

The Case of the Justified Junior

Case Written by Eve Purdy & Teresa Chan

Case

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Objectives:

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Expert Responses

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It was 6:30 am on a typical Wednesday morning in April. The department was finally getting under control, and Samantha the PGY4 resident surveyed her Emergency Department tracker board with pride. Her attending, Dr. Wittenburg, had challenged her with 'running the department' that night. Sure, Dr. Wittenburg had been around to review, but seeing as Sam was only a mere 3 months away from becoming an independent practitioner, she had observed and supervised but had seen very few patients on her own. Just the way that Sam liked it.

"If only I didn't have that clinical clerk with me, then this board would be perfect," thought Sam, as she noted one last patient who he had yet to disposition...

Mrs. Kim.

Sam sighed just thinking about having to go and talk to her. Thus far, she had avoided all contact with Mrs. Kim, pawning her off on the medical student. She'd been trying to let Mike, the clinical clerk, call the shots on 'his' patients. He was a 4th year medical student, newly matched to their residency program. But now, it was time for Sam to set things straight and get Mrs. Kim out of 'her' department.

"Ok, Mrs. Kim, so the plan is that we'll call your son and he'll come pick you up right?" yelled Sam towards Mrs. Kim, trying to wake her up.

Mike was somewhat taken aback at Sam's sudden involvement with Mrs. Kim. Sure, he had been reviewing with her all night, but Mrs. Kim had been his patient initially. Now, it seemed that Sam was taking over.

Mike fidgeted impatiently, waiting for Mrs. Kim to sit up. She was a fragile looking 69-year-old lady who was cocooned within several blankets on a stretcher in the hallway.

Mike had noted throughout the night and during his frequent reassessments that Mrs. Kim seemed to be very 'off' last night, and had pleaded with Sam to let her stay for a few hours of observation. Sam had reassured

Mike that she knew Mrs. Kim quite well, since she was a frequent visitor in their emergency department.

Earlier in the shift, Sam had explained in detail the frequency at which Mrs. Kim would come in, and regaled Mike with stories of the more trivial visits - like when she came in for a paper cut because she, apparently, had run out of bandages at home. However, it seemed like Sam was getting more and more impatient as the night shift progressed.

"But... Dr. Sam... I really don't want to bother my son. Can't you wait just a short while longer?"

"No. You've been here all night," Sam stated firmly. "I'm calling your son."

And with that she threw down the chart marched towards the unit clerk's desk to call Mrs. Kim's son.

Mike started to follow, at first assured by Sam's confidence, but then he couldn't help but stop midway down the hallway and look back at Mrs. Kim. There was something that didn't feel right. Like many medical students, Mike didn't know exactly what was bothering him. Was it the unanswered and unclear reasons for Mrs. Kim's repeated visits? Had anybody asked her why she kept coming back to the ED or did they just patch her up and send her home. Was it Mrs. Kim's reluctance to call her son? She knew that if his mom was in the ED all night he would want to know. Or maybe it was just her eyes. She looked sad - but just about everyone looks sad in the ED.

Mike knew he had to say something. Before Sam could pick up the phone he muttered: "Something's not right, I don't think we should call him. She shouldn't go. I don't know why... just a gut feeling."

Sam shook her head thinking about the long 4 years ahead with Mike in their training program if every 'frequent flier' interaction was like this. She replied, laughing:

"You are going to have to do better than that. I need more than your gut feel here because my gut tells me this is just one more of her ridiculous visits. My gut trumps your

gut. She's going home." She picked up the phone and asked Mr. Kim to come by and pick up his mother.

Mike found himself fuming, but knew as a clinical clerk there was an unspoken rule that you could not question the senior resident. Instead, secretly feeling un-respected and frustrated, he took his leave of Sam, mumbling about needing to go to the bathroom. En route, he became more angry at himself: Why hadn't he been able to advocate for his patient more eloquently? He thought about going over Sam's head to their attending, but quickly disregarded that thought. Dr. Wittenburg would most likely just laugh at him like Sam had just done. Instead, he just shook his head in frustration before dousing his face with water and exiting the bathroom.

