

SECRETS OF SUPERVISION

Fight errors by providing residents a medical model of proper care

| By Robin Tricoles

Little information is available on how teaching outcomes involving academic hospitalists and resident physicians affect patient safety and error rates—particularly under duty-hour restrictions on residents by the Accreditation Council for Graduate Medical Education (ACGME).

But data show that when medical errors occur they are often connected with residents' errors in judgment, lack of technical competence, inadequate supervision by senior physicians, and a breakdown in teamwork.¹ In a study of 889 cases resulting in error and injury, 240 involved trainees with at least a "moderately important" role. Among the findings:

- z Residents were involved in 208 of those 240 cases;
- z 168 of the cases occurred in the inpatient setting;
- z 80 of the cases involved obstetrics-gynecology residents, and 45 involved general surgery resi-

dents;

- z Trainees "lacked technical competence or knowledge" of diagnosis in 67 cases; and
- z Attending physicians were involved in 106 supervision failures.

Based on this information, how can academic hospitalists best supervise residents to reduce errors and optimize patient safety and treatment while enhancing residents' training and satisfaction? Academic hospitalists across the United States grapple with this question daily. And a few have come up with ways that meet the needs of patients and residents.

Oversight vs. Hindsight

Reflecting on his residency, Eric Siegal, MD, a regional medical director with Cogent Healthcare in Madison, Wis., and chair of SHM's Public Policy Committee, says he recalls times when he did not receive sufficient oversight from senior physicians. Consequently, he and

his patients suffered, he says.

"We were thrown into things with little or no supervision, and we were told to sink or swim," he says. "The good news is that we learned a ton on our own. The bad news is we hurt people in the process. So, the question is how do you walk a line of creating house staff who are autonomous and competent while protecting the patient?"

As an attending physician at the University of Wisconsin, Dr. Siegal says he gave his residents autonomy to make decisions. But there were things he did not let them do alone or without first asking. "The obvious thing was procedures," he notes. "When residents did procedures, I was standing right there next to them. The extent to which I got involved was entirely dependent on the extent to which the resident was competent."

Likewise, Alpesh Amin, MD, MBA, professor and chief, division of general internal medicine and execu-

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tive director of the hospitalist program at the University of California, Irvine, says he gives residents oversight but doesn't hover. "Otherwise they're not learning from experience by only doing what someone else tells them to do," he says. "But without oversight, you don't prevent errors."

Dr. Amin, a member of SHM's Board of Directors, says that as an attending he begins the month with an orientation, reviewing items that help prevent hospital errors. For example, he urges residents before giving medicine to think about possible renal insufficiency and drug interactions. He says he also stresses the importance of preventive techniques.

Developing a system that allows residents to feel comfortable approaching their attending with questions is also vital, says Dr. Amin. Meanwhile, the attending needs to feel he can ask residents pointed questions, yet allow them to think things through.

Dr. Siegal maintained a dialogue with residents regarding the degree of supervision they needed. "A week into the rotation, I asked them how they felt," he recalls. "Are you getting enough supervision? Too much? Most residents have a reasonable sense of what their deficiencies and discomforts are."

Joseph Li, MD, director of the hospital medicine program at Boston's Beth Israel Deaconess Medical Center and assistant professor of medicine at Harvard Medical School, and Kenneth Epstein, MD, MBA, a hospitalist and director of medical affairs and clinical research at IPC-The Hospitalist Company, agree. Dr. Li, also an SHM board member, says not only are residents seeking the right amount of supervision, they're also seeking the right type of supervision based on their strengths and weaknesses. He says residents also are looking for something else—a medical model. "I think they look for someone to model themselves after," he suggests. "I think all of us do through-

out life, sometimes on purpose but also without intending to do so to better ourselves and learn how to do things."

Culture Change

Once an atmosphere rife with assigning blame for medical errors, teaching hospitals are changing how errors are found and disclosed, says Michael Lukela, MD, director of the pediatrics program at the University of Michigan and assistant professor of internal medicine and pediatrics.

