LIFE

LEARNING TO ADDRESS IMPAIRMENT AND FATIGUE TO ENHANCE PATIENT SAFETY

TEACHERS GUIDE II

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Learning to Address Impairment and Fatigue to Enhance Patient Safety

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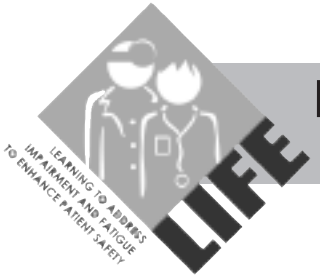

LEARNING TO ADDRESS IMPAIRMENT AND FATIGUE TO ENHANCE PATIENT SAFETY

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PREFACE

Many of us view the goal of the ACGME's outcomes project as producing competent residents. But the emphasis on competency extends to us, in our own continuing professional development, as well as our programs. Perhaps of greatest importance, is the implicit emphasis on creating competent programs and institutions in which our trainees train.

Generally our best learning opportunity is not the self-motivated, self-actualized, "model resident". Rather, we usually stretch the most by encountering resident situations that are in some way "challenging". For an individual program director, these opportunities are usually relatively rare. But there is the inevitable "first time", when you encounter one or more of the tough issues: substance abuse, depression, and burnout among others. Fortunately, these are almost never encountered on the same day.

This project was conceived as a tool to give program directors, faculty, and residents the opportunity to think through many of these situations prospectively. In the safety of a learning setting, "vignettes" such as the ones presented in this program, can be reflected on without the usual complicating factors such as dealing with particular personalities, or the frenzy of immediate decision-making.

I am grateful to my DIO, Dr. John Weinerth, for mentoring my early efforts as a program director, and now rewarding me with the time and space to work with GME. To my co-collaborator, Dr. Cefalo, DIO emeritus at UNC, I appreciate your patience and model of effective multi-tasking as DIO, Associate Dean, and Chair! My special and ongoing thanks to Joe Kertesz, who contributes wisdom, respectfulness, and kindness to all he does.

To our committed Advisory Board, and skilled faculty and contributors, words provide insufficient thanks. The errors are mine; the kudos are all yours. To DazMedia, Lori Rochelle and Mike O'Malley, I appreciate your making our concepts come to life. To Dr. Osborne, I will always appreciate your challenging me towards greater collaboration and scope, and allowing this effort to be creative as well as content rich.

I hope these curricula can serve as a tool for implementing effective strategies to address fatigue and impairment. Ideally, we hope to prevent certain situations, and when not prevented, to identify early, and manage respectfully and responsibly. As we do so, we demonstrate practice-based learning and improvement, as well as professionalism, systems-based practice, and interpersonal, and communication skills.

Let me know how we can improve.

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LEGAL ISSUES IN RESIDENCY TRAINING

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GOAL

This module introduces the participants to many of the legal issues that are inherent to residency programs. The module also suggests strategies for avoiding litigation when taking action against residents, while at the same time presenting important information about the legal process.

LEARNING OBJECTIVES

After working through this program, you should be able to:

- Discuss corrective action plans for residents with performance or behavior problems and the legal ramifications of each type of action plan
- Define what professionalism means within a legal context and recognize how to respond to breaches of expected standards of professionalism
- Explain the legal issues involved when residents are considered "students" versus when residents are considered "employees"
- Distinguish between academic and misconduct matters and be able to deal with both appropriately
- Identify the possible areas of litigation in which an institution associated with residency training can become involved
- Describe preemptive measures that can help in avoiding litigation

SCENARIO SUMMARY

A program director is meeting with a legal counselor about a resident who has been suspended (a decision of the Clinical Competence Committee or CCC) for inadequate performance. A psychiatrist, mandated by the program, has already diagnosed the resident and advised her to seek treatment, which she refused to do. The program director is asking about the next steps for a plan of action.

The legal counselor replies that there are no options remaining, and the resident will have to be retained by the program. She also states that the program director and the program will have to deal with any ramifications by themselves.

DISCUSSION QUESTIONS:

- What are the implications of a required psychiatric examination?
- What kinds of information should the program director, faculty, and/or hospital management (DIO) have regarding a resident's medical condition?
- Did the program and Clinical Competence Committee (CCC) take the correct action in suspending the resident?
- Does the resident's confirmed psychiatric condition qualify her for leave under the FMLA?