Defeated, he emerged from the washroom... and found Dr. Kathy Wittenburg standing in the hallway.

"Oh, Mike! Sam told me I might find you here," she said, a wide smile on her face. "I brought you a coffee and a cookie... Thanks for all your hard work last night. Sam said you did a good job!"

"Oh... thanks," Mike said as he half-heartedly took coffee cup from the all-too-chipper attending physician.

"Is everything ok, Mike?" inquired Kathy. She had noticed that Mike had sulked out of the washroom and his hair was a bit of a mess - tell-tale signs of the frustrated medical student.

"Um..."

Dr. Wittenburg sat down on the bench in the hallway and motioned for Mike to do the same.

"What is it?" she asked Mike gently. "Was Sam being hard on you last night?"

"No..."

"So...?"

"Well..." Mike was hesitant to continue. He didn't want to get a reputation as a tattletale. He was about to start residency in this program, and he had heard that Sam also had been hired as an attending starting in July.

"Well... You know, Mrs. Kim?"

"Yes, of course."

"I told Sam that there's something going on with her, but I can't quite put my finger on it... But, she says Mrs. Kim is here all the time for little things... I'm sure she knows better than I do... But, I don't know... I just feel like there's something else."

Sitting back, Kathy surveyed the young resident-to-be and pondered the scenario.

Kathy had interviewed Mike for her residency interviews just a few short months ago, and recalled the fantastic sense of empathy that Mike had displayed at the time. She remembers thinking that the only downside to his empathetic spirit was that Mike might run into issues with getting overly involved with patients.

On the flip side, Sam was sometimes quick to jump to conclusions. An excellent diagnostician and proceduralist, Sam had needed coaching on interpersonal skills when she was more junior. She had worked hard and had overcome these, but last night Kathy had charged her with a lot of responsibility. Was this affecting her judgement?

"Hmmm... Seems to me that there's a difference of opinion around Mrs. Kim's case," she reflected. "In that case, why don't I wander over there and poke my head in and see what my 'spidey sense' tells me."

Questions for Discussion

1. When is it ok to 'question' authority or raise concerns?
2. How do you encourage medical students to speak up?
3. How do you respond when you receive a 'challenging question' as an attending or supervising resident?
4. How do you debrief a situation when a learner is 'wrong'?
5. As an attending or senior resident, how do you admit when you are wrong?

Competencies

ACGME	CanMEDS
Team Management (ISC2) Patient Safety (SBP1) Systems-based Management (SBP2) Professional Values (PROF1) Accountability (PROF2)	Communicator Collaborator Health Advocate Scholar

Intended Objectives of Case

1. Outline an approach for discussing differences of opinions between team members.
2. Discuss the effects of a power differential on the teaching and learning environment.
3. Discuss the effects of a power differential on clinical care scenarios.
4. Contrast the learning priorities of a junior learner, senior learner and an attending in the clinical emergency medicine environment.
5. Develop an approach to discussing error in a blame-free manner.

Making Better Decisions

by Heather Murray MD MSc FRCPC

This case raises a number of different issues. These issues are around:

- 1) Team Leadership
- 2) Cognitive Bias
- 3) Authority

1. What is the role of the team leader?

Sam's personal agenda of looking good for her attending and the day shift team by having a "clean board" is interfering with her role as an effective team leader. As team leader, Sam needs to consider the opinions of the other members of her team. Managing disagreement is an important leadership skill, and the first step is listening to alternate opinions in a courteous, respectful manner. Junior team members often have extensive information about patients, as they spend far more time interacting with them. The advantage of health care teams is the ability to collect and pool a diverse collection of information and knowledge to improve diagnostic accuracy. Sam should be encouraged to view Mike as an asset with information that can help her and make her job easier, rather than as a nuisance. She doesn't have to agree with Mike's concerns, but since she has trusted him with Mrs. Kim's assessment she needs to give him the opportunity to express his thoughts.

