Results

**insert table of demographics of interviewees**

We sought to better understand how residents perceived patient care ownership by asking directly what that phrase meant to them. Residents universally recognized the term and defined it using these five categories: being recognized as the doctor taking care of the patient, being the primary communicator, being the person to make decision, holding the most knowledge about the patient, and feeling responsibility. Some challenged the term, remarking “ew. I don’t own anybody. I think we should be thinking about more like partnership” because otherwise we may be “taking away the agency of the patient and the family” [PS]. Because of this skepticism, we are careful to use the term ‘patient care ownership’ rather than the more commonly phrased ‘patient ownership.’ The resulting five themes, discussed in more detail below, follow a flow that aligns with cultural historical activity theory (figure 1).

![Figure 1. Patient Care Ownership as a Cultural-Historical Activity Theory](image-url)
Different residents put different emphasis on the five themes of patient care ownership, and many mentioned more than one and often in ways that interwove them together. We first will describe each theme and then the ways the residents connected the themes.

**Theme 1**  
**Recognition: ‘I am their doctor’**

Recognition is to be seen as a patient’s doctor, to be “treated like you are the expert, even if maybe, again, you don’t know their immunosuppressant regimen that you still know something of [the patient]” [P28]. Recognition occurs at both an external and internal level. At the external level, the connection or relatedness between residents, patients/families, and supervisors/staff determines the amount of recognition the resident receives and often also relies on trust. When others see that a resident’s “perspective on [a patient’s care] is valued and deemed...valid and important” [P10], residents feel worth and purpose. Without recognition as a real provider, residents felt less ownership and less motivation to care for patients. One frustrated resident reported a time when they suggested a plan only to be told “You’re the intern. You don’t know what you’re talking about” as though de facto interns’ opinions aren’t valid. The resident’s response was “I’m not going to touch this patient.” [P16]

Internally, residents may start to recognize that they are part of the team and less a lower level in the traditional hierarchy: “I don’t know that I saw him so much as my senior anymore as more of like another colleague that I was sharing information with and sort of making decisions with” [P16]. There is a feeling that can arise from within based on one’s own actions and not external recognition – a “feeling like you are actually the patient's doctor...[like] you understand what is happening to them and have a plan, whether that's right or wrong...[feeling] like you are the person who is helping them, and who knows what's happening...” [P25].

**Theme 2**  
**Communication: ‘the first contact’**

A second theme of patient care ownership is communication – to be the “first contact when the parents or the nurses have questions or want to talk about the plan” [P15] and then to also make all the involved parties’ voices heard. Communication supports the connections or relatedness between resident, supervisor/staff and patient/family. Communication requires time and space. Time is born out of the structure of things – the schedule, the demand of other menial tasks – “I was on the rotation for a month, and so I got to know [the patient] pretty well...the attendings switch more than the residents do. So I did get to feel like they actually though of me as their doctor, which was nice” [P25]. Space, too, can be afforded by structural components but also relies on cultural expectations – what level of detail needs to be double-checked, how much should an attending speak on rounds. Giving this space for residents empowers them and boosts their confidence. Finally, artifacts like phones and computers, play a role in communication, often hindering opportunity to spend time with families because of the scut-work involved in the daily house officer operations.

**Theme 3**
Decision-making: ‘not just running it by the fellow or attending’

“Decision-making over the patient”, the third component of patient care ownership, was held as a gold-standard of patient care ownership – brought up again and again in the first few breaths of what patient ownership means [P23]. Giving residents space affords them the opportunity to make decisions:

I think when your senior and attending...give you the space and...show that they trust you and really let you make decisions on your own. And don't check in as frequently. That makes you kind of feel like you have more ownership versus if you have someone who's constantly checking in and saying "have you done this? Did you do this? What was the outcome of this?" so frequently then you kind of feel like you're doing more of the scut work while they're overseeing it. P18

Not creating space decreases the trainee’s sense of purpose and motivation:

