

# How do Perceptions of Autonomy Differ in General Surgery Training Between Faculty, Senior Residents, Hospital Administrators, and the General Public? A Multi-Institutional Study

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**OBJECTIVE:** Identify barriers to resident autonomy in today's educational environment as perceived through 4 selected groups: senior surgical residents, teaching faculty, hospital administration, and the general public.

**DESIGN:** Anonymous surveys were created and distributed to senior residents, faculty, and hospital administrators working within 3 residency programs. The opinions of a convenience sample of the general public were also assessed using a similar survey.

**SETTING:** Keesler Medical Center, Keesler AFB, MS; the University of Texas Health Science of San Antonio, TX; and the University of Nebraska Medical Center, Omaha, NE.

**PARTICIPANTS:** A total of 169 responses were collected: 32 residents, 50 faculty, 20 administrators, and 67 general public.

**RESULTS:** Faculty and residents agree that when attending staff grant more autonomy, residents' self-confidence and sense of ownership improve. Faculty felt that residents should have less autonomy than residents did ( $p < 0.001$ ). When asked to reflect on the current level of autonomy at their institution, 47% of residents felt that they had too little autonomy and 38% of faculty agreed.

No resident or faculty felt that residents had too much autonomy at their institution. The general public were more welcoming of resident participation than faculty ( $p = 0.002$ ) and administrators ( $p = 0.02$ ) predicted they would be. When the general public were asked regarding their opinions about resident participation with complex procedures, they were less welcoming than faculty, administrators, and residents thought ( $p < 0.001$ ). The general public were less likely to think that resident involvement would improve their quality of care ( $p < 0.001$ ).

**CONCLUSION:** Faculty and senior residents both endorse resident autonomy as important for resident development. The general public are more receptive to resident participation than anticipated. However, with increasing procedural complexity and resident independence, they were less inclined to have residents involved. The general public also had more concerns regarding quality of care provided by residents than the other groups had. (J Surg 72:e193-e201. Published by Elsevier Inc on behalf of the Association of Program Directors in Surgery)

**KEY WORDS:** graduate surgical education ownership, patient care, autonomy

**COMPETENCIES:** Patient Care, Professionalism, Interpersonal and Communication Skills

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## INTRODUCTION

Self-determination theory states that human beings have a natural tendency to develop toward autonomous behavior,

and those who are able to act autonomously learn better and achieve superior performance.<sup>1</sup> The Halstead method<sup>2</sup> for graduate medical education and the Accreditation Council for Graduate Medical Education Program Requirements for Graduate Medical Education in General Surgery<sup>3</sup> both support gradually giving the surgical resident increasing levels of responsibility and autonomy as they approach graduation in preparation for independent practice. This method for resident education has been successfully producing excellent surgeons for more than 100 years.<sup>4</sup> More recently, there have been mounting concerns regarding the preparedness of general surgery graduates for independent practice owing to a lack of autonomy in their training.<sup>5</sup> This concern has culminated with the American College of Surgeons creating the “Transition to Practice Program in General Surgery” that was developed to “help fill the perceived gaps in training today.” The first cited goal of the experience is to “obtain enhanced autonomous experience in broad-based general surgery.”<sup>6</sup> In addition to creating the Transition to Practice Program, over the last 3 decades, the number of residents seeking fellowship training after residency has slowly increased and exceeds 80%, causing some to attribute this trend to the lack of autonomy in residency.<sup>2</sup>

The perception of lost autonomy in surgical residency has been a mounting problem over the past 30 years. Multiple factors have been implicated and include the 80-hour work week,<sup>2</sup> new and innovative technologies being applied to general surgery,<sup>2</sup> financial constraints,<sup>7,8</sup> legal limitations,<sup>9</sup> quality of patient care,<sup>10</sup> and public opinion.<sup>11</sup> In a recent survey of attending surgeons by Minter et al.<sup>12</sup> investigating autonomy given in the operating room (OR), factors that promoted autonomy included resident skill and faculty comfort with the procedure. The most commonly cited reasons for limiting autonomy included increased focus on patient outcomes and expectation of surgeon involvement by patients and hospitals. In a survey addressing barriers to resident-attending communication with the goal of improving patient safety, one barrier cited was resident fear of losing autonomy.<sup>13</sup> Granting autonomy to a trainee is made more difficult in the medical profession by the potential for pain and suffering of the patient because of a complication. However, many studies show at least equivalent outcomes as compared with nonteaching institutions.<sup>14-16</sup> Ten Cate<sup>17</sup> points out that trust is developed between a resident and supervisor when a competent resident executes a task when appropriate. This not only builds trust but is also a definition for performance, i.e., not only being competent to do a task, but executing a task when it is appropriate to do so. Most supervisors can identify which residents they trust, even if they cannot identify why. Without trust, it is difficult for supervisors to extend sufficient autonomy to residents.

In the current educational climate, there is increasing focus on achieving competency. This is evidenced by the

core competencies and milestones mandated by the Accreditation Council for Graduate Medical Education.<sup>3</sup> There are also multiple articles in the literature attempting to evaluate entrustable professional activities.<sup>12,17-20</sup> Both of these are attempts to measure a resident’s ability and trustworthiness for increasing levels of independence in an effort to guide faculty regarding when to grant the appropriate level of independence at the appropriate time in resident training.

The issue of resident autonomy in education is multifaceted and involves not only the resident and teaching faculty but also the patient who is under the care of the surgical teaching service. Hospital administrators are also indirectly affected by standards for supervision of residents concerning reimbursement as well as quality, safety, and liability concerns. The aim of this study was to evaluate the perceptions regarding resident autonomy from the perspective of the surgical trainee, surgical instructor, hospital administrator, and the general public. We hypothesized that the perceptions of the resident and the faculty surgeon would be more closely allied than those of the hospital administration or the general public. Our second hypothesis was that residents and faculty would favor more autonomy in training when compared with hospital administration and the general public.

## MATERIALS AND METHODS

For this study, surgery residents, teaching faculty, and hospital administrators were surveyed at each of 3 general surgery resident training programs: Keesler Medical Center, the University of Nebraska Medical Center, and the University of Texas Health Science Center at San Antonio. Institutional review board approval was obtained at Keesler Medical Center before commencement of the study. The resident group was limited to general surgery residents in clinical postgraduate year 3 (PGY3) to PGY5. The hospital administration group surveyed was composed of the Chief Medical Officer; Chief Nurse; Chief Legal Counsel; Head of Quality; and Chief Executive Officer, President, or Vice President (or equivalent) of any hospital that was associated with training residents from 1 of the 3 participating training programs. The general public group was a convenience sample of adult ( $\geq 18$  y of age) nonmedical persons encountered by the investigators through association (e.g., neighbors and community groups). There were no other exclusion criteria.

Similar surveys were created for each of the 4 groups (Appendix). Each survey was specific to the appropriate group of participants, but the questions were constructed to be similar to the other groups for purposes of comparison. A 5-point Likert scale was used for all questions except 2 questions asking the participant to rate the degree of independence appropriate on a scale from 0 to 10 for a

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