Editorial

Supervision and Autonomy in Academic Hospital Medicine

Kwame Dapaah-Afriyie, MD, MBA[1], Fred J Schiffman, MD, MACP[2] [a]

[1] Division of Hospital Medicine, The Miriam Hospital, Warren Alpert School of Medicine at Brown University, [2] Medicine, The Miriam Hospital, Warren Alpert School of Medicine at Brown University

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Academic hospitalists are charged with an academic mission, in addition to caring for patients and meeting inpatient throughput metrics of their various institutions. These metrics include the length of Inpatient stay (LOS), Observed versus Expected LOS (O:E ratios), discharge times, and patient experience. Meeting these requirements should enhance, not eclipse, the academic mission, which requires time and effort to impart the requisite knowledge and skillset to our adult learners - students and residents. It is also imperative that we embrace measures to ensure the financial well-being of our institutions since there can be no academic mission when there is a financial crisis.

Many strategies have been proposed to help enhance the role of academic hospitalists and to help enhance the learning environment. The fast-paced inpatient environment requires targeted measures to achieve goal congruence and set goals. In addition to the broad objectives of medical training for our adult learners, there are individual set goals that must be defined and refined as part of the "training program" mission. Collaboration with attending physicians is critical for optimizing medical education and patient care.

Resident goals in training programs and attending physicians' interactions with residents are influenced by three main factors (3P's), which include:

1. Professional goals, which are shaped primarily by interests, and exposure to other clinicians. These include short-term and long-term components such as the need to meet patient care metrics and career goals.
2. Prior experiences in clinical settings: These either negatively or positively affect the level of trust and determine the comfort level in ceding control and granting autonomy in all aspects of patient care to enhance professional growth in the learning environment.
3. Personality traits play in role in determining the level of assertiveness in assuming assigned responsibilities in clinical settings.

All interactions between attending physicians and residents/students begin with the premise of ensuring professional development without compromising patient care.[1]

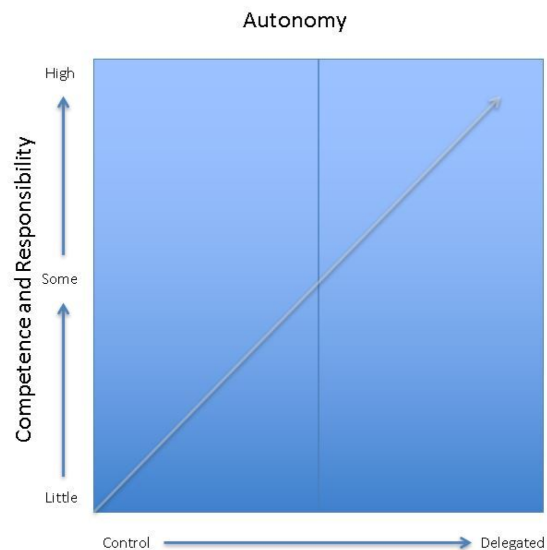

Figure 1. Mutual Satisfaction Grid

Figure 1 describes a mutual satisfaction grid between increased autonomy and responsibility. Throughout individual rotations and the training program, attending physicians should encourage residents to accept greater responsibility and autonomy. Mutual satisfaction will result if this occurs. The goal should be to move steadily in the direction indicated in the figure.

As residents are observed to make cogent diagnostic and therapeutic decisions, and appropriately handle tasks, more responsibilities are granted, and they are encouraged to exercise more autonomy within the confines of mutually agreed upon parameters and set new goals.[2] Unmet expectations result in frustrating experiences on either side of this academic relationship. Steps to stay on track and to ensure expectations are being met include:

Expectations must be:

1. **Communicated:** Although broad guidelines are incorporated into the orientation programs for residents and attending physicians, specific and individ-

a Associate Program Director, Internal Medicine Residency Program
Sigal Family Professor of Humanistic Medicine
Vice Chairman of Medicine

ual expectations must be communicated early, re-evaluated, and acted upon. Residents also need to know and embrace patient throughput metrics at the core of their hospitals' operations. Hospitalists who care for patients with a medical team must also be conversant with residents' career goals and associated individual needs.

2. **Realistic:** Significant aspects of training programs' goals must be emphasized and integrated with individual career goals. An expressed interest in a specific field should be accompanied by sophisticated knowledge about managing all medical conditions. While patient throughput metrics are critical (as noted above), the educational mission of academic medical centers must harmoniously co-exist within this reality.[3] Hospital throughput metrics should consider the academic mission. Compromises may be needed to create a win-win situation.
3. **Attainable:** Goals should be attainable regarding essential aspects of professional and personal wellbeing. Leaders and teachers must demonstrate methods to encourage work-life balance, strategies to avoid burnout and develop resilience, and specifically included in the broader curriculum.
4. **Reviewed and refined:** Feedback is a critical endeavor that is required to solidify set expectations and modify them based on real-life circumstances or new information. Performance metrics should be used to create and assess the balance between autonomy and supervision partnership. Residents currently lacking expertise in a key aspect of patient care should not expect full, unsupervised autonomy. Attending physicians should encourage stellar residents in their ability to grow and mature and encourage their increasing autonomy,

Autonomy must be granted, acknowledged by the recipient, and reviewed periodically by the attending physician-resident dyad. These reviews should form the basis for granting more autonomy.[4] Progressive responsibility should be assigned by the attending physician and acknowledged by the recipient. Recipients should be informed about expectations and critical factors required for more responsibilities to be assigned.

DISCLOSURES

The authors have no conflicts of interest to disclose.

CORRESPONDING AUTHOR

Kwame Dapaah-Afriyie
Professor of Medicine, Clinician Educator
Warren Alpert School of Medicine at Brown University
Division of Hospital Medicine
The Miriam Hospital,
164 Summit Avenue, Providence, RI 02906
Tel: 401-793-2104 Fax: 401-793-4047
Email: kdapaahafriyie@lifespan.org

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REFERENCES

1. Carbo AR, Huang GC. Promoting clinical autonomy in medical learners. *Clin Teach*. 2019;16(5):454-457. doi:10.1111/tct.13066

2. Kennedy TJ, Regehr G, Baker GR, Lingard LA. Progressive independence in clinical training: a tradition worth defending? *Acad Med*. 2005;80(10Suppl):S106-S111. doi:10.1097/00001888-200510001-00028

3. Accreditation Council for Graduate Medical Education. Common program requirements. Accessed February 15, 2021. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2020.pdf

4. Halpern SD, Detsky AS. Graded autonomy in medical education—managing things that go bump in the night. *N Engl J Med*. 2014;370(12):1086-1089. doi:10.1056/nejmp1315408