Inaccurate assumptions that underlie the initial scenario include the following:

- Program directors need to be wary of any action taken against an impaired resident
- Residents are always ready to take legal action against any disciplinary steps taken by the residency program/hospital
- The only time that a legal counselor needs to be brought into a situation is when there is a legal threat

SCENARIO RERUN

A program director is meeting with a legal counselor about a resident who has been suspended (a decision of the Clinical Competence Committee or CCC) for inadequate performance. A psychiatrist, mandated by the program, has already diagnosed the resident and advised her to seek treatment, which she refused to do. The program director is asking about the next steps for a plan of action.

The legal counselor informs the program director that the appropriate process was not followed in this particular resident's case. The appropriate process would have been to focus on the resident's academic deficiencies and involve the Employee Health Program for a 'fit for duty' assessment. Calling another meeting with the CCC and the legal counselor is the next step to work out a plan of action.

The rerun attempts to teach the following principles:

- Make sure that there is sufficient documentation concerning any resident who exhibits inadequate performance
- Do not base any corrective action on the personal health of a resident
- Involve the necessary resources including the Employee Health Program and the legal counselor as soon as a resident with suspected problems is identified
- Fit for duty evaluations can be mandated, but should be directed by Employee Health and not the program director in order to protect the program

PROGRAM TEACHING POINTS

RESIDENTS WITH PROBLEMS

The goal of every residency program is for every resident to successfully complete the program, however, residents who are disruptive or otherwise not trainable need to be dealt with in a fair and legally sound manner. If a resident is not competent to practice the profession or specialty safely and independently (commensurate with their level of training), action is necessary to prevent passing the incompetent physicians on to the next level, or worse, the patient population.

The program director is usually the point person when a problem is identified and is in charge of monitoring the workplace behavior of certain residents before they are even identified as residents with problems. Program directors are also in charge of remediation or corrective action plans when they are needed.

Every program should have carefully designed policies for handling grievances that protect the resident's due process as well as the needs of the sponsoring institution. Careful attention to these policies facilitates effective action and minimizes the chances of litigation.

RESIDENT DISCIPLINE

Resident discipline should be generally thought of in one of two major categories: academic remediation/improvement or behavioral misconduct. Academic deficiencies are generally handled in a way that treats residents as students, and therefore provides an opportunity for remediation. Misconduct matters should be handled as employment matters and, often do not require an opportunity for remediation. Allowing a resident with behavior issues an opportunity to commit further misconduct often creates greater risks of liability than removing the resident from the program.

Academic Deficiencies	Behavioral Misconduct
Residents are students	Residents are employees
Curriculum	Personnel Policies
ACGME Requirements	Workplace Requirements
Academic Law	Employment Law
Notice and opportunity to cure	Notice and opportunity to respond

The ACGME requires institutions to provide residents with "fair and reasonable written institutional policies and procedures for grievance and due process." Due process is an individual's right to be adequately notified of any charges or proceedings involving him or her, and the opportunity to be meaningfully heard at those proceedings. For academic deficiencies, due process can be thought of as 'notice and the opportunity to cure'. For misconduct matters, it is 'notice and the opportunity to be heard'. In both types of situations, due process must also involve a 'reasonable decision-making process'.

S A M P L E
DUE PROCESS POLICY

I. Purpose:

To establish a policy for all post-graduate training programs within the ABC Hospital to use in reviewing all actions resulting in dismissal or otherwise altering the intended career path of the house officer.

II. Scope:

This policy will apply to all house officers who participate in a graduate medical education (GME) training program within the ABC Hospital. Due Process, as described within, applies to actions that are taken as a result of academic deficiencies or misconduct (see related Academic Improvement Policy and House Officer Misconduct policy)

III. Definitions:

A. *House Staff or House Officer* – refers to all interns, residents and fellows enrolled in a post-graduate training program.

B. *Graduate Training Program* – refers to a residency or fellowship educational program.

C. *Dismissal* – The act of terminating a house officer's participation in a training program prior to the successful completion of the course of training, whether by early termination of a contract or by non-renewal of a contract.

