Accepting the Risks in Creating Confident Doctors

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What does it take to make a medical expert? Practice, practice, practice. And, unfortunately, some error along the way.

Patients instinctively know this, which explains the near universal preference for a seasoned doctor over a freshly minted one. I have yet to hear a patient clamor to be treated by a young resident.

Medical educators are keenly aware of it, too, and of a conflict at the heart of medical training: what may be best for making a skilled, independent-thinking doctor may not always be best for patient comfort or safety.

How, for example, can an inexperienced psychiatry resident learn how to do empathetic but rigorous interviewing to assess patients’ risk of harming themselves or others, without leaving some patients feeling misunderstood or badly treated? How can a doctor become expert at using psychotropic drugs or doing psychotherapy without making mistakes along the way?

Just as we want psychiatrists in training to become confident and knowledgeable, we also have to protect patients from the errors that result from their inexperience.

But one day, our residents will leave the protective cocoon of training and go out on their own. Have we struck the right balance among education and training and patient safety to produce psychiatrists who can function independently? I’m not sure we have.

Late one night not long ago, a senior resident called me to the emergency room. The patient, who was well known to this resident, was a young woman with borderline personality disorder who had superficially cut her wrists after an argument with her boyfriend — something she had done numerous times before.
The patient almost immediately regretted her behavior. She never had any serious suicidal intent; she was just enraged with the boyfriend.

The doctor was just two months shy of completing her residency, and evaluating a patient’s risk of harm to self or others is a critical skill that is taught early and often to psychiatric residents. She knew perfectly well that the patient was prone to dramatic gestures, but not to suicide.

Why, then, was she calling me to ask about such a basic issue? Despite having all the knowledge about risk at her fingertips, she didn’t feel confident in her judgment.

She is hardly alone, of course. I have received more phone calls from recent graduates in the past several years than I can ever recall. While I can’t pretend this is a representative survey, many of my colleagues have noticed the same trend. And the questions, like my resident’s, are basic ones: when a patient should be hospitalized, how far to push a medication.

Also, more graduates are reaching out to me to ask for extra supervision. Almost always, they “know” what they are doing, but don’t feel confident about it.

The fault, I believe, lies with medical educators like me. In the pursuit of patient safety, we have deliberately prevented residents from acting independently on their own judgment in situations where a patient poses a theoretical risk.

The situation reflects a series of reforms that began in the 1980s with limits on residents’ work hours. More recently, the Accreditation Council of Graduate Medical Education set a maximum workweek of 80 hours for residents, with a maximum shift of 30 hours. And in 2008, the Institute of Medicine recommended further limiting the maximum shift to 16 hours.

Don’t get me wrong. I’m all for minimizing risk and medical error. And we want regulatory oversight and supervision to be most stringent where the stakes are highest, as they are in an emergency room.

Still, there are no reliable national data that these regulatory changes have had a significant impact on preventable medical error or patient mortality rates. And I think there is a cost to the development of professional identity of young doctors. It is hard to feel confident and independent unless you are given ample opportunity to stand on your own — and risk making a mistake.

The fact is that all physicians in training pose an inherent risk to patients. We should do everything we can to minimize this risk but recognize that it may impair physicians’ self-confidence.

If the changes in residency training are shown to enhance patient safety — and that is a big if — they will certainly be worth it. And who knows: it might even shift the
stereotype of the omnipotent physician to a more humble one.

Just don’t be surprised if your doctor seems a little more hesitant and uncertain than you might like.