Working with the Professionally Challenged/Challenging Resident

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Professionally Challenged/Challenging Resident

Objectives

• Develop strategy for evaluation of resident who demonstrates unprofessional behavior

• Develop a plan of action for addressing the resident who demonstrates unprofessional behavior
Case #2

You’ve just received the fourth complaint about resident M.B. from nursing staff.

She is currently in a dispute with your Program Administrator regarding time off which was unapproved.

Senior staff likes M.B., but she consistently gets very low evaluations from the med students.

What should you do?
An estimated 3-5% of physicians and nurses exhibit ‘disruptive’ (unprofessional) behavior.

The Joint Commission Journal on Quality and Patient Safety

Safety Culture

Instituting a Culture of Professionalism: The Establishment of a Center for Professionalism and Peer Support

Jo Shapiro, MD, FACS; Anthony Whittemore, MD, FACS; Lawrence C. Tien, MD

Leaders of medical institutions are responsible for creating environments in which physicians, scientists, and other health care professionals are able to sustain their deep capacity for high-quality, compassionate care. Creating such environments depends on supporting a culture of trust, which has been identified as the core of successful leadership.

The mission statements of both academic and communi-

Article-at-a-Glance

Background: There is growing recognition of the importance of professionalism in patient care. Professionalism, enforced, can result in medical errors, adverse patient outcomes, and unsafe work conditions.

Table 1. Primary Reported Professionalism Lapses by Physicians/Scientists, January 1, 2010–June 30, 2013 (N = 201)

<table>
<thead>
<tr>
<th>Complaint Category</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demeaning</td>
<td>55 (27)</td>
</tr>
<tr>
<td>Angry</td>
<td>51 (25)</td>
</tr>
<tr>
<td>Uncollegial</td>
<td>16 (8)</td>
</tr>
<tr>
<td>Patient communication</td>
<td>16 (8)</td>
</tr>
<tr>
<td>Shirking responsibilities</td>
<td>11 (5)</td>
</tr>
<tr>
<td>Hypercritical</td>
<td>8 (4)</td>
</tr>
<tr>
<td>Clinical competence</td>
<td>8 (4)</td>
</tr>
<tr>
<td>Misconduct</td>
<td>7 (3)</td>
</tr>
<tr>
<td>Sexual innuendo</td>
<td>6 (3)</td>
</tr>
<tr>
<td>Other (for example, sexual harassment, substance abuse, boundary issues, leadership competence)</td>
<td>23 (11)</td>
</tr>
</tbody>
</table>

Professionally Challenged/Challenging Resident

Plastic Surgery
Prog Reqs 7/1/17:
• IV.A.5.e
• V.A.2.b
• V.B
• VI.A
• VI.A.5

V.B. Faculty Evaluation

V.B.1. At least annually, the program must evaluate faculty performance as

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Plastic Surgery
Prog Reqs 7/1/17:
- IV.A.5.e
- V.A.2.b
- V.B
- VI.A
- VI.A.5

V.A.2.b) The program must:

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V.A.2.b)(1)

provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones; (Core)
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Why is professionalism ‘special’?

• Subordinate interests to the interests/needs of patients (Hippocratic Tradition)
• Seek excellence in competency (Hume)
• Treat all with respect (Patients, colleagues, subordinates)
• Definition of professional = self-regulating
• If medicine doesn’t self-regulate will lose [any semblance of] autonomy
• Unprofessional behavior – unless corrected - tends to recur or continue through practice
Unprofessional Behavior and Professional Outcomes
Maxine A. Papadakis, M.D.
Dr. T is a senior-level resident who has had average to above average evaluations in the program, until about 2 months ago. From the beginning of an away rotation, he has been noted to be late arriving to clinic, did not follow up on a VIP patient as instructed by the supervisor, has not participated in your program’s video-teleconferenced grand rounds, has not engaged in any of the social activities there (historically a popular part of that rotation), and has not responded to the program coordinator’s prompts re: logging recent duty hours. The site supervisor’s mid-rotation evaluation “this is the laziest resident I’ve seen in a long time.”
How is a ‘Challenging learner’ situation analyzed in your institution?

First level = within the program

Your professional role

Use your policies & procedures, terminology
Consult with your DIO (early & often!)

ALWAYS get the other side[s] of the story!

Clinical suspension for investigation?
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Academic vs Misconduct – ACGME requires ‘Due Process’

• **Academic Action** (+/- Professionalism)
  1. Notice of deficiency
  2. Opportunity to *improve*
  3. Reasonable decision-making process
     “Fair hearing” not required
     Opportunity for “neutral reviewer”

• **Misconduct (some Professionalism)**
  Notice of misconduct
  Opportunity to be *heard*
  Reasonable decision-making process
Professionally Challenged/Challenging Resident

Misconduct: Observed behaviors

- Absenteeism (also part of academic deficiencies)
- Drugs, firearms* in the workplace
- Legal (arrests, indictments, etc. - depends)
- Fighting, stealing
- Etc.

