Residents in Difficulty: The “Problem” Resident or The Resident With a “Problem”

Dr. A
- First two years
  - “needs to take more initiative”
  - “needs better organization”
  - “stays late to get all the work done, slow…”
  - Faculty complain about medical decision making
- Third year: multiple critical night float incidents
  - Dx = cellulitis; actual dx = gangrene
  - Inappropriate management of DKA
  - Mismanages RP Hemorrhage

Dr. B
- Transfer from another program
  - “desires a more academic place”
- Resident rumors about uncollegial behavior
- Signing out without finishing workups
- Intern complaints about lack of support
  - Tells intern to look up info
- Critical incident: refuses to help intern with sick patient; patient dies

Outline
- Magnitude of the problem
- Present a staged approach to the problem resident
- Discuss relevant legal issues

Definition – Problem Resident
- ABIM
  - “A trainee who demonstrates a significant enough problem that requires intervention by someone of authority”

So what is your experience?
How common is this problem?
Problem Resident: Magnitude

- Intern end-of-year ABIM scores (Fastrack):
  - 56% satisfactory
  - 14% satisfactory and left program
  - 3% marginal
  - 1% unsatisfactory (50% stay in program)
- “Satisfactory”
  - Transfer residents: 20 - 80% substandard

Do FasTrack Ratings Predict Disciplinary Action?

- 66,171 diplomates -1990-2000
- A low professionalism rating (4 or below) and poor performance on the certifying exam predicted increased risk
  - Nearly twice the risk
  - Over 80% of actions were for unprofessional behavior
  - 31% related to substandard pt care

Papadakis Annals 2008

Problem Resident: Deficiencies

- Yao and Wright study (1999 survey)
  - 94% of programs with at least one resident in difficulty
    (Suspect substantial under-reporting)
- Areas of Difficulty
  - Insufficient knowledge (48%)
  - Poor clinical judgment (44%)
  - Inefficiency (44%)
  - Inappropriate interactions (39%)
  - Provision of poor skills (36%)

Problem Residents: APDIM Survey 2008

- Survey of IM Program Directors
  - 268 programs responded (72% of 372 programs)
- IM residents requiring remediation often have deficiencies in multiple competencies.
- Deficiencies across competencies; remediation most successful for Med Know (86%); least successful for Professionalism (41.2%).
- Application materials rarely identify individuals at risk.
- Deficiencies rarely (5.6%) self-identified.


Approach to evaluation and remediation

1. Problem Identification
2. Investigation
   - Problem confirmation and definition
3. Remediation / Probation
4. Follow-up and decision-making
How do PDs become aware of problem residents (or resident problems)?

**Problem Identification**
Most common process:
- Direct observation in clinical setting
- Critical incident/complaint
- Poor performance (morning report/ITE)
- Neglecting patient care responsibilities

Most common individuals:
- Chief residents
- Attending thru verbal comments
- Other residents
- Written comments from attendings less frequent, self and patients rare

Yao and Wright, 2000

**Common characteristics of initial complaint/concern**
- Vague / poorly defined
- Subjective (“gut feeling”)
- Explainable / defensible
  - Single incident
- Uncertainty

**Faculty Challenges**
- Conflicts:
  - Advocate vs societal/professional obligations
  - Institutional loyalty
- Tendencies:
  - Minimization and temporization - “excuses”
  - Difficulty providing negative evaluation
    - Lack of clearly defined standards
    - Unrecognized value of formative feedback in a competency-based system
- Fear of litigation

**Investigation**
- Preliminary data gathering and decision
- Determine potential impact
  - On patients
  - On peers

**Impact on Patients**
- Patient safety/quality of care must be first concern
- IOM: No longer acceptable that “errors predictable part of the training process”
  - How will patient safety be ensured if the problem resident continues with clinical duties?
  - Should the resident continue with clinical duties?
Impact on Peers

- Failure to act:
  - Confirm potentially pernicious component of the hidden curriculum
    - "It really doesn't matter?"
  - "Having warm bodies is what really matters"
  - Resentment
  - Stress and burnout

Burnout

- The state of being incapable of producing a desired effect or result.
- Three components
  - Emotional exhaustion
  - Depersonalization
  - Professional inefficacy

Burnout (and Depression)

- Univ. of Washington Study
  - 115 residents surveyed
  - 76% of residents met criteria for burnout
  - 50% reported depressive symptoms
  - 53% of residents with burnout reported suboptimal patient care practices

  Shanafelt, Ann Intern Med, 2002

The Effect of Work Hour Restriction

- 2003 follow-up
- 161 IM residents surveyed
  - Career satisfaction increased from 66 to 80%
  - Emotional exhaustion 53 to 40%
  - Negative effect on patient care and education
  - Overall majority approved of WHR (65%)

  Goitein Arch Intern Med. 2005

Burnout – Physicians vs General Population

46% of responding physicians reported at least one symptom of burnout.

