

Session 17. Training Issues for Residents and Students, Part II: Ethical and Professional Conflicts that May Arise When Trainees Question What They are Told To Do

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Overview

As outlined by the American Board of Pediatrics,¹ The American Academy of Pediatrics,² and others,³ medical professionalism invokes the principles of honesty and integrity, reliability and responsibility, commitment to lifelong learning, self-awareness and knowledge of limits.

Residency training requires learners to expand their medical knowledge, acquire essential skills, and work in teams with shared responsibilities. Trainees need to learn how to identify and address common ethical dilemmas faced in their role as learners with relatively limited knowledge, experience, and judgment compared with their supervisors and superiors. Ethical duties to patients lead to professional obligations that may demand interpersonal negotiation between members of the care team, conversations that may be difficult.

In this teaching module, we will focus on ways that the current hierarchical model of training can foster challenging disagreements between team members at different levels of training and experience regarding important medical care decisions. The trainees' duty to deliver the best possible care to patients creates an obligation to address these disagreements, an undertaking not without risk.

Instructor's Guide

- Case Summary
- Alternative Cases
- Learning Objectives
- Suggested Reading for Instructor
- Case Discussion
- Conclusions and Suggestions

Case Summary

A 3-month-old is hospitalized early in your night on call with wheezing following 2 days of rhinorrhea and cough, a day of fever to 101°F, and a report from the emergency

department that the infant is in respiratory distress. The birth and past medical history are unremarkable. On examination, the infant is well-appearing, crying but consolable, and wheezing, but not in respiratory distress. Testing of a nasal swab for common respiratory viral pathogens will not be performed until the next morning. Your senior resident tells you that the infant needs a full sepsis work-up, including lumbar puncture, but you disagree. You believe that the diagnostic tests are not indicated and will cause harm, in the form of pain, for the infant.

Alternative Case

A 4-year-old is admitted with a 2-day history of vomiting, diarrhea, fever, and mid-abdominal pain. Laboratory tests and abdominal ultrasonography are normal in the emergency department, where the child is hydrated intravenously. During rounds with the attending physician, you mention your concern regarding the abdominal pain, but the attending physician reassures you that it is attributable to abdominal cramps and wants no further imaging performed. You run into a friend, a pediatric surgical fellow, and ask your friend's advice (without first consulting the child's attending physician). After reviewing the history and examining the patient, your friend recommends a CT scan to rule out appendicitis. When you approach the parents for consent to perform the CT scan, they decline to agree to the test unless it is first approved by the child's attending physician.

- Do you need to follow the instructions of your supervisors in these cases?
- What are the best actions to take in situations in which you have a dispute with a supervisor about treatment?
- Are you taking risks by challenging the authority of your supervisors?
- Are there times when it is not appropriate for a junior trainee to challenge the directions of a supervisor?

Learning Objectives

1. Reconcile obligations to pursue the best interests of the patient with awareness that limitations in experience and education may restrict a trainee's capacity for sound clinical reasoning.
2. Be prepared to address disagreements with team members at more advanced levels of training and experience regarding important medical care decisions, even if doing so carries a risk to the junior trainee of appearing to challenge authority.
3. Appreciate the potential for misunderstanding or misattribution of supervisors' and trainees' clinical reasoning and the factors that influence it.
4. Understand the role and obligations of mediators and other supervisory professionals to help resolve such disagreements.

Suggested Readings for Instructor

General materials on professionalism are listed as the first 3 references,¹⁻³ in the final

section of this chapter.

Discussion of a broad range of issues in ethics and professionalism that commonly challenge trainees can be found in the references by Bercovitch and Long 2009,⁴ Brody and Doukas 2014,³ Carrese et al 2011,⁵ McDougal and Sokol 2008,⁶ and Moon et al 2009.⁷

Factors that influence when trainees “ask for help” and the critical importance of clinical team function are presented in the references by Goldszmidt et al 2015,⁸ Hauer et al

2015,⁹ Janss et al 2012,¹⁰ Kennedy et al 2007,¹¹ Kennedy et al 2009,¹² Loo et al 2012,¹³ and Piquette et al 2015.¹⁴

Case Discussion

Do you need to follow the instructions of your supervisor in these cases?

The relationship between a supervisor and junior trainee in the health care setting is one in which the trainee is both dependent on the supervisor for care oversight and education and obligated to deliver the best possible care to patients who are the joint responsibility of all involved. The expectation that a junior trainee follow instructions of a supervisor can come into conflict with duties of beneficence (and nonmaleficence) if the trainee experiences a supervisor’s directive as an order to do something potentially harmful. This is one of many sources of moral distress cited by health professionals, particularly nurses, who work in what have traditionally been considered to be subordinate roles.

The more urgent or emergent the clinical situation, the less time there is for a trainee to question the directive of the supervisor. The more crucial the diagnostic or therapeutic conflict between supervisor and trainee to the well-being of the patient, the more important it is to take steps outlined below.

What are the best actions to take in situations in which you have a dispute with a supervisor about treatment?

The best course of action is for you to ask for explanation. It is possible that your understanding of your supervisor’s clinical reasoning, or of the factors influencing it, is mistaken or incomplete. In order that your reasons for challenging their authority not be misunderstood or misinterpreted, you must strive to express your perspectives as clearly and respectfully as possible. This is more challenging in times of heightened stress caused by a large workload, concern for sick patients, and moral distress created by the expectation that you deliver care or render treatments that you believe may not be in the patient’s interests. If work within the clinical team is not experienced as taking place in a “psychologically safe environment,”^{10p842} trainees may feel inhibited asking questions or expressing differing viewpoints to their superiors.