IV. Academic Matters:

The Hospital's Academic Improvement Policy affords due process to house officers who are dismissed from a residency program or whose intended career development is altered by an academic decision of a program. See Academic Improvement Policy for delineation of the specific processes available to a house officer to challenge an academic decision made by his/her department.

V. Misconduct Matters:

The Hospital's House Officer Misconduct Policy affords due process to house officers who are disciplined or dismissed from a residency program in a manner that alters their intended career development. See House Officer Misconduct Policy for delineation of the specific processes available to a house officer to challenge discharge or discipline decisions based on alleged misconduct by a house officer.

IDENTIFYING RESIDENTS WITH PROBLEMS

- Evaluations and other documents
- Direct observation and feedback from:
  - — Nurses and Allied Health Workers
  - — Peers
  - — Patients
  - — Medical Students
  - — Attending Physicians

Attending physicians should have a structured forum where the faculty can discuss concerns as well as critique resident performance. In these forums, verbal assessments should be part of the evaluative process.

CLINICAL COMPETENCE COMMITTEE (CCC, PROGRESS AND PROMOTIONS, EVALUATION COMMITTEE)

- Evaluates achievement of the core competencies and the curriculum
- Identifies misconduct matters
- Enlists verbal feedback from the faculty
- Recommends actions (promotion, remediation) to the Program Director

Once a resident with problems such as suboptimal performance or disruptive behavior has been identified, prompt action is required to prevent the possibility of more serious incidences from occurring, and to decrease the exposure of other personnel and/or patients. Additionally, prompt intervention can be the key to immediate improvement. Delayed intervention is not helpful to the resident or the program. Appropriate action decisions can be made when program directors are knowledgeable about the policies and available resources.

POLICIES AND PROCEDURES SHOULD INCLUDE:

- Physician and/or Employee Code of Conduct
- Misconduct Policy
- Academic Performance/Improvement Policy
- Due Process
- Grievance
- Leave of Absence
- Duty Hours
- Evaluation Policy
- Promotion Policy
- Termination and Non-Renewal Policies

All of these policies and procedures should be written as concisely as possible and reviewed by an attorney who is familiar with academic issues. Program and departmental policies must also be reflective of the institution's GME, and HR policies and processes. Due process policies are typically institutional policies and include a forum such as a 'fair hearing committee' or a 'review action'.

An effective program director has a team at his or her disposal to assist in various matters. Knowing your team and having a good working relationship with each

member will enhance a program director's ability to act effectively. The team should include the director of GME or designated institutional official (DIO), and may also include representatives of legal, human resources, employee health, security, and other departments in the hospital. Appropriate referral and counseling services should be coordinated with your institution's occupational (employee) health department and human resources.

ACADEMIC ISSUES

Corrective action for academic problems should involve a multi-step process. The first, and most important step is to notify the resident of the concerns. Typically, this is accomplished through routine verbal feedback provided by the supervising attending during an assigned rotation. When concerns are not resolved at this juncture, they should be documented in the rotational evaluation. If deficiencies remain, then the message needs to be amplified. One way to do this is to give the resident a letter or memo which includes notice of the academic deficiency(ies), the program's general expectations for achievement, and a timeline for appropriate completion.

FORMAL NOTIFICATION SHOULD INCLUDE THE:

Adapted from the five-step policy of Dr. John Weinerth, Duke University

- Deficiency described in behaviorally specific terms with examples
- Remediation plan, including a timeline
- Defined goals, including points of assessment
- Consequences of success or failure to meet the goals
- Signature of Program Director (and others as dictated by your policy)

The timeframe and goals of the remediation plan do not usually follow a standardized program, but should be designed to fit the needs of the resident, the deficiency, and the program. Progress on a remediation plan can be measured both objectively and subjectively, and the assessment should reflect the goals. The process is then documented in the resident's performance file along with a follow up letter stating whether the resident successfully completed the plan, and future monitoring.

If the resident has successfully completed the plan, then no further action is warranted. If, however, the resident does not adequately complete the remediation, then further action may follow. Some institutions utilize a "probation" status as a next step. Typically, probation is handled like the remediation process, but it is commonly reported in future requests for verification, and therefore would be subject to due process. Probation is not a required next step. As long as a resident has been given notice and an opportunity to cure, institutions may choose to have policies that allow them to take actions ranging from continued remediation to immediate dismissal from the program.