<table>
<thead>
<tr>
<th>Physicians</th>
<th>General Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burnout Symptoms</td>
<td>Burnout Symptoms</td>
</tr>
<tr>
<td>38%</td>
<td>28%</td>
</tr>
<tr>
<td>(IM – 54% - 2nd highest)</td>
<td></td>
</tr>
<tr>
<td>Dissatisfaction-Work/life</td>
<td>Dissatisfaction-Work/life</td>
</tr>
<tr>
<td>Balance</td>
<td>Balance</td>
</tr>
<tr>
<td>40%</td>
<td>23%</td>
</tr>
<tr>
<td>(IM – 44%)</td>
<td></td>
</tr>
<tr>
<td>60 hour work week</td>
<td>60 hour work week</td>
</tr>
<tr>
<td>38%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Shanafelt Arch Intern Med 2012

Potential Causes

- Secondary causes
  - The 6 Ds
  - Systems issues
- Impairment
- Cognitive vs Non-cognitive
Secondary Causes

- Causes (6Ds):
  - deprivation
  - distraction
  - depression
  - dependence
  - disordered personality
  - disease

Reality of Secondary Causes

- Does not excuse poor performance
- Presence may necessitate LOA
- Evaluation by non-teaching physician (employee health) to assess ability to work and learn

  *Your role is as an educator, not a treating physician. You should not diagnose/treat your learners*

Is a Secondary Cause Resulting in Impairment?

Impairment

“....unable to fulfill professional or personal responsibility because of psychiatric illness, alcoholism or drug dependence.”

Annals 1988

Magnitude:
- Narcotic addiction 30 - 100X more likely
- Residents - 13-14% with alcoholism

Who to suspect?
- Frequent absences, tardiness
- Weekend problems
- Impulsivity, irritability
- Performance change

.... *Requires decompensation!*

Learning Disabilities and ADHD

- ~ 5% of med students
- Minority diagnosed in medical school
  - Only a problem with standardized tests when volume of material exceeds coping strategies
- Exposed in residency
  - Stimulus rich environment
  - Need for extensive synthesis and processing of diverse data
Problem Confirmation and Definition

- Further diagnostic evaluation:
  - Utilize employee health
  - SP-based exam, mini-CEX, CSR
  - Time with the "GOLD STANDARD" evaluator (Core Faculty)
- Identify the specific deficiency(s)
  - Cognitive vs. Non-cognitive

Cognitive vs. Non-cognitive

- Cognitive:
  - knowledge, higher cognitive (clinical judgment) and clinical skills → growth along a continuum
- Non-cognitive:
  - professionalism, inappropriate interpersonal skills → “on / off” manner (right vs. wrong)
- Not mutually exclusive

Dr. B

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- Resident rumors about uncollegial behavior
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  - Tells him to look up info himself
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Decision Point - Options

- No further action - routine evaluation
- Counseling - routine evaluation
- Counseling - follow-up
- Further evaluation
- Remediation
- Administrative action
  - Probation, delayed promotion, dismissal

Problem identified

Pt safety at risk
  - No pt safety concern
    - Non-cognitive (Behavioral)
      - Cognitive (Academic)
    - Pull from Pt care
      - Fitness for duty
        - Accommodate
          - Remediate
            - Dismiss

Cognitive Problems - Remediation

- Specific to the deficiency
- Improvement opportunity
  - Requires a change in culture!
  - Not disciplinary/punitive action –it’s part of learning
- Outline plan including resident’s responsibility to improve
- Define target objectives and intermediate goals and objectives for continuous improvement
Remediation
- Delineate consequences of failure
  - Probation
- Establish time frame
  - *Cannot be open ended*
- Assign mentor/advocate
- Document everything
- Protect resident confidentiality
- Comply with due process

Proposed Model for Remediation

- Multi-modal Assessment
- Diagnosis of Deficiency and Development of Individualized Learning Plan
- Instruction/Remediation Activities with Deliberate Practice, Feedback and Reflection
- Focused Reassessment and Certification of Competence/Mentoring

The State of the Art
- Remediation of the deficiencies across the continuum from medical school to practice: a thematic review of the literature.
  - 13 studies describing small single-institution efforts to remediate MK and clinical skills
  - Paucity of evidence to guide best practices

Non-cognitive Problems - Probation
- Professionalism or deficient interpersonal relationships
- Professionalism problems
  - Unmet professional responsibility
  - Lack of effort toward self-improvement
  - Diminished relationships
- Corrective action: stop behavior —— *probation*