In many situations, engaging the supervisor in dialogue will largely resolve the conflict over appropriate patient management. All care teams need to have access to an outside party who can help mediate disagreements about care. This may be another senior

resident, a chief resident, another inpatient attending physician, or the chief of service. The duties of such mediators are to listen carefully to all considerations and be guided by the best interests of the patient.

Are you taking risks by challenging the authority of your supervisors?

Challenging the authority of your supervisors can put you and your patients at risk. By virtue of their greater degree of experience and training, your supervisors may have taken additional considerations into account or been in similar clinical situations that put them in a good position to make what may be the most sound diagnostic and therapeutic

decisions. At the same time, they may not have access to or appreciate all the information that you know by virtue of your close, current work “at the bedside” with the patient and family. Although engaging supervisors in respectful discussion about disagreements is an advanced professional skill worth fostering, you also run the risk of being viewed in an unfavorable light, depending on the dynamics of the process.

Training programs are intimate social groups in which the reputations or perceived attributes of particular members endure. These can form the basis of preconceived notions about how safe it is to disagree with a supervisor that influence a trainee’s comfort level in presenting differences of opinion. This may have a strong effect, together with other characteristics of their relationship, on help-seeking behavior by the trainee.¹⁰

Are there times when it is not appropriate for a junior trainee to challenge the directions of a supervisor?

There are times, such as life-threatening emergencies demanding patient resuscitation, when the importance of maintaining a smoothly running, hierarchical team is critical to ensuring the best chance of favorable patient outcomes. In these instances, responsibilities for directing care tend to be shifted to the highest-level professionals available, and all impediments to carrying out treatment must be minimized. Even during patient resuscitation, however, any participating team member who feels that an error is being made, or is about to be made, should not remain silent.¹⁵

In the cases presented, critical illness or insufficient time are not significant barriers to engaging your supervisor in discussion about alternative proposals for management. The second case scenario suggests the potential for harm resulting from delayed diagnosis of a condition, such as appendicitis, which could call for surgical intervention. The greater the likelihood that following instructions from your resident or attending may lead to harm to your patients, the more incumbent it is on you to argue for your own preferences in planning and delivering treatment. At the same time, trainees need to be aware that their own preferred diagnostic or therapeutic suggestions may add unnecessary risks of harm (eg, radiation from an abdominal CT scan) and expense.

What should the resident do in these specific situations?

Interns face difficult decisions when supervising physicians disagree with their inclinations. Interns should not act contrary to the orders of supervisors, who likely have greater experience and knowledge. Nor should they “go around their back,” as this

violates the integrity of decision-making on behalf of the patient and the safeguards inherent to clinical supervision of trainees.

In the first case, the intern should discuss foregoing the lumbar puncture directly with the senior resident. A senior mediator, such as the admitting resident, chief resident, or attending physician, may be able to help them reach agreement. Potential mediators may not be impartial. In the end, if everyone is advising the intern that the lumbar puncture should be performed, then the intern should perform the procedure. If the intern still feels a conflict of conscience over this order, the intern may object to the assignment and ask

that duty for the patient be transferred to a colleague. As in other clinical situations in which the trainee objects to administering care on moral grounds, responsibility for care remains with the trainee until reassignment of care duties can be accomplished.¹⁶

In the second case, the intern should not arrange for the CT scan unless it has been authorized by the attending physician. Regarding the solicitation of other opinions, there is disagreement about the appropriateness of obtaining a curbside consult without the attending's prior knowledge. Some may perceive it as disrespectful, and indeed the most courteous approach would be to first ask the attending if pediatric surgical consultation is acceptable. If the intern has serious concerns about the plan and has reason to believe the attending may not be receptive to obtaining consultation, it is appropriate for the intern to seek the opinion of a senior physician mediator. The intern's ability to solicit other opinions when unsure about the plan is both essential to clinical education and a crucial safeguard to patient care.

If the child's condition worsens or the suspicion for acute abdomen grows, the intern can appeal to the attending physician or other senior mediators in the hospital to assist in communicating these concerns. Regardless of whether the CT scan is performed, the team will need to continue performing serial examinations on the child for signs of appendicitis, intussusception, or other abdominal emergency.

Conclusions and Suggestions

Disagreements with supervisors about important medical care decisions obligate trainees to question directives issued by those overseeing care. Following directions that may be harmful challenges fundamental ethical commitments to patient care and causes moral distress in trainees and fellow health professionals. Physicians are guided by duties of beneficence (and nonmaleficence) and to act virtuously on behalf of their patients: in the words of Brody and Doukas, "doing the right thing (whatever puts the patient's interests first and foremost) in the right way and with the right attitude."^{3p985}

Trainees should act in ways that help the care team function smoothly and maintain favorable professional reputations for themselves. As such, they are obligated to develop the capacity to engage supervisors in respectful discussions regarding disagreements about care when potential for harm to the patient exists. Trainees can model this practice after colleagues and others whom they observe doing it well, similar to ways they learn to refine other communication skills. They need to reconcile their obligations to pursue the

best interests of the patient and prevent avoidable harm while not acting or appearing to act in an insubordinate fashion. Senior physicians need to direct care in approachable and nonthreatening ways that foster dialogue and discussion about the best care possible for patients.

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