

## Using a reflective exercise during orientation to discuss issues of supervision, communication and ideal patient safety practices

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When new postgraduate trainees are recruited, their prior experiences with patient safety principles are unknown. Nevertheless, we assume they will immediately adopt a culture of safety that includes requesting and ensuring proper supervision. In this project, the Postgraduate Office and Risk Management worked in concert to educate and investigate models and pitfalls of supervision.

This orientation workshop investigated the manner in which failures of supervision work in concert with the hidden curriculum to influence patient-safety practices across disciplines and various levels of training. All new trainees attended a mandatory orientation. This included a 25-minute video presentation that was preceded by an open-ended questionnaire given to over 300 newly hired interns, residents and fellows asking for descriptions of situations in which they witnessed a failure of supervision and their corresponding response. Our analysis revealed 3 types of failures of supervision. These include failures of monitoring, guidance and feedback. Students' corresponding action was either stifled or acted upon due to a variety of deterrents: fear, powerlessness, middle of the night, or examples or instructions of superiors.

Working with Risk Management provides a viable way to educate trainees on supervision. Using a video of a medical error is effective. In addition, we suggest that during early stages of medical education, learners often make their decisions based upon a reward and punishment model; however, this model does not singularly rest upon the governing principles that guide the practice of patient care, but also includes those values and behaviors that determine their own fate in relation to the medical hierarchy.