2. Is cognitive bias causing a diagnostic error?

From a risk management perspective, this case has some red flags. Sam's decision-making at the end of a night shift amidst a competing agenda of "clearing the board" should be viewed as potentially flawed. Pat Croskerry has identified a number of cognitive biases that interfere with diagnostic accuracy. He suggests that awareness of times and patterns of risk prone decision-making (metacognition) may help alleviate diagnostic error. In front line specialties such as Emergency Medicine, the diagnostic error rates have been estimated between 10 and 15%. (Croskerry, 2013)

Sam has 'anchored' on the idea that Mrs. Kim's visit is for a trivial reason, and may be ignoring evidence to the contrary. As she becomes an attending physician, Sam needs to be aware of times when she has potentially flawed or biased thinking, and develop strategies to pause and check her thinking during those times. These could include shift changes, dislike of patients or team

members (or other strong personal emotions), and situations when external priorities compete with patient care, like the "clean board."

3. How do authority gradients affect medical error?

Clinical medicine has a hierarchical structure, which can make medical students reluctant to challenge more senior physicians. Mike shows this reluctance because he is both insecure about his lack of experience, and concerned about negative personal and career repercussions.

There are lessons to be learned from the military and the aviation industries about preventing error in the setting of "authority gradients." One strategy for resolving conflict is to enlist an impartial 3rd party whenever there is disagreement between team members. Another is to coach team members in effectively communicating their level of concern. These expressions of concern should escalate from expressing impartial curiosity ("Could these symptoms be due to depression?"), to communicating a specific issue ("I'm worried that she could have an undiagnosed medical problem with all these ED visits"), and finally to expressing an immediate threat with a request for support ("She looks really sick and you need to come and see her right now."). (Cosby & Croskerry, 2004) Mike needs to know that expressing concern about patients to clinical supervisors is always appropriate, and that structured language for communicating urgency may help him to do so more effectively. Similarly, this may be a situation where collecting collateral information from other experienced team members (e.g. the veteran nurse who is also taking care of Mrs. Kim) is invaluable.

So... how might Mike have handled the situation better?

Mike's empathy for Mrs. Kim is important and shouldn't be discouraged. However, he needs to translate his intuitive worries into a more structured clinical query. A differential diagnosis for an elderly patient with frequent visits for vague, minor complaints could include elder abuse, depression, suicidality, substance abuse, cognitive impairment, delirium, and a host of other problems. The next step in Mike's development as a clinician is to think in terms of what might be wrong with Mrs. Kim, and how to initiate an appropriate assessment of those concerns.

Expert Response

Can we move away from being “wrong” towards making better decisions?

Physicians are educated with an expectation of individual perfection. This is inculcated in systems with a culture of shame and blame around medical errors. [Brian Goldman has given a powerful TED talk entitled “Doctors Make Mistakes. Can We Talk About That?”](#) which should be required viewing for physicians. Open acknowledgement of errors is a key first step in improving patient safety. Modelling this attitude and approach for trainees is essential.

This case boils down into a dichotomous outcome where someone will be “wrong” and someone will be “right” - an attitude that necessarily pits one team member against another. Moving away from this approach towards honest, open reflection on where we can be led astray and how the team can help prevent these errors can improve patient care.

Conclusion: What would I do?

I would have a group discussion with both Sam and Mike about the potential for medical error in this case. It could include a personal anecdote of a similar case with an unfortunate outcome. It is an excellent case to raise awareness of the cognitive biases that interfere with effective decisions, the role of teams and effective team communication in preventing error, and the importance of all team members sharing responsibility for patient safety. The issue here is not who is “wrong,” but how an effective medical team can work together to guard against diagnostic errors.

