ANALYSIS OF HYPOTHETICAL CASE #1

You are the SURGERY CLERKSHIP DIRECTOR. The Surgery department recently recruited a transplant surgeon whose schedule is growing quickly, outpacing the surgeon's assigned block time when students are scheduled to be in the OR. When you contact several students who are absent from a didactic session, they explain that the transplant surgeon requires a third-year medical student to be present during every case. Students report that they typically hold retractors during these cases and teaching is focused on the fellow and residents. They do not feel comfortable asking to leave the OR to attend other scheduled clinical and educational sessions out of concern that it will compromise their clerkship grade.

1. What is the conflict? **Students are missing assigned didactic sessions because they are required to assist in surgical cases.**

2. Why is there a conflict? **Because these stakeholder perspectives appear incompatible:**
   - Clerkship director: *We require student attendance for didactics because they are linked to the medical school's learning objectives for our clerkship.*
   - Transplant surgeon: *Being present to assist with transplant surgery is educationally valuable for students and showcases team-based surgical care. Also, I need their help assisting.*
   - Students: *We are caught in the middle of a no-win situation. Either choice can put our clerkship evaluation at risk. If we had a real choice, some of us would rather be in the OR and some would rather be at didactics to push for a better score on their end-of-clerkship exam.*

3. As clerkship director, what is your strategy for understanding and managing this conflict?
   - **Self-awareness:** *I am ready to be very assertive in achieving my goal of the students attending their required didactics. I want to be as collaborative as possible in light of the important contributions made by the transplant surgeon, but how collaborative I am will depend on what the surgeon really wants. If I cannot create a win-win* (collaborating) *outcome I will push for a fair compromise (equitable concessions). This will be easy/hard for me because my preferred conflict style is* (complete using your results from the **Thomas-Kilmann Inventory**).
   - **Skilled inner listening:** *What am I telling myself and what inferences am I making? Do I have preexisting ideas about surgeons in general, this particular surgeon, students in general or these particular students? Am I focusing on facts that support these beliefs and not using logic* (**the ladder of inference**)? *I need to hear different perspectives that create a truer understanding* (like **the cone in the box**).
   - **Skilled inquiry**: You arrange separate conversations with the surgeon and the students. In each meeting you ask inquiring questions that only they can answer, holding back your own interpretations. You schedule and conduct these conversations paying attention to their physiologic needs (tired, hungry, post-call?) and reassuring them about safety ("Am I in trouble? Is this confidential?"). During the meetings you use the **PEARLS** to address their potential social and self-esteem needs through statements of Partnership, Empathy, Acknowledgement, Respect, Legitimation and Support.

- **Skilled advocacy:** In each meeting you listen carefully, restate what you understand to be the other person's perspective and thought process. Before explaining your perspectives you ask their help in trying to understand the process by which you came to your interpretation. You continue using statements from the **PEARLS** as needed. You succeed in learning the transplant surgeon's perspectives described in #2 above.
- **Insights and outcomes:** Your management of this conflict has yielded insights that will prove very helpful in creating a win-win (collaboration) or equitable concessions (compromise) outcome. Here are two potential scenarios:
    A. The transplant surgeon has an urgent need for surgical assistants and is much less concerned about students missing out on educational value. You collaborate to create a **win-win outcome.** This could require engaging the department chair as an ally in advocating either for more residents and fellows (if feasible for the program director), with hospital administration for more surgical assistants (PA's), or with the OR committee for a different schedule that allows the students not to miss didactics.
    B. The transplant surgeon has other options for surgical assistants but worries that the students will miss out on important lessons about surgical anatomy and team care in the OR. The surgeon acknowledges the importance of didactics and you acknowledge the educational value of these cases. In exchange for the surgeon agreeing not to ask students to assist during didactics, you agree to create a transplant surgery elective so interested students can benefit from this experience. The outcome will be fewer students seeing these cases, which is concession on the surgeon's part. Because you paid attention to Maslow's hierarchy and took such care using the PEARLS, this feels like **an equitable compromise.**

ANALYSIS OF HYPOTHETICAL CASE #2

You are the INTERNAL MEDICINE RESIDENCY PROGRAM DIRECTOR. Third-year residents in your program do several rotations at a smaller affiliated hospital where all of the internal medicine staff physicians attend on the inpatient service in 1-week assignments. Although the relationship between the main hospital and affiliated hospital has improved in recent years, many of the senior physicians feel like they are second-class citizens in the eyes of the residency program. One of the senior physicians is on service and asks the residents how to manage patient problems that would typically result in a subspecialty consultation. When the third-year resident suggests that a consultation be obtained, the attending becomes upset and contacts the program director, asking that the resident be disciplined for insubordination.