FURTHER CORRECTIVE ACTIONS FOR ACADEMIC PROBLEMS REQUIRING DUE PROCESS INCLUDE:

- Probation or other reportable statuses
- Extension of training
- Election not to promote
- Non-renewal of contract
- Termination or dismissal

In addition to notice and an opportunity to cure, due process requires that academic decisions be made in a reasonable manner. One way to assure this is to give residents an opportunity to raise concerns by requesting a review of the decision. This review can be accomplished in a variety of venues, ranging from a simple meeting with another decision-maker, to a complex multi-party hearing. Be aware of your institution's due process policies and processes associated with academic decisions as well as misconduct issues.

GME PROCESS: ACADEMIC MATTERS

STRUCTURED FEEDBACK
Routine feedback consistent with educational programs:
Verbal feedback, Rotational and Summative Evaluations
Discussion and recommendations of the Program's Clinical Competency Committee

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"LETTER OF DEFICIENCY" (Non-Reportable Warning)
Issued when there are concerns that routine feedback is not effecting necessary improvement
Triggers consultation with GME
Provides resident with formal notice and opportunity to cure
Letter co-signed by Administrative Director of GME
Extension of contract/training period/repeat of rotation*

↓

REPORTABLE ACTIONS ALLOWING A REQUEST FOR REVIEW (Due Process)
Election to not promote to next PGY level
Extension of contract/training period/repeat of rotation*
Denial of credit
Termination
Triggers second consultation with GME; VPMA is notified of any of these actions

↓

REQUEST FOR REVIEW
Process review to assure the process leading up to the action was fair
Request by resident submitted to hospital Director of GME
Director appoints a physician reviewer (Program Director or core faculty member)

If resident or program director remain aggrieved, then either party can request a final review by the VPMA

↓

VPMA (or designated individual) FINAL REVIEW
Final and binding decision; Assures process was fair and reasonableness of decisions
VPMA conducts review with support of AVP Academic Affairs

* Some institutions might classify an extension of contract/training period/repeat of rotation as a non-reportable warning or as a reportable action depending upon the amount of remediation and impact on the resident's futurre.

ROLE OF PHYSICIAN REVIEWER:

1. Review Complaint
2. Meet with Resident
3. Review the file
4. Talk to the Program Director
5. Include others, as appropriate, to assist in the decision-making process
6. Determines if sufficient notice and opportunity to cure, and reasonableness of decision.

ROLE OF GME (ADMINISTRATIVE) DIRECTOR AND OR DIO:

1. Appoint Physician Reviewer
2. Assist Physician Reviewer to identify other potential participants, if warranted
3. Attend meetings with resident and reviewer
4. Prepares communication on behalf of reviewer back to the resident
5. Monitors timely completion of process
6. Notify VPMA(or designated individual) of action

S A M P L E

Academic Improvement Policy

I. Purpose:

To establish a policy and procedure for all programs at the ABC Hospital to use in the normal process of evaluating and assessing competence and progress of house staff enrolled in programs of post-graduate medical education. Specifically, this policy will address the process to be utilized when a resident/fellow is not meeting the academic expectations of a program, and therefore, fails to progress.

II. Scope:

This policy applies to all Graduate Medical Education (GME) training programs at the ABC Hospital.

III. Definitions:

A. *House Staff or House Officer* – refers to all interns, residents and fellows participating in a program of post-graduate medical education.

B. *Post-Graduate Training Program* – refers to a residency or fellowship educational program.

IV. Process:

Structured Feedback: All residents and fellows should be provided routine feedback that is consistent with the educational program. Feedback techniques include verbal feedback, rotational evaluations and summative evaluations (See Evaluation Policy). Each residency program must have a Clinical Competency Committee ("CCC")[1], that is charged with routinely assessing house officer performance.