I found that when there was a fellow for me to ask questions to, or when the third year was there, I sometimes failed to think through it myself fully, and sometimes I would just defer to their judgment...that initial moment of decision-making and thinking through it, sometimes I found myself not taking as much ownership, and allowing other people to help me come to a decision...sometimes that would even result in me... The fellow would have to remind me, "Did you do this? Did you do this?" And I found that when they weren't there with me, I was much more careful and keeping track of all my tasks and having a big bird's eye view on the team. P3

When space isn’t possible, even “to just have a voice” in the decision-making process was enough for residents to feel patient care ownership [P32]. And when this isn’t possible, patient care ownership can still be preserved if the resident presents as “the face of the decisions to the family” [P30].

Theme 4
Knowledge: ‘knowing the patient backwards and forwards’

Knowing your patient is the fourth theme of patient care ownership. This knowledge can be big picture understanding or details that no one else may know:

You need to be the first one to know new results about the patient and to know all the little details about the patient's history or what current meds they're on in their course, that other people who are more kind of supervising and looking over things wouldn't necessarily know. P20

Gaining knowledge about your patient is hard and even harder to come by in high acuity (less familiar) situations for residents, yet they find this understandable and may even not desire “full ownership” because they “don’t have the knowledge to be able to manage them.” [P24] However, knowledge of patient care does not always have to heed the hierarchy of medicine. Continuity over the course of a rotation can give space for a trainee to have knowledge that structurally an attending may simply not be able to gain, even with complex patients.

So often the attendings are on for less time than we are. And so we know some of the kids better, the complex stuff, even if the attendings have more experience and might be able to make each
individual decision, sometimes the complex kids or the socially more complex kids, we end up having more ownership over. P21

Theme 5
Responsibility: ‘you should take responsibility’

Residents spoke about responsibility, the fifth component of patient care ownership, as the culmination of all the other facets of patient care ownership. “When...responsibility is met with...some recognition, perhaps influence, like there’s actual impact to be made, then that begins to feel more like ownership” [P1]. If the resident has knowledge of “the clinical situation the best or as good as anyone can” [P35], if they are able to contribute to decision-making, if they can advocate, or if they are seen as someone to be held accountable, they feel more responsibility.

Interwoven Themes

The themes of patient care ownership overlapped for each resident in a myriad of ways. For instance, while recognition often relied on trust, it didn’t always have to if communication between resident and the staff, supervisor or family was strong. And while decision-making was the gold standard for patient care ownership, often communication was a surrogate marker for residents of patient care ownership when decision-making was not feasible, either by acuity or resident or supervisor comfort. Finally, communication was also felt to often be essential to knowledge acquisition and decision-making. Residents highlighted that they could not attain knowledge if they were not kept in the communication loop. One resident pointed out “ventilator settings are being changed and you have no idea” [P34]. However, with proper communication, residents can use knowledge to be more comfortable and confident in decision-making or communication with others which creates opportunities for more recognition as a doctor. Residents are uniquely positioned to gain special knowledge of patients when a rotation provides the infrastructure for continuity on a level that supervisors are not also able to attain due to the constraints of their schedules.

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Old Themes
THEME #1: OPPORTUNITY FOR DECISION-MAKING
Is affected by the learning environment, patient factors, and resident factors.

Learning Environment
- Culture
- Subspecialist Involvement

Patient Factors
- Complexity
- Acuity

Resident Factors
- Confidence
- Knowledge
- Seniority

THEME #2: PATIENT CARE OWNERSHIP
Is affected by inclusion in decision-making and relationships with patients and families.

Inclusion in Decision-Making

Patient Care Ownership

Relationships with Patients and Families

**Did vary by institution**
THEME #3: CULTIVATION OF PURPOSE

Is attributed to relationships and voice.

Families
Team
Supervisor
Relationships

Purpose
Finding
Holding
Voice

"I think the main thing that I look forward to is being heard and acknowledged. I think that's it...So it's a conversation. It's not someone's completely looking over me..."
~Interview 2