Top 10 Attending Practices for Promoting Resident Autonomy

- Negotiate Expectations in Advance
  - Situations that warrant communication between the attending and the team
  - Preferred method of contact for both the attending and the resident
  - Resident’s teaching role
- Embrace the Resident as the Team Leader on bedside rounds
- Create a “safe space” for the resident away from the team
- Catch them doing something right and acknowledge it in front of the team
- Direct “responsive oversight” to the resident; not the interns
- Batch small concerns for planned meeting times to allow space
- Be tolerant of practice variation
  - Distinguish style from right/wrong
  - When changing the plan, make your reasoning transparent
- It’s okay to chart stalk; but don’t touch the orders
- Stay away from the team’s work space, except during “routine oversight”
- Ask, Don’t Tell... The best leader is the best follower
Further Reading....


Role Reversal in “Attending Rounds:” Promoting Resident Autonomy and Leadership

Maggie Benson, MD
Anna Donovan, MD MSc
Elena Lebduska, MD
Raquel Buranosky, MD MPH
By a show of hands:

• How many weeks do you spend as a ward attending each year?
  o 2 to 4 weeks
  o 5 to 10 weeks
  o More than 10 weeks
By a show of hands:

• How many years have you served as a ward attending?
  o 1 to 4 years
  o 5-10 years
  o More than 10 years
By a show of hands:

• As a ward attending, how many days per week do you join your team for morning bedside walk rounds?
  o 5 or more
  o 3 or 4
  o 1 or 2
  o 0
By a show of hands:

- When the attending is present on morning walk rounds, who is the primary “leader” of rounds?
  - The attending
  - The resident
Autonomy and its preservation is a hot topic...
SUPERVISION

2003

• The program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.

2011

• Residents and attending should inform patients of their role in the patient’s care
• Faculty functioning as supervising physicians should delegate portions of that care to resident physicians
• Senior residents or fellows should serve in a supervisory role of junior residents
• The privilege of progressive responsibility in patient care delegated to each resident must be assigned by the program director and faculty
• The resident is responsible for knowing the limits of his/her scope of authority
• Programs must set guidelines for circumstances and events where residents must communicate with appropriate supervising physicians
• Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of the resident and delegate the appropriate level of patient care authority and responsibility.
• In particular, during the PGY 1 year, residents must have supervision level 1 or 2a (see below)
• Levels of Supervision. In the development and description of systems to oversee resident supervision and graded authority and responsibility, each program must use the following classification of supervision.
  – Direct Supervision — The supervising physician is physically present with the resident and patient
  – Indirect Supervision:
    • Direct supervision immediately available – The supervising physician is physically within the confines of the site of patient care, and immediately available to provide Direct Supervision
    • Direct supervision available – The supervising physician is not physically present within the confines of the site of patient care, is immediately available via phone, and is available to provide Direct Supervision
  – Oversight—The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
“OLD” Supervision to Autonomy

Direct Supervision  Indirect Supervision  Autonomy
The optimal educational environment is built on providing learners autonomy even while they are being supervised.
Autonomy AND...not vs.... Supervision

• Autonomy:
  • OLD: allowing a learner to make decision in the absence of a supervisor
  • NEW: Acting on one’s volition, an innate need that drive the desire to learn (1)

• Supervision:
  • Ensuring that ultimate care decisions are in the control of a more experienced physician
  • Ensure Patient Safety
  • Promote Professional Development

• Maintain Autonomy even when Supervision is still required
Direct Supervision

How can we give early learners autonomy?
Indirect Supervision

How do we allow for more learner autonomy while still providing adequate supervision?
Goal: Prepare Learners for UNSUPERVISED Practice

Not quite the same as Independence because real world is team work and help-seeking
Residents and faculty view autonomy differently (at least in the peds world)

- Resident behaviors
  - Residents rated their skill in patient care higher than did faculty

- Faculty behaviors
  - Faculty rated their skill in providing autonomy higher than did residents
Many influences on entrustment decisions

Clinical Oversight: Conceptualizing the Relationship Between Supervision and Safety

Tara JT Kennedy, MD, MEd\textsuperscript{1,2,3}, Lorelei Lingard, PhD\textsuperscript{2,3}, G. Ross Baker, PhD\textsuperscript{4}, Lisa Kitchen, MSc\textsuperscript{3}, and Glenn Regehr, PhD\textsuperscript{3,5}

- **Routine oversight**: activities scheduled in advance
- **Responsive Oversight**: activities triggered by concerns
- **Direct Patient Care**: supervisor jumps in
- **Backstage Oversight**: activities learners may not know are occurring to ensure optimal care

