admitted under their name are receiving a high standard of care. As a supervisor, Dr. Singh should be aware of Sam's relative inexperience and provide tight oversight until he has demonstrated that this supervision can be relaxed safely [8]. I appreciate that some programs may not support this ideal. However, a poor institutional culture does not relieve Dr. Singh from his responsibilities as the attending physician.

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The Art of Doing Right

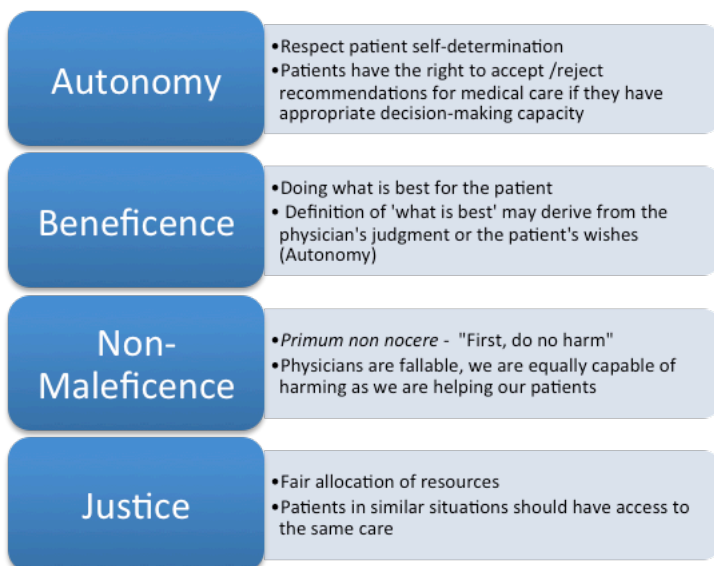
by Jacky Parker MBBS, MHSc CCFP(EM)

This case raises many issues, primarily those of duty of care to the patient, collegiality, accountability, interprofessional relationships, and creating a learning environment that is safe for the learners and their patients. Grave deficiencies in all of these areas have led to a situation where the patient has languished for three days, gradually worsening to the point of sepsis and near arrest.

The primary responsibility of all members of the health care team is to the patient. We have to ask ourselves, "is this patient receiving the best possible care?" Ethical patient care, in North America, is often grounded in "Principlism", a balancing of four equally weighted (but sometimes contradictory; hence many ethical dilemmas!) principles that govern decision-making.

The first principle is that of patient autonomy. Are the patient's informed and capable wishes being respected? The second and third, which are important in this case, are beneficence and non-maleficence. Are they acting in the patient's best interests, avoiding harm to the patient and providing help? The fourth principle, justice, determines a fair and equitable distribution of available resources.

Framework for Biomedical Ethics



Assuming the patient wishes to be treated, and that the resources are available, the principles of beneficence and non-maleficence mandate that Debbie must act to obtain the care that she thinks is in the patient's best interest. Yet she is conflicted, as she feels that to do this she has to throw her Senior Resident "under the bus".

It is often difficult to do the right thing in such a scenario out of a misplaced sense of collegiality, a misguided loyalty to the struggling Senior, or out of fear of personal repercussions for speaking out. But Debbie has a fiduciary relationship with her patient, meaning she has to put her patient's interests above her own. "Whistle blowing" cannot be undertaken lightly. However, in this instance, there are grave issues at stake and the attending needs to know that his patient is critically ill without an adequate care plan in place.

A Framework for "Doing Right"

P. C. Hebert, in "Doing Right", provides guidelines for ethical whistle-blowing:

1. Ensure the wrongdoing (harm) is grave
2. Document all information
3. Look for peer support
4. Follow institutional channels of complaint
5. Make disclosures in good faith
6. Assume that your disclosures will be made public.

In the presented case, the harm to the patient is indeed grave. Has Debbie voiced her concerns to other members of the team? Are any contradictory care plans documented? Is she doing this in good faith? And has she spoken directly to the Senior? "You seem to have a lot on your plate. Is there anything I can do to help" would be a first step in preserving a good relationship with him.