*In Texas, you can openly carry a handgun in a hip or shoulder holster, provided you have a concealed-handgun license.
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What about dysfunction/impairment?
The 7 “Ds” of dysfunction*

1. Distraction (life events of 20s-30s)
2. Depression (2–35%)  
3. Drugs (alcoholism 5–15% resident surveys)
4. Disease (thyroid; meds for other disorders)
5. Disability
6. Deprivation (sleep, OSA, pre-event dieting)
7. Disorders (personality)

*Sen S., et al. Arch Gen Psychiatry 2010
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Mental Health Concerns - Not your job to diagnose or treat – need means for professional assessment & management

Numerous, can be multiple

• Depression (up to and including suicide)
• Anxiety
• Burnout
• ADHD/ADD
• Personality disorders

Substance use
• With medical board/PHP, individual’s medical license can usually be protected
When there is concern re: **Professionalism**

PACC*

- **Person** – performance in the program; prior?
- **Act committed**
- **Circumstances**
- **Consequences** – was the patient harmed?

*Concept developed for ACGME Workshop by W. Scott Jones, M.D., DIO at SAUSHEC, San Antonio, TX, and used with permission.*
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Your CCC learns:

• P – marriage in trouble, he’s being accused of child neglect; trying to commute home on 2-3 x/wk (3 hr drive) – has been late ‘a couple of times’ d/t traffic; very tired, very stressed

• A – distracted, inattentive; recent dx ADD, trying online CBT, not yet on meds, missed seeing patient

• C - VIP and his entourage had already left the clinic before Dr. T could get to him, PA said she’d help him with that (but didn’t)

• C – distrust of the away group, uncertain whether they’ll continue to support that salary line; credit for the rotation?

PACC*
Person – performance in the program; prior?
Act committed
Circumstances
Consequences – was the patient harmed?
The Professionally Challenged Resident

BK gets beeped as he is about to present a case to the visiting professor. After conference you overhear the residents grumbling about the fact that BK always avoids presenting.

A few weeks later, you ask BK to change a dressing. When you check on the patient. The dressing wasn’t changed. BK says he asked the nurse to get supplies but none were available.

A faculty member reports that she was unsure BK was actually in the ED when he called about an ED consult.
VI.B. Professionalism in new Common Program Requirements

Describes **professionalism** in the context of being a physician:

- Ultimate responsibility - comprehensive patient care
- Supports patient safety
- Personal responsibility
- Understanding and acceptance of their personal roles in:
  - accurate reporting of work hours
  - patient outcomes
  - clinical experience data.

Critical importance of:

- Awareness & accountability for fitness for duty
- Responsiveness to patient needs supersedes self-interest
- Sometimes - best interests of the patient served by transitioning care
The Professionally Challenged Resident

Your chief resident tells you she is concerned that YQ came in from home to see a patient in the ED while YQ was drunk.
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How is a ‘professionally challenged resident’ situation adjudicated in your institution?

• Role of program leadership - CCC
  • What are your program policies?
  • How are they shared with & role-modelled to your residents?
  • Are your evaluations (resident and faculty) of professionalism useful?

• Role of GME leadership – GMEC & DIO

• Due process
  • ACGME - IV.C.1.b) The Sponsoring Institution must have a policy that provides residents/fellows with due process relating to the following actions regardless of when the action is taken during the appointment period: suspension, non-renewal, non-promotion; or dismissal. (Core)
  • Do you have an appeal process?
  • Beginning and end points of appeal?
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Standards

• Consider system-wide uniform standards, definitions of remediation, discipline, extension, etc.
• Verbal Counseling
• Letter of Counseling / Program Level Remediation
• Program or Institutional level ‘adverse status’ (probation, warning, etc.) (Reportable)
• Termination (Reportable)
• Non-renewal (Reportable)
• Professionalism contract?
• Naval Medical Center, San Diego (Medicine program)
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All in your SI (Residents, Programs, GME) benefit from:

• Explicit expectations ‘essential abilities’ – part of GME Policy Manual
• Policies and procedures
• Sound evaluations/systems (most important job of your faculty)
• Attestations (resident is responsible for knowing) – at interview & orientation (form with url)
• Resident Contract – incorporation by reference
• Due process
• Willingness to follow institutional processes
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GME Policies

• Create levels of academic status – in-program, institutional level, whether or not reportable, etc;
• what can be appealed (Instit Reqs)?
• how will your institution handle ‘appeal’ – construct of person/panel/etc; how high up the org chart does the process go?

• Non-renewal – what does that mean? Wasn’t the resident ‘promised’ a program by matching? (NRMP and ACGME language) annual contracts
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Written documentation
• Why resident is being counselled/remediated/whatever
• Implications
• Timeline and means for reassessment
• Return to good standing
• Consequences of failing to remediate
• Rights, resources

• Notes to the file - prn
An Evaluation of Plastic Surgery Resident Selection Factors

Fan Liang, MD, Pamela A. Rudnicki, BS, Noah H. Prince, MD, Stuart Lipsitz, ScD, James W. May Jr., MD, and Lifei Guo, PhD

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OBJECTIVE: Our purpose was to provide a metric by which evaluation criteria are prioritized during resident selection. In this study, we assessed which residency applicant qualities are deemed important by members of the American Association of Plastic Surgeons (AAPS). tolerant of narcissism (CTE p = 0.002, 0.005, and 0.003, respectively). Lastly, academic surgeons and program directors look more favorably upon strong team players (CTE p < 0.00001 and p = 0.008, respectively), but less so over time (Mantel-Haenszel trend p = 0.006).
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In summary,

• Develop strategy for management of professionally challenged residents and the faculty involved
• Construct program level policies/procedures
• Make your culture crystal clear – on day 1 and thereafter – what will and won’t be tolerated
• Identify potential actions to mitigate negative fall-out for participants, other learners, faculty, and patients
Challenging Learners

THANK YOU!
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