Objectives for Today

• Introduce a successful model for rounding that promotes resident autonomy and leadership skills

• Identify strategies faculty can employ to promote resident autonomy and leadership while serving as an inpatient attending
  – Routine Oversight
  – Responsive Oversight
  – Backstage Oversight
“Routine Oversight:”
Promoting Autonomy on Bedside Walk Rounds
Large Group Discussion

• As a ward attending, what are strategies you use to PROMOTE resident leadership and autonomy on bedside walk rounds?
Inpatient Rounding at Pitt

• Residents started rounding independently from attending several years ago

• Logistics refined over time

• Now attendings walk round with the team only once or twice per week

• Resident leads rounds when attending is not present
Walk Rounds at Pitt

• Rounds occur at the patient’s bedside
• The players:
  – Patient
  – Bedside Nurse
  – Nurse Case Manager
  – Medical Students
  – Interns
  – Resident
  – +/- Attending
Rationale for Our System

• Time at the bedside is decreasing over the years
• Reduced trainee autonomy somewhat offset by resident-led rounds
• Residents prefer bedside rounds
• Bedside rounding is just as efficient as rounding outside the patient’s room
• Patient-centered and patients like it
• Adding RN’s to the mix consolidates care, improves efficiency for all, and provides important input on our patients

Gonzalo, TLM, 2009.
Days When the Attending Walk Rounds

• Attending joins team for rounds at 9am
• Interns and medical students present at the patient’s bedside with input from the nurse and patient
• Resident or attending can lead rounds
• No formal didactics in the afternoon, just clinical check-in and staffing new admissions
So What Happens When the Attending Doesn’t Walk Round with the Team?

• 7a-residents/interns arrive, see new patients, pre-round
• 9a-11a-Multidisciplinary team rounds (sans attending)
• 11-11:30-Resident and attending run list alone
• 3-4 p-Attending comes to team room to:
  – Hear updates on patients from interns/students
  – Staff new admissions
  – Didactic session
Afternoon Didactic Sessions

• Small group, interactive
• Teaching to all levels of the team
• Can involve resident in topic selection, leading discussion
• Three Formats
  – Case-based
  – Chalk talks
  – Bedside
Training Residents to Lead Rounds

- Leadership retreat for rising PGY-2’s about pearls for walk rounds
- Retreat mid-year PGY-2 on teaching skills
- Setting expectations about patient-centered, multidisciplinary focus at the beginning of the inpatient rotation
- Attending feedback on the resident’s leadership and teaching style on days they observe resident leading rounds
Training Attendings for This Model

• Role reversal
  • Attending teaching role moves to formal afternoon teaching rounds
  • Rounding in the morning moves from “routine” to “backstage” oversight

• Faculty development sessions

• Feedback and remediation
What Residents Want

• Housestaff Lunch
• Written survey and large group discussion
• 37 housestaff
  – 12 interns (9 categorical, 3 TY/prelim)
  – 25 PGY 2-3 residents (12 PGY 2, 11 PGY 3)
• Multiple Choice Questions
• Open-ended Questions
  – Best Practices
  – Worst Practices
I prefer my attending joins morning bedside rounds with the team ___ days per week
When the attending is present, I prefer the ___ is the primary leader of walk rounds.
How does the attending allow the resident to lead?

• Set expectations: Clearly state the resident is the leader of rounds even when the attending is present
• Instruct medical students and interns to direct presentations to the resident
• Assume a listening role
• Hold questions and comments until after the presentation; avoid interruptions
When the attending is NOT present on rounds, residents prefer to “run the list” outside of the team room

- Creates “safe space” where the resident can discuss uncertainty and maintain role as team leader
- Allows resident and attending to present a unified front to the rest of the team
May WANT the attending to take over when...

• Difficult patient encounter
• “When I want to see something done well.”
  – May include leading rounds...
I prefer to have a **teaching** role during afternoon teaching attending rounds.

