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Integrating midlevel practitioners into a teaching service

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Abstract

Meeting the educational needs and requirements of surgical resident physicians while achieving optimal patient care is a challenge for program directors. Midlevel practitioners (MLPs) were employed by a large community teaching hospital to augment the surgical teaching service, to improve continuity of patient care, and to provide resident physicians with greater flexibility to participate in classroom, operative, and clinical educational experiences. The MLPs were carefully integrated into the surgical program by creating the necessary buy-in, developing positive relationships, decreasing resistance, and reinforcing acceptance when demonstrated. MLPs function at the level of junior resident physicians and are active participants in the teaching and evaluation process. Structurally, MLPs receive their assignments from and report to the chief resident physician, but are ultimately responsible to the program director. Instituting the program required providing financial justification to administration and flexibility in meeting the diverse needs of the four teams. As a result, surgical resident physicians have been sufficiently freed from service activities to be able to capitalize on learning activities that range from surgeries to conferences. MLPs can be integrated into a surgical teaching program and become a positive force in the education of resident physicians.

Keywords: Midlevel practitioners; Nurse practitioners; Physician assistants; Resident physician education; Surgical education

Teaching hospitals are hiring midlevel practitioners (MLPs), ie, physician assistants (PAs) and nurse practitioners (NPs), in an effort to provide safe, cost-effective, high-quality patient care while protecting the integrity of the academic program within the new resident physician work-hour constraints. The most common MLP model uses a 2-tiered system that includes both resident physician–based teaching services and MLP-based nonteaching services. Patients are allocated to the services based on the learning needs of the resident physicians [1–3] and the Accreditation Council for Graduate Medical Education requirements. Our institution chose to integrate MLPs into the teaching service to providing resident physicians with flexibility in allocating their time as well as direct educational and clinical support.

Inova Fairfax Hospital is an 835-bed community teaching hospital in northern Virginia with 36,000 operative cases performed in 33 operating rooms (ORs)/y. The level I trauma center provides care for >2300 multiply injured patients/y. In addition to hosting resident physicians from several area medical schools, Inova began a new independent surgical residency in 2003. Workload, educational, and financial considerations drove the decision to incorporate MLPs into the surgical service, and the decision was reinforced by the passage of the Accreditation Council for Graduate Medical Education 80-hour workweek. Decrease in total and consecutive allowable hours resulted in a personnel deficit, which potentially threatened both provision of care and resident physician education. MLPs provided a win-win solution by meeting the patient care needs of the services while preserving educational opportunities for the resident physicians. The integration of MLPs into the surgical teaching program was designed to lighten the resident physicians' clinical loads, to provide a stable nucleus for each surgical team, and to assure greater continuity and quality of care for patients. The four existing surgical services varied widely in composition and practice, making a flexible approach to role definition and integration essential.

Rather than recruiting for a specific credential, we looked for essential skill sets and competencies. The ideal applicant was a PA or NP who could be used interchangeably with a

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midlevel resident physician and who had procedural as well as patient management skills and was a "good fit" for the institutional culture and the difficulties of the change process. Position and experience determined variations in starting salaries and benefits, which ranged from $70,000 to $85,000 with a 23% benefits package for a 40- to 44-hour workweek and "comp" time for overtime and extra duty.

Negotiating the Obstacles

Institutional culture influences receptivity to change, interpersonal dynamics, flexibility, cooperative style, and how day-to-day activities are carried out. Introduction of new roles into an organization often causes a number of problems, including the following: (1) role ambiguity leading to conflict between coworkers, (2) perceived displacement, (3) refusal to accommodate the new role and/or /person, and (4) failure to support the new role with required structural changes.

Furthermore, implementation of the MLP role specifically required a shift in a number of values and beliefs, including who should provide what level of care, who should provide direction to beginning resident physicians, what collaboration should look like, and who to depend on for what. To ease the transition, the program director carefully managed the process by creating buy-in and positive relationships, decreasing resistance, and enforcing change when appropriate.

Step 1: Create buy-in

In the project-planning phase, the program director sought input from medical staff and existing PAs and NPs and introduced the idea to all levels of staff on all impacted units at their respective staff meetings. The concept and role of MLPs was thoroughly discussed with house staff in their orientations. Each team provided input on the needs of the team, and the program director selected the candidate with the skill set that best matched those needs. The job description for each MLP was tailored to the service, team, and units on which they work. Thus, each team received what they wanted and needed.

Step 2: Walk softly and establish positive relationships

The first MLPs initially worked for several months as first assistants in the OR. This enabled them to gain the respect of the attending physician surgical staff and gave them the opportunity to see the idiosyncrasies and habits of the surgeons. This strategy facilitated the development of positive relationships between attending physicians and MLPs that later provided the foundation for mentoring relationships on the floor.

Step 3: Decrease resistance and accentuate the positive

MLPs were assigned cases by the chief resident physician, rounded in the morning, and covered the floors during conferences and when the rest of the team was in the OR. This worked to the resident physicians' benefit, and the seniors quickly learned to rely on the MLP as they would a fellow resident physician. The senior resident physicians who were inflexible and who did not effectively capitalize on the skills of the MLP suffered an increased work load as a result of their rigidity.

Step 4: Reinforce good behavior and carry a big stick

The program director counseled all resident physicians about the role of the MLPs and insisted on resident physicians' cooperation with them. Our evaluation criteria for professionalism (as expressed in the new core competencies) emphasized the relationship between the 2 sets of professionals. The concept of "the team" became a mantra as MLPs wrote their share of notes, dictated discharge summaries, wrote orders, and covered for resident physicians when they were elsewhere. MLPs were able to fully function in their roles when the medical staff bylaws were amended to be consistent with the state practice acts for NPs and PAs.

Although most NPs do not have specific OR experience, our first MLP was an NP/registered nurse first assistant who brought both skill sets and gave additional flexibility to the team. The next hire was a PA who also has OR competency. These MLPs were specifically hired because their skill mix matched the needs of the surgical team and the need of the units on which they would function. Our PA and our NP/registered nurse first assistant both perform rounds on the floors and go to the OR as needed. Although allowed by state regulation, they do not place chest tubes and central venous catheters independently.

Trauma services required a different skill mix to enhance their team and meet the needs of the trauma patient population. Rather than OR coverage, the trauma service needed someone to provide comprehensive patient management in the intermediate care unit. As an extension of the critical care unit, IMC patients are physiologically complex, have multiple consultations, and require constant monitoring. The trauma NP's ability to manage the IMC fairly autonomously has allowed resident physicians to spend more time in critical care units, covering traumas and managing discharge planning on the floors. The NP does not assist in the OR or attend "codes" in the trauma bay.

Our most recent hire is a NP who has been cross-trained on all services. When the services are fully staffed, this individual works from 10 AM to 6 PM to provide coverage for the surgical floor when the other MLPs and the postcall house staff have left because of the 24/6 rule. Matching each MLP skill set and role to the specific needs of each service, team, and/or unit has been critical to acceptance of MLP integration. Furthermore, institutional flexibility has also