"The focus is now on patient safety and looking more broadly at how medical errors come about," he says. "The focus is shifting away from the individual while not overlooking the personal responsibility. There should be safeguards in place, which should prevent errors from occurring, so errors are not just about one person."

"Trainees want to know about the culture. What if they do make an error? Who should they talk with? Their attending? Many are fearful, but these fears don't have basis. It's based on what they experience in medical school, saw on TV, and learned from observing others."

Instead, Dr. Lukela says residents should be saying: "I don't understand how my patient got this wrong medication. How can we prevent that?" It's up to us as educators to step back and say, "That's a great question" and get them to think about why errors happen."

Residents want to focus on the big picture—to learn the art of practicing medicine and get support to do what they need to do, says Dr. Amin. And attendings are looking for residents motivated to learn. "It takes time, energy, and motivation to teach—just like it takes time, energy, and motivation to take care of patients," he says. "And the hospitalist is in the perfect position to do that."

Hand-Off Errors

Although hand-offs long have been a part

of hospital medicine, the ACGME's recent resident work-hour limit has raised questions concerning its benefits and drawbacks.

"The concept of 80 hours [a week] is a very good one, but practically it has meant increasing the number of hand-offs," says Dr. Lukela. "And when you're increasing the number of handoffs, there's an increased potential in increasing errors."

To prevent errors, Dr. Amin says it's essential to develop a culture around proper hand-offs. "Taking care of patients is not just about getting a history and giving patients drugs or doing surgery," he cautions. "It's also thinking about potential errors that can occur and minimizing them through the process of care."

Dr. Lukela agrees, saying the key part of the hand-off that affects efficiency, quality of care, and error reduction is the thought process of the physician handing off. What is the patient's history? What tests are pending? What is the action plan? And from day one in the hospital, he says, there needs to be a discharge plan so residents know what direction the patient is going in.

Residents also need to learn that information needs to be meticulously transmitted when there is a transition of care from hospital to nursing facility or from hospital to home. "Residents may view life in the academic center as a vacuum from the outside primary care world," says Dr. Epstein. "The residents may see the care as what they did in the hospital, but the care is part of a continuum from the primary care, the person's doctor," he says.

Team Approach

For hospitalist Julia Wright, MD, associate clinical professor of medicine and director of hospital medicine at the University of Wisconsin School of Medicine and Public Health in Madison, teamwork coupled

with redundancy has proven an effective method of teaching residents while delivering first-rate patient care.

"I structure the learning environment so that each person knows what level of responsibility he has within the health-care team," she says.

Dr. Wright requires that medical students learn how wards work, that interns learn more about diagnosis and management, and that residents learn how to assign responsibility to the patient team while taking responsibility for patient care. Meanwhile, the attending makes sure the proper diagnosis has been made, and the treatment plan has been carried out.

This arrangement she finds helps her teach and helps prevent errors. "What happens is that there's some duplication of effort within the medical team," says Dr. Wright. "But you want more than one person checking to make sure things are getting done, and that way it's not only excellent care for the patient, but it's a learning environment."

The Bottom Line

Dr. Wright says she favors training residents by teaching them about each patient being cared for and that patient's particular manifestation of a disease. "This method fits in very well with the whole idea of how each one of us is working to help this patient with this condition. I like to pool information and actually take care of the patient as we talk about a condition: helping that patient improve, helping make the diagnosis, helping decide on a treatment. The bottom line is the patient, getting the patient excellent care," says Dr. Wright.

"As teachers, we try to teach with emotions," says Dr. Li. "When we teach trainees to care for patients we try to think about how to make it memorable for them—and you remember something that's emotional." "So, despite some of the challenges we face, I think we're at a better place than we were 10 years ago, having hospitalists on the wards. And I think 10 years from now, we're going to be in an even better place. We'll have the luxury of 10 more years of clinical experience and emotional experience to impart to trainees." **TH**

Robin Tricoles is a medical writer based in New Jersey.

Reference

1. Singh H, Thomas EJ, Peterson LA, et al. Medical errors involving trainees. A study of closed malpractice claims from 5 insurers. *Arch Intern Med.* 2007 Oct;167(19):2030-2036.