Shoring up professionalism

Building on disagreements between residents and attending physicians

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Disagreements between trainees and attending physicians are common, inevitable,[1-2] and, to a certain extent, healthy and appropriate. Students should question their teachers[3]; teachers should defend their views. When disagreements are framed as opportunities for intellectual self-improvement, they make teaching more vibrant and learning more engaged.

Sometimes, however, disagreements raise troubling issues partly because of the unusual status of residents. On the one hand, residents are licensed *physicians* committed by history, tradition, and professional ethics to exercising their own independent clinical and moral judgment to protect patients' best interests. On the other hand, residents are *trainees.* As such, they might not have had sufficient experience to be given ultimate responsibility for patient welfare, and they are administratively and legally subordinate to attending physicians.

Traditionally, disagreements have been resolved in a hierarchical manner. Three recent changes in the atmosphere of clinical medicine, however, suggest the need to revisit management of disagreements between residents and attending physicians. First, there is new emphasis on medical errors and quality improvement.[4] Residents could be in a unique position to identify errors made by attending physicians.

Second, concerns regarding changes to health care systems have renewed efforts to enhance and safeguard medical professionalism. The "Four Principles of Family Medicine,"[5] published by the College of Family Physicians of Canada, describe professional responsibilities, such as the expectations that physicians be "skilled at collaborating as team members or team leaders," that they practise an "approach to health care… based on the best scientific evidence available," and that they "recognize when their own personal issues interfere with effective care."

The third recent change is the growing role of hospitalists in caring for inpatients.[6] Physicians who specialize in the care of hospitalized patients might deliver higher-quality care than physicians who only intermittently care for hospitalized patients.[7] Senior residents in many training programs are, in effect, hospitalists. In some clinical settings they might have more experience caring for hospitalized patients than attending physicians who work primarily in the community.

These changes suggest the need to re-examine old traditions. It is no longer appropriate, in this age of rigorous health services research and commitment to quality improvement, to rely on outdated canards about the superior experience of attending physicians or on the historically rigid hierarchies of training programs. We present the following vignettes to illustrate the types of disagreements that can arise between trainees and attending physicians.

Case 1. What does the evidence show?

> F.W. is a 71-year-old with bronchiectasis seeing his family physician. A resident examining the patient believes that F.W. is doing well and is at his baseline. By contrast, the resident's preceptor believes that steroids should be added to F.W.'s medical regimen. The resident reports that a systematic review failed to identify any rigorous trials or meta-analyses that provide strong support for use of steroids in this setting.[8] The preceptor is not familiar with the article and disagrees about the weight of the evidence. Instead, he describes cases he has seen in which patients with stable but substantial bronchiectasis improve after steroids are initiated.

This disagreement turns on 2 issues. First, the resident is more familiar with the literature than the attending physician; this is common. To the extent that decisions should be evidence-based, it is crucial to adopt treatments that are supported by scientific evidence. On the other hand, the attending physician has had more clinical experience and might be appropriately skeptical of the value of the systematic review in this setting. Clinical experience is a type of evidence that cannot be lightly dismissed.

Cases such as this highlight the importance of trainees' and preceptors' working together to maximize the effectiveness of clinical supervision.[9] In this case, the resident and attending physician might review the evidence supporting steroid use in this setting. They might also discuss the strengths and weaknesses of systematic reviews and meta-analyses versus the smaller individual studies that they include. Such a review would allow important disagreements to be brought into the open as part of the educational experience[10] and help a resident to be treated as an equal.[11] Review of these papers might lead to a discussion of what evidence-based medicine really means and of the limits of evidence. This disagreement could become the basis for a discussion about appropriate habits of thought in reaching therapeutic decisions.

Case 2. Is the patient ready for discharge?

> J.F. is a 25-year-old with pyelonephritis admitted to a family medicine service for intravenous antibiotics and

analgesics. On the second hospital day, she is afebrile and can tolerate some oral intake, but continues to have intermittent vomiting and moderate back pain. The house officer suggests that she be discharged with a prescription for oral antibiotics. The attending physician disagrees and requests that she remain hospitalized with intravenous antibiotics for an additional day.

This case illustrates how clinical judgment, utilization review, and medical economics overlap. Disagreement about the optimal timing of discharge and, indeed, even the need for admission,[12] offers the team a chance to review the evidence that can be used to guide such decisions. It might also allow general discussion of appropriate resource allocation, the moral rectitude of bedside rationing, and the meaning of individual suffering.[13,14] If the patient's prognosis would not be changed by early discharge but her suffering would be greater, would another day in hospital be appropriate? An authority-driven hierarchical approach might obscure opportunities to ask important questions about the appropriate use of health care resources, or the relationship between treatment goals and clinical decision making.