First and foremost, her main priority is obtaining the best possible care for her patient. And for all intents and purposes, the Senior is already under the bus, and not by her hand.

Expert Response

Let's now turn to Dr Singh's responsibilities. As attending, he is ultimately responsible for all care given in his name. He also has responsibility for the supervision and training of his residents, including the sinking senior. He needs to know that there is a problem in order to be able to fix it. Patient care has been somewhat haphazard lately and a patient under his service has been declining, without a care plan, for the last 3 days. This certainly begs the question of why he is not fully aware of this situation already?

His response to the poor judgement and indecisiveness of the Senior Resident should not be blaming and punitive, as much of the responsibility lies on his own shoulders. Most medical harms and errors are brought about by complex circumstances - we should always keep this in mind. They are rarely black or white. After the patient's needs are addressed, he needs to sit down privately with the Senior and discuss the circumstances that are preventing him from providing adequate care. Is it an issue with knowledge and understanding that could be remediated? It is a lack of confidence? Was he afraid to ask for help? Is there a personal crisis or substance abuse issue that needs to be addressed? Involving the Program Director may be helpful.

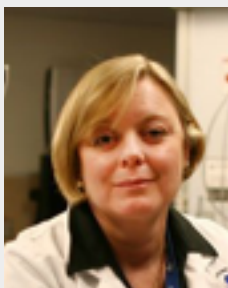
Let's turn our attention now to Dave. Dave is a senior nurse with considerable experience and has worked with many residents. He has no difficulty in speaking directly to Debbie about his concerns, and also should be able to speak freely to the Attending and the Senior Resident. The wisdom of respected senior nurses is often appreciated and shouldn't be ignored. However, sometimes in hierarchical structures this can be difficult in practice. If his attempts to counsel the Senior Resident or advise the

Attending of the chaotic care plans fall on deaf ears, his alternative is to take his concerns to his own nursing hierarchy, and ask for help from his Nurse Manager.

All of this comes down to communication and to the development of an open environment where the healthcare team can voice their concerns with the goal of improving patient care and safety.

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About the Expert

Dr. Jacky Parker, MBBS MHSc CCFP(EM), graduated from the University of Newcastle upon Tyne in the UK and has been practicing emergency medicine in Ottawa for 30 years. Early in her training, she had an interest in the Humanities, always asking the "why" and not just the "what" when approaching patient care. She completed a Masters in Medical Ethics from the Joint Centre for Bioethics at the University of Toronto. She is faculty and Director of Emergency Ethics at the Ottawa Hospital and Assistant Professor at the University of Ottawa. She enjoys teaching bioethics to anyone who will listen!

Curated Community Commentary

By Sarah Lockett-Gatopoulos MSc, MD, FRCPC (candidate)

This month's case presented the difficult scenario in which a new chief resident, Sam, struggles to fulfil his responsibilities, resulting in suboptimal patient care and a loss of confidence with his team. When Dave, a floor nurse, intervenes in the care of Mrs. Smith by speaking directly to the attending, Dr. Singh, Debbie, Sam's junior resident, finds herself in an uncomfortable position.

The case generated an excellent response from our online community, focusing mostly on the role of medical hierarchy in patient care. The following themes arose.

The Patient Comes First

Dr. Lillian Kao initiated our discussion with a very clear mandate to care for the patient first and foremost. It was echoed throughout the comments that patient care must proceed to the highest standard, without regard for medical hierarchy. As Dr. Andy Little astutely put it, 'patient care always trumps seniority, personal pride, or the pecking orders of medicine' as he relayed a story of picking up his senior resident's medical error as an astute intern.

Dr. Anna Patricolo noted that an important aspect of delivering safe patient care in a teaching hospital is to let your learners know whom they should be speaking to when the hierarchy fails. Dr. Tom Bouthillet encouraged juniors to speak up when patient care is suffering.