- **Yes**: 2
- **Sometimes**: 6
- **No**: 4

**Number of Residents**

- **PGY 1**: Blue
- **PGY 2**: Green
- **PGY 3**: Purple
Residents “sometimes” want a teaching role during afternoon rounds

- Want option of teaching... or not...
  - Might NOT want to if high census, intern off with lots of notes to write, etc
- Prefer to know the topic and expectations in advance to allow for preparation
- Want feedback on their teaching
- Even if not serving as the teacher, still want input into the content
  - Ask at 11:00 huddle
  - Make a list of topics on the board
Large Group Discussion

- If you were asked to serve as a ward attending at Pitt, what would make you uncomfortable about this model of rounding?
The Attending Perspective: Promoting Autonomy on Walk Rounds

• Allow resident to determine:
  – Order of patients when rounding
  – Teaching points
  – Clinical decisions
  – Flow of discussion with patients and staff

• Give feedback on teaching and clinical management after rounds

• Have team members present to the resident
The Attending Perspective: Autonomy during Afternoon Didactics

• Allow resident to:
  – Select the topic, format, and/or patient
  – Run the teaching session
    • Give timely feedback on teaching afterwards

• Provide some flexibility with timing and format of afternoon rounds

• Provide a time to meet with the resident alone after walk rounds so you are on the “same page” with clinical decisions in the PM
Routine Oversight

• Reflect on one change you can make to bedside rounds to promote resident autonomy
Promoting Autonomy while Managing from a Distance

Perception is Reality
It is All in the Framing......
Types and Levels of Supervision

• Routine oversight: activities scheduled in advance

• **Responsive Oversight**: activities triggered by concerns

• Direct Patient Care: supervisor jumps in

• **Backstage Oversight**: activities learners may not know are occurring to ensure optimal care
Responsive Oversight

• Reaction to some trigger identified by the supervisor
  – Requested by trainee or initiated by attending
• Increase in supervisor’s direct participation in patient care
• Double-check of the clinical work done by trainee
  – Repeating physical exam
  – Observing a procedure
Triggers: Situation Specific and General

• Situation Specific
  – Clinical Cues (unexpected change in patient condition)
  – Information from a Secondary Source (nurse concerns)
  – Language Discrepancies (inaccuracies in language or clinical information: “non cardiac chest pain” with an abnormal EKG)

• General
  – Clinical cues (sicker patient on your team, or patient with demanding family members)
  – Ability of trainee (supervisor is uncomfortable with learner’s level of competence. Why first week give less autonomy than 2\textsuperscript{nd} week)
Backstage Oversight

• Activities learners may not know are occurring to ensure optimal care
  – Chart stalking in your office
  – “Eyeballing” new admissions
  – “Checking in” with the nurses
Cases: Your Way and Their Way

• Responsive Oversight
• Backstage Oversight
Case 1: Responsive Oversight

• You are a ward attending in your second week on service
• Your resident is a capable 3rd year resident
• You rounded in the morning with the team and have a plan for established patients
• The resident notifies you of a new admission at 3:30pm
• Mr. Jones is a 67 yo man presenting from the ED with acute chest pain...
Case 1 Discussion

• Reflect on your process for evaluating and discussing the plan for your new admission

• Now imagine you are the 3\textsuperscript{rd} year RESIDENT on the team. How would you like the attending to participate in this patient care experience?
What residents want in evaluating a new admission

• Time and space to develop a plan before receiving attending input
• Medical students and interns to present to the resident first, before attending involvement
  – Reaffirms resident as leader
  – Otherwise, takes resident out of the loop
What residents want in evaluating a new admission

• Want attending to defer to their plan if its reasonable and there isn’t evidence otherwise
  – “Have a good reason for changing plans of housestaff and a high threshold for doing so”
  – If making a change, make your reasoning transparent
Case 1 Discussion

• Now compare your current process with “what residents want”
• Reflect on one change you can make to your process to make your residents “feel” more autonomous (perception is key!)
Case 2: Backstage Oversight

• As the attending, you establish a plan for Mr. Jones with the team
• At 6:00 pm, you “chart stalk” from your office and notice that Mr. Jones’ hemoglobin has dropped from 12.5 on admission to 8.5 this evening
• A nursing note states the team was notified of the change in hemoglobin
Case 2 Discussion

- Reflect on the process you would use to discuss this change in status with the team
- Now imagine you are the RESIDENT. How would you want your attending to participate in this patient care experience?
What residents want when discussing a change in status

• Want anticipatory guidance about what the attending should be contacted about
• Do NOT want the attending to communicate directly with the intern without including resident
• Want an opportunity to make and establish their own plan first
What residents want when discussing a change in status

• Do NOT want attendings to place orders or consults... EVER...

• Do NOT want attendings to “hang out” in the team room outside of scheduled rounding times
Case 2 Discussion

• Now compare your current process with “what residents want”
• Reflect on one change you can make to your process to promote resident autonomy.
Wrapping It All Up
Time to Share

Please share one thing you will do differently after today’s discussion...
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• Ask, Don’t Tell... The best leader is the best follower
A leader is best when people barely know he exists, when his work is done, his aim fulfilled, they will say: we did it ourselves.

—Lao Tzu
Questions or Comments?