1. What is the conflict? **The resident perceives that a subspecialty consult is needed to provide optimal care to the patient, whereas the attending physician disagrees.**

2. Why is there a conflict? **Because these stakeholder perspectives appear incompatible:**
   - Resident: *Instead of getting a consult the attending is asking me what I would do. I don't understand why. At the main hospital where we spend most of our time, the standard of care is to request subspecialty consults in this situation. I have never seen that not done.*
   - Senior attending: *I've been practicing for 30 years and have expertise managing patients like this, and I have always used a Socratic method to teach the residents. Are they teaching residents to get consults on everyone before thinking through what they would do? Do they not respect the expertise we have here in the community? This is unacceptable.*

3. As program director, what is your strategy for understanding and managing this conflict?
   - **Self-awareness:** *Resolving this successfully requires that I learn more about what happened during their interaction. I am ready to be very assertive in obtaining an equitable outcome for the resident and I am ready to be very cooperative in light of the important contributions made by the community hospital faculty. If I cannot create a win-win* (collaborating) *outcome I will push for a fair compromise* (equitable concessions). *This will be easy/hard for me because my preferred conflict style is* (complete using your results from the **Thomas-Kilmann Inventory**).
   - **Skilled inner listening:** *Suggesting a consult does not seem like insubordination. What am I missing? The senior attending has practiced at this hospital for many years, and has lived through some of the hardest times when the relationship with us was strained. I wonder if that's influencing the attending's reaction to the consult suggestion, i.e., that the attending does not feel respected* (**Maslow's hierarchy of needs**). *On the other hand, this resident is one of our best in terms of clinical judgment and professionalism, so I wonder if the attending is up-to-date on management of this problem. I need to be careful, as this belief could bias my willingness to accept that the resident said something inappropriate* (a misstep on **the ladder of inference**). *I need to gather different perspectives to get to a more detailed and comprehensive understanding* (like **the cone in the box**).

- **Skilled inquiry**: You arrange separate conversations with the resident and with the attending physician. In each meeting you ask inquiring questions that only they can answer, holding back your own interpretations. You schedule and conduct these conversations paying attention to their physiologic needs (tired, hungry, post-call?) and reassuring them about safety ("Am I in trouble? Is this confidential?"). During the meetings you use the **PEARLS** to address the participants' potential social and self-esteem needs through statements of Partnership, Empathy, Acknowledgement, **Respect,** Legitimation and Support. You succeed in learning the perspectives of the resident and attending physician described in #2 above.
- **Skilled advocacy:** In each meeting you listen carefully, restate what you understand to be the other person's perspective and thought process. Before explaining your perspectives, you ask their help in trying to understand the process by which you came to your interpretation. You continue using statements from the **PEARLS** as needed.
    - You work to provide additional perspective for the resident, e.g., how the consult request may have been perceived, and how this particular attending is known to be a fan of the Socratic method in which "why" questions are used to spur critical thinking and for which ordering a consult would be the wrong answer.
    - You work to provide additional perspective for the attending, e.g., how common it is to obtain consults at the main hospital where residents train, how some residents may not have experienced the Socratic method, and how evaluations of the community hospital rotation show it to be a highly valued experience for the residents.
- **Insights and outcomes:** Your management of this conflict has yielded insights that will prove very helpful in creating a win-win (collaboration) or equitable concessions (compromise) outcome. Here are two potential scenarios (both may be in play):
    A. The attending physician accepts that the resident did not mean to question their judgment and was inexperienced with the Socratic method. The resident understands how jumping to the consult was perceived by the attending, and that the attending's intention as to develop their critical thinking skills. You facilitate a meeting in which they each feel respected for their shared intentions to provide excellent patient care and their shared interest in teaching and learning. Both are happy with this as a **win-win outcome.**
    B. The resident reminds you that the main hospital has created evidence-based care pathways that make a consult the best choice for this particular patient, and asks whether the attendings at the community hospital are aware of this pathways. You realize that the community hospital attendings were not involved in the preparation or implementation of the care pathways, and that this will be perceived as a lack of respect for their expertise and teaching roles.

As program director you take ownership of this oversight and the resulting conflict, and you explain this to the attending physician. You promise to share the care pathways that were implemented at the main hospital. If the attending can organize a meeting of the community hospital staff to determine which pathways they can endorse and which are too restrictive, you promise to share this with the residents before the rotation so misunderstandings like this happen less often. Because you paid attention to Maslow's hierarchy and took such care using the PEARLS, this feels like **an equitable compromise.** Concessions were made by the attending (the resident will not be disciplined; work is involved in evaluating the care pathways), the resident (it was not the resident's fault but they were made to look bad in the eyes of their program director and the community hospital attendings), and the program director (who took responsibility, apologized and has additional work ahead to make this right).

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Scenario #1:

John is an M3 and has performed very well in the first two years of medical school. He is now on the Internal Medicine clerkship and has been having a difficult time. He just doesn't seem to fit well into the team and doesn't quite understand why. He has attended rounds on time every day though doesn't always come into the hospital in time to pre-round on his patients. He also has worn flip flops to work on several occasions and has looked disheveled. On Tuesday on rounds, the attending arrived, and rounds began. John was the student covering the second patient seen. When the attending looked at John, he presented information, including labs, that were already reported on yesterday's rounds. The senior resident realized the problem and promptly reported the correct assessment and labs. She then turned to John and said, "I'm fed up with you. You come late every day, you look like you just rolled out of bed, and you never remember anything we have discussed the day before. For sure I can tell you I am giving you 1s on your end of clerkship assessment!"

Discussion:

What is John's role in this situation? Did he contribute to the problem? What is his insight? What could he have done differently?

What is the senior resident's role in this situation? What could she have done differently?