References & Resources

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About the Expert

Heather Murray (@HeatherM211) is an emergency physician and award-winning medical educator at Queen's University, Kingston, ON, Canada. She is an Associate Professor in the Department of Emergency Medicine and is cross-appointed to the Department of Public Health Sciences. She teaches diagnostic reasoning, evidence-based medicine and research skills to undergraduate medical students and emergency medicine residents at Queen's.

Expert Response

Power Dynamics, Communication, and Trust

by Megan Ranney MD MPH

This case raises some interesting questions about power. We must recognize that there is a hierarchy in medicine, whether or not we want to acknowledge it. We also must recognize that there are conflicting priorities for trainees and their supervisors.

Trainees come to our hospitals to learn, and supervisors are present to ensure maximum benefit for each patient. Supervisors, especially in the emergency department setting, are also responsible for a variety of non-care-centered factors, including “flow,” compliance with government regulations, consultant relationships, and patient satisfaction. The struggle of competing objectives for patient care and for trainee learning is highlighted in this case. The two trainees have a power differential (medical student vs. supervising senior resident), but there is also a power differential with the attending physician. Indeed, research shows that issues of power are highlighted in the training hospital (versus in community practice)[1].

Power Plays and Other Issues

Interestingly, power - the authority to make decisions, and to define the terms of an interaction - is intricately involved with issues of trust[2]. The issue of trust is particularly salient for the trainee/supervisor relationship, as illustrated in this case. Sam didn't trust Mike's assessments, and Mike didn't trust Sam's assessments; neither trusted themselves to talk to Dr. Wittenberg about the case. Indeed, in my opinion, labeling this case as illustrating a problem of “power differentials” overlooks the true underlying issue: trust.

Many of the conflicts in this case - between Sam and Mike, but also between both of them and Dr. Wittenberg - could have been avoided had the two trainees and the attending developed trust beginning. Studies in other healthcare settings suggest that trust is based on (a) role perceptions; (b) demonstrated competence; and (c) good communication over time[3,4]. The situation in this case occurred because of lack of clarity about Role perceptions (what was the role of the senior resident? Did the medical student still have a right to approach the attending?); Competence (on all fronts); and Communication (how to best interact in cases of conflict).

Communication issues

In this case, I'll focus on the last issue, of communication, ignoring the role perceptions and competing priorities of all three healthcare providers. There were a number of critical communication breakdowns throughout the night, which could have been avoided:

- a) Sam's desire to “set things straight” about Mrs. Kim: this destroyed Mike's trust in her, but also her trust in Mike;

- b) Mike's lack of effectiveness in communicating his concerns; and
- c) Dr. Wittenberg's lack of communication with both trainees about this case over the course of the night.

If this were me...

If I were debriefing the trainees in this situation, I would suggest the following:

- 1) **Sam needs to balance her pressures to “fly through the department”, and her innate biases about Mrs. Kim, with her in-the-moment obligation to both the patient and the trainee.** One potential solution would be for Sam to elicit from Mike his reasoning for what might be wrong. Was he concerned that she was a victim of elder abuse? If so, Sam could counsel about proper screening techniques. Alternatively, was he concerned that she had dementia or an undiagnosed metabolic, toxicologic, or metastatic process? If so, Sam could counsel about next steps in a workup. So doing may allay Mike's concerns; would offer a terrific teaching opportunity regarding the difficult patient; and would allow Mike to develop trust in Sam's decision making.

Additionally, I would counsel Sam on the importance of team relationships[5]. At my hospital and residency program, all members of the ED team have to complete a full-day training on team dynamics. This program, titled Project CLEAR, teaches team members about the importance of “check backs” during critical moments, and about the importance of having all team members (some of whom may be lower on the medical hierarchy) being comfortable with questioning the plan at all points during patient care. This program has resulted in improved patient safety and satisfaction[6]. A similar approach may be useful for trainees like Sam[7,8].