S A M P L E

Academic Improvement Policy (cont'd)

IV. Process (cont'd):

"Letter of Deficiency": When a house officer has been identified as having a deficiency, it is expected that the he/she will receive routine structured feedback in order to identify and correct the issue. When the program director/CCC deems that routine structured feedback is not effecting the necessary improvement, or if the Program Director/CCC determines that the deficiency is significant enough to warrant something more than routine feedback, the Program Director/CCC may elect to issue a "Letter of Deficiency." This letter provides the House Officer with (a) notice of the deficiency and (b) an opportunity to cure the deficiency. "Letters of Deficiency" must be co-signed by the Program Director (or Designee) and the Administrative Director of Medical Education. The issuance of a "Letter of Deficiency" does not trigger a report to any outside agencies. The Program Director will provide the house officer with feedback consistent with the letter of deficiency. If, the house officer satisfactorily resolves the deficiency(ies) noted in the Letter of Deficiency, and continues to perform acceptably thereafter, the period of unacceptable academic performance does not affect the house officer's intended career development.

Failure to Cure the Deficiency: If the Program Director/CCC determines that the house officer has failed to satisfactorily cure the deficiency and/or improve his/her overall performance to an acceptable level, the Program Director/CCC may elect to take further action, which may include one or more of the following steps:

a) Issuance of a new Letter of Deficiency

b) Election not to promote to the next PGY level

c) Requiring the repeat of a rotation that in turn extends the required period of training

d) Extension of contract, which may include extension of the defined training period

e) Denial of credit for previously completed rotations

f) Dismissal from the residency or fellowship program

Reportable Actions: The decision not to promote a house officer to the next PGY Level, to extend a house officer's contract, to extend a house officer's defined period of training, to deny a house officer credit for a previously completed rotation, and/or to terminate the house officer's participation in a residency or fellowship program are each considered "reportable actions." Reportable Actions are those actions that the Program must disclose to others upon request, including without limitation, future employers, privileging hospitals, and licensing and specialty boards. Some policies would allow House Officers who are subject to a Reportable Action to request a review of the decision.

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1. The Clinical Competency Committee may be referred to as the "Progress and Promotions Committee" or other terminology. This is a departmental committee that consists of the faculty and others as deemed appropriate by the department. This committee should meet regularly to assess resident/fellow performance and make recommendations to the program director regarding further action.

S A M P L E
Academic Improvement Policy (cont'd)

Request for Review: A review of the decision to take a Reportable Action may be requested by the house officer. For example, a Request for Review would be submitted to the Administrative Director of Medical Education within fourteen (14) days of learning of the Reportable Action. Upon receipt of a Request for Review, the Administrative Director will first determine whether the matter is reviewable under this Policy, and if so, the Administrative Director shall appoint a neutral physician reviewer who will:

i) Review the complaint
ii) Meet with the house officer
iii) Review the house officer's file
iv) Meet with the program director
v) Consider any extenuating circumstances
vi) Consult with others, as appropriate, to assist in the decision making process; and
vii) Determine whether this Policy was followed, the house officer received notice and an opportunity to cure, and the decision to take the Reportable Action was reasonably made

The Administrative Director of Medical Education will:

i) Appoint the physician reviewer
ii) Assist the physician reviewer to identify other potential participants, if warranted
iii) Attend all meetings held by the physician reviewer
iv) Coordinate communications between the physician reviewer and the house officer
v) Monitor timely completion of the review process
vi) Notify the Vice President of Medical Affairs of the request for review

Opportunity for a Final Review: If either the house officer or the program director disagree with the decision of the physician reviewer, either can request a final review of the decision to take a Reportable Action by the Vice President for Medical Affairs (VPMA*). For example, a request for final review would be submitted to the Assistant Vice President for Academic Affairs within fourteen (14) days of learning of the Physician Reviewer's decision. The VPMA* will conduct a final review in conjunction with the Assistant Vice President for Academic Affairs. The roles of these individuals and the process are the same as described in the "Request for Review" above. The decision of the VPMA* constitutes a final and binding decision. Upon conclusion of the review, a report of the final review will be provided to both the house officer and the program director. The Hospital's Academic Improvement Policy affords due process to house officers who are dismissed from a residency program or whose intended career development is altered by an academic decision of a program. See Academic Improvement Policy for delineation of the specific processes available to a house officer to challenge an academic decision made by his/her Department.

