Resident/Attending Conflicts in Case Management

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The Case*

An R2 resident is called to assess a 5-month-old baby scheduled to undergo incision and drainage of a large abscess on the thigh. The baby is an otherwise healthy full-term infant with no medical history of note. The baby is afebrile and looks well nourished. The mother states that the baby takes only breast milk and had been breastfed just two hours ago.

The attending (who also happens to be the head of the department) is called to assist. It is 10 p.m. He feels strongly that it is unnecessary to wait the advised four hours and states that the resident should go ahead and arrange for the baby to be brought to the O.R. Once the attending arrives in the O.R., the R2 resident once again talks to the attending about the NBM guidelines and states that he feels uncomfortable about the baby not being adequately fasted. The attending shrugs it off and says that he does not believe that these guidelines are always based in reality. He insists on going ahead with the anesthetic.

The baby is brought into the O.R. and all monitors are attached. The attending decides on an inhalation induction with intubation once the desired level of anesthesia is obtained. Just before intubation, the baby starts to regurgitate and a significant amount of milk is suctioned from the mouth. The baby desaturates rapidly and looks cyanotic. With vigorous suctioning and rapid successful intubation, the baby's saturation picks up. The period of desaturation lasted less than three minutes. The case proceeds and the rest of the anesthetic and postoperative recovery are uneventful.

The attending states that he has never had that happen to him in all his years of anesthetic practice. He does mention to the family that there was a small episode of vomiting on induction, but that there is nothing to be concerned about. The resident suggests keeping the baby overnight for observation. The attending agrees. The baby does well and is discharged the following morning.

1. Should the resident remain involved with the case even though he does not agree with management?
2. What is the liability for the resident if the baby comes to harm if he was or was not involved with the case?
3. Should the episode of desaturation be disclosed to the baby's parents?

*This case represents a hybrid of several real cases. We discussed the implications regarding this scenario with Risk Management at the University of Washington Medical Center (with thanks to Cindy Jacobs, J.D. for taking the time to go over this scenario). This may not be entirely representative of the entire U.S. and even other hospitals in the same state since there are various subtle differences in the applicable laws for different states. Local policies and guidelines in the various hospitals may also vary.

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Various policy documents from ASA as well as other regulating bodies cover difficult interactions in the hospital environment such as dealing with an impaired colleague, dealing with difficult patients and discussing medical errors or bad outcomes with family members. One aspect that has received less attention is the interaction between residents and attendings in situations where there is conflict regarding optimal care. Similar issues occur where care may be shared by a nurse anesthetist and an attending anesthesiologist. Conflicts between residents and patients, and residents and colleagues, are common. For example, 90 percent of medicine residents reported in one survey that they had experienced uncomfortable interactions or situations with patients or colleagues that were "wrong, improper, unethical or unprofessional."[1]

Issues involved

Medicolegal Liability:

It is clear in this situation that the attending is liable in the event of a complication; however, the resident has an independent liability.

The preferable course of action would be to resolve the conflict. The national policy is described in the Team Strategies and Tools to Enhance Performance and Patient Safety, or TeamSTEPPS™. This is an evidence-based training curriculum designed to improve communication and teamwork skills among health care professionals that was developed by the Department of Defense and the Agency for Healthcare Research and Quality (AHRQ). This includes strategies to deal with conflict resolution in the form of the "two challenge rule." If the resident's statement regarding the potential for a full stomach is ignored, the concern should be assertively voiced at least two times. The attending should acknowledge this.

Another framework to resolve the conflict is "CUS": state your Concern and why you are Uncomfortable. If the result is still not satisfactory, state "This is a Safety issue."

The "DESC" mnemonic can be used if the discussion becomes personal or hostile:

D: Describe the specific situation.
E: Express concerns about the action.
S: Suggest other alternatives.
C: State consequences – in this instance, the potential for an aspiration pneumonia.

If conflict resolution techniques fail, the best option open to the resident to avoid liability would be to contact someone more senior with his concerns. The University of Washington Medical Center (UWMC) policy, for example, works on the chain of command principle. This addresses the issue of the resident being intimidated to call someone more senior. The chief resident can be contacted and he/she can then take the concerns further to either the program director or the medical director on call. The UWMC policy regarding disruptive behavior also includes a section on unprofessional behavior, including an incident reporting process as well as mechanisms for further review and the conduct of any necessary follow up.

