SUPERB Safety: Improving Supervision for Medical Specialty Residents

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The Challenge

Institutional policies on resident supervision are guided by the Accreditation Council for Graduate Medical Education (ACGME) and Residency Review Committee Program Requirements. These standards address the availability and quality of clinical supervisors, and highlight the importance of affording learners a graduated level of responsibility throughout training to develop them into competent physicians ready for unsupervised practice.

Although many surgical and procedural-based specialties have long included explicit language addressing clinical supervision, this has not been the case for medical specialties. In their 5-year review of the impact of the initial 2003 duty hour regulations, the Institute of Medicine report *Resident Duty Hours: Enhancing Sleep, Supervision and Safety*[1] recommended augmenting supervision for all residents across all specialties through immediate access to an onsite supervising physician at all times, including nights and weekends. The July 2011 ACGME duty hour requirements include explicit definitions of the levels of supervision.[2] The challenge to programs is how to balance supervision and patient safety with the development of progressive responsibility.

What Is Known

In internal medicine and other medical specialties, the accreditation standards and local practice are moving toward a more defined role for supervision. At the same time, the best faculty strategies for supervision are not clear. A review of the literature supports that enhanced attending-level supervision may have a positive impact on patient clinical outcomes.[3] In the special case of overnight supervision, the effects of nighttime presence of supervisors have been equivocal with respect to patient and educational outcomes.[4] Although hospitalists seem to represent an easy answer to nocturnal supervision, their effect on supervision in the context of resident learning is not clear. Hospitalists supervisors do not supervise in a uniform manner.[5] However, it is clear that self-reported changes in attending oversight practices can result from faculty development.[6]

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Rip Out action items

Supervisors must:

1. Understand their institutional policies
2. Discuss medical uncertainty with trainees and tailor the supervisory experience
3. Encourage faculty development to enhance/learn supervisory skills
4. Use an overall framework to consider oversight strategies

Program Directors must:

1. Identify milestones that demonstrate readiness to supervise among trainees
2. Formalize the evaluation of these milestones

Managing Uncertainty and the SUPERB/SAFETY Model

ACGME standards endorse a direct approach to manage resident uncertainty by defining specific circumstances that require supervisory input. Residents are often not trained to recognize and manage their own uncertainty, and they may use an informal hierarchy of individuals for advice that do not include attending physicians. In turning to the literature, peers, or fellows first, residents may not pursue attending oversight at potential times of patient vulnerability, which may generate delays in indicated care and adverse patient events that may be related to unclear expectations from both residents and attending physicians.[7]

To improve these varying expectations, training may benefit from the use of a theoretic framework for educating both residents and attending physicians. Qualitative work examining internal medicine resident and attending perspectives on ideal and suboptimal supervision generated a bidirectional model of suggested supervisory strategies: the "SUPERB/SAFETY" model (TABLE).[8] Using a collaborative approach to clinical supervision, the model describes the following characteristics of ideal supervision: *expectations* are clear and established from the beginning of the relationship; *communication* regarding new or active patients during the coverage period is planned, and both parties maintain easy availability; the *impact of uncertainty* on decision making is appreciated; *assistance* is involved early when uncertainty is recognized; and finally, clinical supervision requires *different amounts of intensity for different learners and experiences*, not "one size fits all."[8]

TABLE **The SUPERB/SAFETY Model**

Attending Physician		Resident	
S	**Set Expectations for When to Be Notified**	S	**Seek Attending Physician's Input Early**
	"I'd like you to contact me if a patient is discharged, goes to the ICU, goes to surgery or another service, dies, or leaves AMA."		*"Involving your attending early can often prevent delays in care and provide quicker results. They are also legally responsible for patients."*
U	**Uncertainty Is a Time to Contact**	A	**Active Clinical Decisions**
	"It is normal to feel uncertain about clinical decisions. Please do contact me if you feel uncertain about a specific decision."		*"Contact your attending if an active clinical decision is being made (surgery, invasive procedure, etc)"*
P	**Planned Communication**	F	**Feel Uncertain About Clinical Decisions**
	"Let's talk around 10 PM on your call nights and before you leave the hospital each day. If you get busy or forget, I will contact you."		*"It is normal to feel uncertain about clinical decisions. You should contact your attending if you feel uncertain about a specific decision."*
E	**Easily Available**	E	**End-of-Life Care or Family/Legal Discussions**
	"I am easy to reach by page, or you can use my cell phone or my home phone."		*"These complex discussions can change the course of care. Families and patients should also know that the attending is aware of the discussion."*
R	**Reassure Resident Not to Be Afraid to Call**	T	**Transitions of Care**
	"Don't worry about waking me up, or if calling is a sign of weakness, or that I will think you are stupid. I would rather know what is going on."		*"Transitions are risky for patients. Contact your attending if someone is being discharged, transferred to another service or ICU, or hospital."*
B	**Balance Supervision and Autonomy for Resident**	Y	**You Need Help With the System/Hierarchy**
	"I want you to be able to make decisions about our patients, but I also know this is your first month as a resident so I will follow closely." (Tailor for more experienced residents to emphasize autonomy)		*"Despite your best efforts, system difficulties and the hierarchy may hinder care for patients. Attendings can help expedite care through direct attending involvement with consultants, etc."*

How You Can Start TODAY

1. Identify supervision policies at your institution.
2. Seek out existing faculty development opportunities to improve supervisory skills.
3. Begin discussion with trainees about situations warranting attending-level contact.

What You Can Do LONG TERM

1. Assist or lead improvements in institutional and program supervisory policies.
2. Create faculty development opportunities to improve critical supervisory skills such as direct observation.
3. Involve trainees in the discussion and education about effective supervisory practices.
4. Evaluate milestones towards progressive independence and readiness to supervise.

Note: The SUPERB SAFETY model was studied in internal medicine residents, and the focus of this model is on supervision in the inpatient teaching settings in medicine and other medical specialties.

Resources

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