Non-cognitive Problems
- Right vs. wrong behavior
- Goal: Behavior must stop
  - Consider secondary causes
  - Consider counseling
  - Review standards
  - Responsibility for adherence is resident’s
- Insight may be a problem
Comparison of Corrective Action Plans

<table>
<thead>
<tr>
<th>Deficiency</th>
<th>Cognitive or Ineffective Behavior (Skills)</th>
<th>Non-cognitive: Unprofessional/Inappropriate Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process</td>
<td>Remediation</td>
<td>Probation</td>
</tr>
<tr>
<td>Goal</td>
<td>Improvement</td>
<td>Stop the behavior</td>
</tr>
<tr>
<td>Expected Progress</td>
<td>Gradual and sufficient</td>
<td>Immediate and sustained</td>
</tr>
<tr>
<td>Faculty Role</td>
<td>Tutors / mentors</td>
<td>Clarification of standards/surveillance</td>
</tr>
<tr>
<td>Outcome if unsuccessful</td>
<td>Extension of training</td>
<td>Dismissal</td>
</tr>
</tbody>
</table>

Legal Issues

- Fear worse than reality
- US Supreme Court - “courts are particularly ill-equipped to evaluate academic performance”
- Courts don’t interfere with professional judgments if:
  - decisions fair and equitable
  - due process followed

Litigation in Medical Education

- 329 cases in ten year span (1993-2002); 171 involved residents
- 63% (108/171) were brought by residents
  - 40% named faculty members as co-defendants
- 80% of claims directly challenged institutional actions (rejection, demotion, dismissal)
- More than half alleged discrimination

Legal Issues

- 13% Lack of due process claimed
  - Institution failed to have or adhere to established policies for reviewing, promoting, disciplining and terminating
- 13% Breach of employment contract claims
- 6% Straight challenges to an institution’s decision to dismiss.

>90% of the time institutional defendants “won”

“Student” or “Employee”?

- Both!
- Protected as students with respect to their educational environment and clinical settings in which they learn
- US Supreme Court ruling (2011): teaching hospitals must pay Social Security and Medicare taxes for their medical residents because they are workers and not students, for tax purposes at least.
- Are your actions directed at an academic issue or a misconduct?
- Due process is required, but looks different

Legal Cases

- Academic (Student) issues
  - Knowledge-based
  - Lack of core competency
  - Lack of specialty training
  - Lack of introspection
- Misconduct (Employee) issues
  - Dishonesty, medical record forgery
  - Harassment
  - Disruptive behavior
  - Theft
  - Violence
Due process for Academic Issues (Students)

- Training programs are free to dismiss or not promote as long as students are:
  - Given notice and opportunity to cure
  - Decisions that are careful and reasoned
    - Clinical competency committee
  - Decisions based upon due process
- Due process should be the process that you do!

Due Process for Misconduct (Employee)

- No need for opportunity to repeat misconduct
- However, must give:
  - Notice of the charges of misconduct
  - An opportunity to be heard
    - Not a trial, hearing, or review board
    - No lawyers, evidence, or testimony
    - A meeting - possibly with a neutral reviewer
  - A careful and reasonable decision making process

Legal Cases: Principles Demonstrated

- University of Missouri v. Horowitz
  - Due process requirements for students
- Stretten v. Wadsworth Veterans Hospital
  - Substantial due process
- Marmion v. Mercy Hospital
  - Non-cognitive issues and adverse effect
- Kraft v. White Psychiatric Foundation
  - Negative clinical evaluations and defamation

Board of Curators of the University of Missouri v. Horowitz (Med Student)

- Excellent academic performance
  - Unsatisfactory clinical performance – poor bedside manner, poor hygiene
  - Student informed promotion at risk
  - Given a one month rotation (5 evaluators)
  - Dismissed after committee review - student not allowed to appear

Missouri v. Horowitz

- Sued:
  - Due process violated
  - Religious discrimination
  - Decision based upon non-cognitive factors not academic performance

Board of Curators of the University of Missouri v. Horowitz

- U.S. Supreme Court upheld decision:
  - Notice of problem and opportunity to cure
  - Student received ample warning
  - Decision at a regular faculty meeting called for the purpose (appropriate due process)
  - Formal hearing/appeal not required
  - Noncognitive factors are grounds for dismissal
<table>
<thead>
<tr>
<th><strong>Horowitz</strong></th>
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<tbody>
<tr>
<td>As long as the student/resident receives:</td>
</tr>
<tr>
<td>• Notice and opportunity to cure</td>
</tr>
<tr>
<td>• Faculty decision is conscientious and deliberate</td>
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</tbody>
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_Courts will not second guess the academic decision_