Case 3. How aggressively should patients be treated?

G.J. is an 80-year-old with breast cancer and mild-to-moderate dementia being seen in a community-based practice. She lacks decision-making capacity. Her daughter says that she would not want to be kept alive on a machine or otherwise suffer, but is not sure whether she would want chemotherapy or radiation treatments. A resident has been caring for G.J. for 3 years and knows her well. He believes that these therapies are not in her best interest and that she would be better served solely by palliative care. The precepting physician, however, recommends a limited trial of these therapies to treat the malignancy.

End-of-life care is one of the most difficult situations that doctors face, and research shows that many doctors and hospitals do not do a particularly good job.[15] A case like this might offer physicians an opportunity to discuss care of patients near the end of life, with an emphasis on how to incorporate both curative and palliative approaches. They could review use of advance directives and appropriate mechanisms for surrogate decision making.[16]

Conclusion and implications

Resolution of disagreements depends upon both parties' willingness to recognize and address problems constructively. Teaching programs should strive to provide an open intellectual environment in which disagreements are regularly emphasized as opportunities rather than threats and in which they are resolved by reason and debate.[17] While time pressures can lead to a focus on diagnosis and management,[18] it is important for trainees and attending physicians to consider the effect of important disagreements that lie under the surface.

Failure to address disagreements can have important consequences for patients and providers alike. Unresolved disagreements can threaten the mastery of skills such as lifelong learning and conflict resolution.[5] They can also become apparent to patients and lead them to question the credibility and professionalism of their physicians.[19] They threaten quality of care by undermining the cooperation of team members and impairing patient-physician communication.[20-22] Finally, the enthusiasm, curiosity, and humility that foster an optimal training environment are difficult to maintain when disagreements between residents and attending physicians are not addressed.[23,24]

Disagreements can be managed to avoid these undesirable outcomes. In an outdated hierarchical system, such disagreements might be seen as a threat to patient care or medical education. In the current health care environment, disagreements between residents and attending physicians should be regarded as sentinel events that serve as opportunities for improving care.

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Ethical concerns in community practice research

Common concerns encountered by the Alberta Family Practice Research Network

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Primary care research is important. "The ecology of medical care" assessed where people in the United States receive health care.[1,2] Of 1000 persons, 217 developed symptoms and sought medical attention. Of these, less than 1% were hospitalized in an academic medical centre. Research done in these centres does not represent common problems or concerns, and many primary care questions might not be detected.

The success of biomedical research has been, in part, due to the infrastructure supporting this research in academic and tertiary settings.[3] With increased interest in primary care research, researchers are approaching family physicians to recruit patients for their projects. While family practice research networks provide resources for primary care research, these community laboratories are inadequately funded.[3,4] Community family physicians have limited resources and expertise to deal with the many research requests that cross their desks. In Alberta, the Alberta Family Practice Research Network, an initiative of the Alberta College of Family Physicians, ensures that research projects are relevant and sensitive to community physicians.

The purpose of this paper is to describe some common concerns among family physicians assessing research projects. We believe it is important to increase awareness of the potential ethical and legal problems that can occur.

Patient recruitment

Community physicians are often approached to assist with recruiting patients for projects. Researchers might request permission to post an advertisement or to give patients a handout describing the research project. These requests seem harmless because specific health information is not being disclosed.

Ethical approval and research ethics boards

It is essential that a research ethics board approve projects before recruitment is undertaken. If the project does not have ethical approval, there could be risks to patients. When family physicians advertise a project in their offices, patients might think the physicians have endorsed the project. Hence, it is important to ensure projects meet certain ethical requirements. Alberta's Health Information Act (HIA) requires a family physician to ask researchers for a copy of the research approval letter before assisting with a project. In provinces that do not have such legislation, this might still be a wise step to take.

Research ethics boards review protocols to ensure that certain criteria are met and that patients' privacy and the confidentiality of their health information are safeguarded. They are guided by the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans,* which articulates a broad ethical framework. This statement can be found at **http://www.ncehr-cnerh.org/english/code_2/**. In most instances, ethical approval by a research ethics board is adequate. The ethics board, however, might not fully understand family practice, the unique doctor-patient relationship, and the effects that research can have on family physicians.

In some cases, researchers might request, and ethics boards might grant, a waiver of the need for consent for the release of health information (such as patient contact numbers). Physicians still have the right, however, to demand consent for release of information in these situations. Even though an ethics board could have reviewed a project it is still important that community physicians consider the power of the doctor-patient relationship to avoid conflicts of interest or misunderstandings.[5] When recruiting patients for a research project, the family physician's role as patient advocate sometimes conflicts with the research role; the family physician might be a "double agent." This role conflict

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