The ultimate aim is similar to Toyota's "Stop the line"[2] policy in which any employee, regardless of rank, has the authority and the responsibility to stop the process when a problem arises. Residents or interns may lack confidence to challenge senior attendings if they believe a medical procedure is not being done correctly. The aim of a "Stop the Line" policy would be to empower any staff member to stop a procedure so that a mistake is not made.

Other options that may result in liability for the resident include:

1. **Refusal to be involved in further care of the patient.** This could be seen as patient abandonment and could in theory leave the resident open to disciplinary action. In practice, it would need to be a very serious breech of professional conduct for a resident to face independent negligence in such a case. Of note, the resident's involvement may not be evident since he/she may not be mentioned in any of the documents relating to the case.

2. **Go along with plan.** Worst case scenario: the case results in permanent injury or death, proceeds to trial, and it is found in favor of the patient. The resident will be assigned a percentage of the blame. The allocation of fault will be decided by a jury, and the attending will likely be assigned the higher percentage of liability. Regardless of how small a percentage liability is eventually assigned to the resident, his name will still be added to the National Practitioner Database, which will also contain the amount paid on his behalf by the medical indemnity insurance. Explanatory notes can be added to the record. Unfortunately, this could theoretically be detrimental in future work applications, although the actual impact of such incidents on future employment is unknown.

Disclosure to Patients

Another issue is the requirement for disclosure. The patient should be told of all unanticipated outcomes. The law does not require admission of liability. There is no legal requirement for disclosure; however, this may be superseded by local hospital policy.

Various organizations endorse the disclosure of errors and adverse events, including the Joint Commission since 2001.

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The National Quality Forum endorsed disclosure as one of the 34 Safe Practices: "Following serious unanticipated outcomes, including those that are clearly caused by systems failures, the patient and, as appropriate, the family should receive timely, transparent, and clear communication concerning what is known about the event." Health care organizations should facilitate disclosure by providing support for physicians and integrating risk management and patient safety practices.

Thirty-four states passed legislation in 2007 that prevents any information provided by a physician during an apology for a medical error from being used in malpractice court.[3] This encourages physicians to acknowledge and explain mistakes to patients and aims to keep an open line of communication.

Issues that have been identified to be the most important to patients during disclosure include:[4]

1) Full disclosure of all harmful errors.
2) Explaining the cause of the error.
3) What can be done to remedy the error.
4) Changes that will be implemented by the physician and hospital to avoid recurrence.

In the event of permanent sequelae, there could be legal implications if the disclosure was not made initially and the error is found later. Of note, the statute of limitation does not apply if there was concealed information at the time of the inquiry.

Conflict Resolution in the O.R.

Conflict, ironically, may in fact be beneficial and can lead to a safer system of care if addressed appropriately. The traditional view is that errors are mistakes made by individuals, and these mistakes can be eliminated by better training and by penalizing the individual responsible for the error. Two large landmark studies[5,6] found that adverse events occurred in 2.9 to 3.7 percent of hospitalizations. In both studies, more than half of these events were preventable errors. The Institute of Medicine created the Committee on Quality of Health Care in America in 1996 in response to these and similar studies. The first report released, *To Err is Human: Building a Safer Health System* (1999),[3] shifts the focus from individuals to address how health care systems can be made safer by accepting that errors happen and to create a system that is less likely to lead to errors. One of the ways in which this can be achieved is to use conflict resolution techniques to address potential management problems.

The case described above is very clear-cut in terms of the intentional risk introduced. In other clinical scenarios, the safest course of action may be less clear. The attending anesthesiologist may have the advantage of a broader experience base. Even experienced clinicians can make errors and can, for instance, become fixated on a particular issue or lose situational awareness. Residents may be able to bring a new perspective to the table. It can be beneficial if the environment is such that the resident can express these ideas freely. On the other hand, if the resident is too intimidated, he/she may be less likely to participate constructively in the process.

Summary

The ideal situation would be for the resident to use conflict resolution techniques to resolve the situation amicably. The only options open would be to go up the chain of command to ensure patient safety and to avoid liability. Most hospitals should have policy documents dealing with unprofessional behavior. Patient safety is enhanced in an environment where anyone is able to voice concerns. There may be situations where the attending may in fact be doing a safe procedure; however, it may be outside the scope of the resident's experience. In this situation, a clear explanation of the rationale behind the intended course of action may be a valuable teaching experience for the resident.

References available upon request from ***communications@asahq.org****.*