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Balancing Supervision and Autonomy: An Ongoing Tension

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Perspective

Graduate Medical Education (GME) has changed substantially over the past 10 years.(1) For decades, physician trainees, commonly referred to as interns and residents, provided direct patient care with very little supervision. The death of 18-year-old Libby Zion at The New York Hospital in 1984 led to the recommendation by the Ad Hoc Advisory Committee on Emergency Services to limit work hours for residents in New York State and catalyzed a national policy discussion on the ability of residents to safely care for patients.(2) In response, in 2003 the American Council for Graduate Medical Education (ACGME) instituted national duty hour limits for residents, and 5 years later an Institute of Medicine (IOM) report recommended that additional measures be taken in GME to improve patient safety.(3,4) Most recently, ACGME, largely following the IOM's lead, mandated even stricter rules on resident work hours.(5) Although controversies around the association between resident fatigue and medical errors have dominated the discussions about these rules and reports, resident supervision—or lack thereof—has also been scrutinized.

Although the concept of supervising trainees in any profession seems logical and necessary, there is debate within the medical education community about how to best supervise trainees while still affording them opportunities to learn through independent decision-making. Few would argue with the premise that supervision is necessary to ensure the safety of patients being cared for by trainees. However, educators must also take into consideration the safety of the trainee's *future* patients. In other words, inadequate supervision may lead to unintended harm to patients in the present, but excessive supervision may lead to unintended harm to patients in the future by limiting the amount of independent decision-making necessary to build confidence and consolidate learning into practice.

The medical literature to date supports the fact that more supervision improves patient safety and that the lack of supervision leads to harm. In one study that examined closed malpractice claims involving trainees, lack of resident supervision was implicated as the most common system factor (occurring in 54% of cases)

contributing to error and was particularly common in the 19% of cases that involved handoff errors.(6) Lack of supervision has also been associated with lower trainee satisfaction and higher rates of resident stress.(7-9) Conversely, direct supervision by an attending physician has been shown to improve compliance with practice guidelines, decrease complications and mortality rates in the operating room, and lead to changes in diagnosis and management.(10-13) It would seem that creating the infrastructure to allow for more supervision and providing education to both trainees and faculty around supervision expectations should be a major focus for teaching hospitals.

The most recent iteration of the ACGME duty hour regulations addresses supervision more directly than the previous version, striving to tailor supervision to the trainees' level of experience and competence.(5) Although one may want supervisors physically present at all times, another challenge facing medical educators is the tension between supervision and service. Supervisors may be called for other patient care duties.

In an effort to clarify the supervision requirements, the ACGME has developed a classification system for supervision with three levels of supervision: direct supervision, indirect supervision, and oversight. A supervisor is either physically present (direct supervision), available to provide direct supervision if needed (indirect supervision), or reviews decisions following patient care (oversight). The type of supervision provided should depend on the level of training and competence of the trainee.

The concept of graduated levels of independence and responsibility form the basis of a new initiative in medical education known as competency-based training. Recently, the ACGME has been working with residency training programs to propose milestones for tracking the progress of residents as they progress within each core competency of their profession.(14) Designed to give program directors more discrete information about individual resident performance, these milestones could allow supervision to be tailored to the needs of the individual trainee based on their demonstration of competence. For example, a medical resident might be expected to verbally transition or "hand off" patients shift-to-shift independently by the middle of their intern year but not to coordinate a complex discharge transition independently until their second year. A surgical resident might be expected to assist with an uncomplicated appendectomy as an intern but not complete the operation independently under supervision until later in training.

Graduated levels of independence and responsibility address the tension between supervision and autonomy by appropriately increasing independence without affecting patient safety. To do this safely, however, we need clear expectations about what constitutes appropriate supervision at which level of training. Ideally, the development of milestones would incorporate mechanisms to objectively measure competency, which in some circumstances may be independent of the year of training. Until a trainee becomes competent, strict supervision should be provided. Additionally, programs should set explicit guidelines about when trainees should communicate with their supervising faculty and promote shared accountability and monitoring between faculty and trainees for adherence to these guidelines. Faculty should be encouraged to verbally endorse these guidelines to create an open environment. When faculty or more experienced residents are too busy with their own clinical obligations to provide appropriate supervision, this tension between service and supervision should be recognized and addressed.(15)

Rather than our profession's previous mantra of "see one, do one, teach one," reductions in supervision should be based upon trainees' meeting explicit milestones of competency. Ultimately, educational leaders should focus on designing programs that—and rewarding faculty who—effectively use supervision to enrich the educational experience for residents and enhance the safety of the patients under their care.

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