<table>
<thead>
<tr>
<th><strong>Written Policies and Procedures</strong></th>
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<tbody>
<tr>
<td>• The more complicated the P &amp; P, the harder it is to comply</td>
</tr>
<tr>
<td>• Policies frequently create a higher standard than required by law</td>
</tr>
<tr>
<td>• What you write defines the due process to which you must adhere</td>
</tr>
<tr>
<td>• Frequently, this policy is different than the process that you do!</td>
</tr>
<tr>
<td>• Does not reflect your routine decision-making practices</td>
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<table>
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<tr>
<th><strong>Stretten v. Wadsworth Veterans Hospital</strong></th>
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<tbody>
<tr>
<td>• Pathology resident</td>
</tr>
<tr>
<td>• Stipulations in appointment letter</td>
</tr>
<tr>
<td>• &quot;for the duration of training unless terminated sooner – subject to periodic review by residency review board&quot;</td>
</tr>
<tr>
<td>• Notified of nonrenewal 9 months into internship</td>
</tr>
<tr>
<td>• Sued: - Entitled to notice and trial-type hearing</td>
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<th><strong>Stretten v. Wadsworth Veterans Hospital</strong></th>
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<tr>
<td>• Wide discretion for decision-maker but &quot;bound not to act in bad faith or in an arbitrary and capricious manner&quot;</td>
</tr>
<tr>
<td>• Resident entitled to:</td>
</tr>
<tr>
<td>• Notice of deficiencies</td>
</tr>
<tr>
<td>• Opportunity to examine evidence</td>
</tr>
<tr>
<td>• Opportunity to present case to decision-maker</td>
</tr>
<tr>
<td>• Full adversarial hearing not required</td>
</tr>
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<table>
<thead>
<tr>
<th><strong>Legal Issues: Due Process</strong></th>
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</thead>
<tbody>
<tr>
<td>• Notice to resident:</td>
</tr>
<tr>
<td>• Written (letter of deficiency)</td>
</tr>
<tr>
<td>• Concerns / charges / deficiencies</td>
</tr>
<tr>
<td>• Consequences</td>
</tr>
<tr>
<td>• Opportunity to review and respond:</td>
</tr>
<tr>
<td>• Examine and address concerns</td>
</tr>
<tr>
<td>• Present to (impartial) decision-maker</td>
</tr>
<tr>
<td>• Formal hearing:</td>
</tr>
<tr>
<td>• Not absolutely required</td>
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<table>
<thead>
<tr>
<th><strong>Marmion v. Mercy Hospital &amp; Medical Center</strong></th>
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</thead>
<tbody>
<tr>
<td>• Resident terminated:</td>
</tr>
<tr>
<td>• Failure to communicate</td>
</tr>
<tr>
<td>• Refusal to consult with attending physicians</td>
</tr>
<tr>
<td>• Refusal to follow hospital protocols</td>
</tr>
<tr>
<td>• Disobedience and disrespect</td>
</tr>
<tr>
<td>• Faculty determined that future patients might suffer</td>
</tr>
</tbody>
</table>
Marmion v. Mercy

Courts upheld that it is not necessary to show adverse effect in order to terminate (or suspend clinical activities)

Kraft v. William Alanson White Psychiatric Foundation

- Trainee denied certificate of completion - unsatisfactory clinical evaluations
- Alleged - defamatory statements by faculty
- Court found:
  - Negative evaluations were not defamatory
  - Relevant to evaluation with limited publication
  - Faculty protected by absolute privilege
  - Evaluation intrinsic to education
  - Implied agreement for evaluation

Childern’s Hospital of Cincinnati

- PGY-3 Transfer Surgical Resident
  - Left hospital during shift/failed to report the next day
  - Complained about covering absent resident
  - PD suspended resident, initiated inquiry, and two days later terminated the resident
  - Identified additional academic problems and incomplete reporting of prior training
  - Resident apologized/requested reinstatement
  - PD refused

Cincinnati

- Resident requested review by GMEC
- PD conducted GMEC review and upheld his earlier decision
  - Did not inform resident of additional findings
- Resident sued and court sided with resident
  - PD did not provide notice/opportunity to “cure”
  - GMEC was not a “fair hearing”
  - PD made the decision
  - PD violated hospital’s policy

Legal Issues: General Guidelines

- Utilize your Legal advisor
- Know Institutional procedures / policies
  - Implement a due process procedure AND FOLLOW IT!
- Early problem recognition
- Make decisions by committee
- Communication and Documentation
  - Concerns, remediation, expectations, consequences

Communicating re: Adverse Actions

- State facts
  - “Failed to meet standards of …”
- Describe mitigating circumstances
  - “occurred during personal stress”
- Describe outcomes
  - Despite remediation, was unable…
  - After remediation, successfully completed program and subsequently
  - Educate about responsibility to disclose
Questions?