- 2) **Mike needs to balance his desire to “do right” by the patient and his inability to articulate his concerns.**

One potential solution would be to encourage him to spend a few minutes thinking about how to better phrase his concern, in a way that increases Sam's trust. For instance, he could say: “Sam, I need your help. I know that this patient is a frequent flyer, but I'm concerned that today's visit represents something bigger. Do you have a couple of minutes to talk through the differential with me?”

- 3) **Dr. Wittenberg needs to be available throughout the night to all of her team members.**

She is correctly delegating responsibility, and allowing her trainees - both of whom are on the cusp of transitioning to their next role - to explore the limits of their knowledge.

Power Dynamics, Communication, and Trust (cont'd)

But a strong supervisor will still keep tabs on how such transitions are going. One possibility could be that she allows Sam to run the department, but checks in regularly with both Sam and Mike to build trust and increase learning.

Conclusion

In conclusion, this case highlights multiple issues related to training dynamics.

Take home points:

- 1) Establish good communication patterns early, especially with trainees
- 2) Perceived power dynamics can make even the most friendly of attendings seem aloof or distant. If you're an attending, make sure to check in with your housestaff. If you're a learner, don't be afraid to ask and speak up!
- 3) There is no substitution for direct observation.

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About the Expert

Dr. Ranney (@meganranney) completed EM residency and fellowship (in Injury Prevention Research) at Brown University...and 10 years later, has yet to leave! She is founder and director of the Brown Emergency Digital Health Innovation program, and Associate Professor in the Dept of EM. Her federally-funded research focuses on the use of "digital health" to prevent injury and co-morbid risky behaviors among ED patients (and disseminating these strategies to ED clinicians). She teaches and mentors on a local and national level in both the EM and public health spheres. She is also an editor for *Annals of Emergency Medicine*.

Curated Community Commentary (continued)

By Teresa Chan MD FRCPC MHPE (candidate)

A qualitative methodology was used to curate the community discussion. Tweets and blog comments were analyzed, and four overarching themes were extracted from the online discussions. Prior to publication, we sent this analysis to several of our community members to perform a "member check" to ensure credibility (ML, HM, EP).

The comments on the case this week fell into two major themes: 1) Speaking Up For Patient Safety; 2) Role-modelling a Team Approach to Patient Care

1) You're Never Too Junior to Speak Up For Patient Safety

All of the participants fully noted that, regardless of their role or 'rank', all team members (including the patient and/or family members) have a role to play in being able to voice concerns. Some suggestions that the 'crowd' came up with for improving the process, however are:

- **Be respectful, but speak up:** Respect seniority, but be willing to be curious, you never know when you improve patient care, or be taught something new. Meanwhile, teachers at all levels (resident to attending) should also strive to create an environment in which it feels safe for learners to do so. Ideally for all on the team being respectful would mean speaking up.
- **Use curiosity to your advantage:** As a student, ask the question if you feel you don't understand - framing your concerns as questions signifies to the senior party that you're willing to learn from them. And if you're wrong, well, then maybe you'll learn why.
- **Admitting you are wrong (or that you have limits) is cool.** Looking it up is even better (for the patient, for the learner etc..). As @TChanMD says: "Don't sweat it - check it!"

- **Debriefing errors in judgement can be critical.** Whether you are the most senior member of the team or the most junior, misses or near-misses can be important learning experiences.

2) Role-modelling a Team Approach to Patient Care

Whether junior or senior, doctor or patient, speaking up was something that was highly valued by all participants. Several participants (@M_Lin, @TChanMD) suggested involving all parties of a care team to formulate a plan. Remember, each provider may have a slightly different snap shot of the patient situation, and they may provide new information. Gathering and formalizing a process to integrate this information is key.

Contributors

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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@academiclifeinem.com or tweet us @Brent_Thoma and @TChanMD to let us know.

Purpose

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