"Imagine it this way. The co-pilot knew the plane didn't have enough fuel to fly around the storm and would probably crash into the ocean. Should s/he really throw the Captain under the bus?"

Dr. Amalia Cochran congratulated Dave, the floor nurse, on speaking up on behalf of Mrs. Smith, acknowledging that 'bedside nurses are often our eyes and ears, both in terms of patient care and trainee behaviour'. Sherri Ludlow RN echoed that:

'Dave did what is expected of all nurses. When we have a concern regarding our patient, we go up the chain of command until our concerns are addressed. We don't do it to undermine the learner, but to ensure positive patient outcomes.'

An Attending Must Know

The attending physician must maintain an appropriate knowledge of all patients and all plans at all times, and ultimately is responsible for the functioning of the senior resident and the team.

Contributors

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

Lillian Kao	Sherri Ludlow
Teresa Chan	Andy Little
Tamara McColl	Anna Patricolo
Christian Jones	Tom Bouthillet
Amalia Cochran	@Signindoc
Andrew Wright	Bo
Tina Choudri	S. Lockett-Gatopoulos
@GirlfriendMD	

Dr. Tina Choudri summed up the idea of attending responsibility best, saying *'we need to have our eyes and ears on every patient and every plan' but also cautioned against 'interfer[ing] too much with decision making if the patient continues to fare well'*. Dr. Andrew Wright agreed that the attending physician, Dr. Singh, was not appropriately caring for his patients in this scenario. Dr. Wright states that *'there is culpability on the part of the attending. In the modern era, it is not acceptable for the attending not to have rounded or know about his/her patients.'* Signindoc suggested that it is the responsibility of the attending physician to be visible on the wards, and available when needed. Dr. Jones also mentioned a series of questions he would ask himself regarding the crisis in Mrs. Smith's care; Important among them, *'Why didn't I pick up on the patient's worsening condition? Am I not rounding adequately?'*

Dr. Kao reminds us that it is important to remember that our residents' decision-making and leadership skills are, at least in part, a reflection of the training they receive. She pointed out that deficiencies persist because faculty have either failed to address them or because a resident was allowed to take on a role for which he/she was not ready. Dr. Jones agreed that a crucial role of the attending is to find out what's needed for the success of the senior. He would meet with the senior, as well as speak with other people who have worked with him, understanding that the senior resident is his responsibility, and *'not just a target for finger-pointing'*.

Despite the fact that the attending is ultimately responsible for the patient, several commenters agreed that it is acceptable for an attending physician to be flexible about patient care plans in order to allow residents to gain autonomy and direct patient care, as long as their plans are safe.

Curated Community Commentary

A Junior must Ask

Junior residents have a responsibility to seek out additional help and advice.

Many participants pointed out the responsibility of the junior resident to seek out help and advice when there was uncertainty. Most acknowledge that this could be difficult, as juniors often worry about calling their attendings 'unnecessarily'. Dr. Jones emphasized the role of attendings in creating a safe space for residents to seek out help, noting that this safe space could be effectively undone 'with one irate comment'. He stated that most staff physicians would rather know about the patient than have the resident "not disturb" them. Dr. Cochran agreed, emphasizing the role of patience in listening to juniors, who should never be chastised for calling, but should be cautioned against failing to call if there is uncertainty.

Commenters acknowledged that Dave, the ward nurse, was right in pursuing action up the chain of command when patient care was suffering. Debbie had a responsibility to speak with Dr. Singh about her concerns. Dr. Singh needed to be aware of, and responsible for, each patient on the ward, and ready to act as a teacher and guide to the chief resident, Sam.

About

The Medical Education In Cases (MEiC) series puts difficult medical education cases under a microscope. We pose a challenging hypothetical dilemma, moderate a discussion on potential approaches, and recruit medical education experts to provide their insights. The community comments are also similarly curated into a document for reference.

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We would love to hear how you did. Please email MEiC@aliem.com or tweet us @Brent_Thoma and @TChanMD to let us know.

Purpose

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