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* VPMA or designated individual such as Associate Dean, CEO

MISCONDUCT ISSUES

Whenever a resident is accused of misconduct, the resident has a right to due process. In this setting, due process means that a resident should be notified of the accusation and be given a meaningful opportunity to be heard. In addition, there must be a reasonable process for deciding whether to take disciplinary action. It goes without saying that, in order to be reasonable, the decision concerning discipline cannot be made before the resident has been heard. Further, and especially when a resident denies the accusations, the decision-making process must include enough independent fact-finding to provide the program with a reasonable basis for reaching a conclusion as to what discipline, if any, is warranted.

Thus, the first step in a misconduct situation is to meet with the accused resident to provide him or her with notice of the accusations and allow the resident an opportunity to respond (to be heard). Following that discussion, the program director – usually in consultation with GME, DIO, legal counsel and/or human resources – should decide upon the scope of any further inquiry, as well as identify the proper parties to conduct the inquiry.

It is important to have a qualified, neutral individual collect facts and provide a report to the program director, so he or she can make a fair decision. The person conducting the inquiry should talk to any other personnel who may be involved. Only when this fact-finding and data collecting (i.e., the inquiry) are complete, should a program director make a decision about taking disciplinary action against a resident. It is very important that all meetings with the resident and others involved are documented. It is also a good idea to have a third person present to witness discussions and take notes. Typically, this person should be someone such as your GME Director, Designated Institutional Official, or other appropriate institutional officer.

At the outset, the resident, the accuser, and each other person interviewed, should be advised of the importance of confidentiality to avoid unfairly tarnishing anyone's reputation. In addition, the resident, the accuser and each other person interviewed should be notified that any form of retaliation, intimidation or interference in connection with the inquiry is itself misconduct that will not be tolerated.

Depending on the type of misconduct, other individuals may need to be involved in the inquiry process. For example, a sexual harassment issue involving a resident and a faculty member will likely need to involve the Department Chair, VPMA, and/or the Medical Staff representative and your harassment office. Or, an incident involving a nurse or other employee may require human resources and/or the employee's union representative to be involved.

Once an inquiry is complete, and a decision based on the outcome is made, another meeting with the resident should occur, again optimally with a third party present. At the meeting, the resident should be advised of the program director's decision.

GME PROCESS: MISCONDUCT MATTERS

ALLEGATIONS ARISE OR INCIDENT OCCURS

Examples of Misconduct: Harassment, Theft, Fighting, Dishonesty, Breach of Confidentiality

Program Director speaks to resident, provides notice of allegations and an opportunity to respond. PD documents same, triggers consultation to Admin. Director of GME

Admin. Director of GME notifies VPMA*, Department Chair, Legal, or Human Resources, as appropriate
Upon resident request, or if PD, GME, Chair, VPMA* and/or HR decide the incident warrants more investigation then a "Full Inquiry" must be done (Non-reportable)

FULL INQUIRY (DUE PROCESS)

Formal notice of allegation and opportunity to respond

Inquiry is administered by Administrative Director of GME
Inquiry will be conducted by appropriate individuals, which may include GME, PD, Chair, HR, Legal, or others
Results of the inquiry will be prepared by GME and/or other responsible individuals and reported back to the resident and the Program Director (Non-Reportable).

OUTCOME FROM INQUIRY ALLOWING REVIEW

If reportable actions result, i.e.

Election to not promote to next PGY level
Non-renewal of contract
Suspension
Termination

REVIEW BY VPMA* OF PROGRAM DECISION (DUE PROCESS)

Final and binding decision; Assures process was fair and reasonableness of decisions

VPMA* conducts review of process to date with AVP* Academic Affairs
Were all policies followed?
Was the appropriate process followed?
Was the resulting decision reasonably made?
Written report of VPMA* decision prepared by AVP* and provided to resident and Program Director

* or designated individual

S A M P L E

GME Misconduct Policy

I. Purpose:

To establish a policy and procedure for all programs at the ABC Hospital to use when allegations of misconduct are made against a house staff officer.

II. Scope:

This policy applies to all Graduate Medical Education (GME) training programs at the ABC Hospital

III. Definitions:

A. House Staff or House Officer – refers to all interns, residents and fellows participating in a program of post-graduate medical education

B. Post-Graduate Training Program – refers to a residency or fellowship educational program

C. Misconduct – Improper behavior; Intentional wrongdoing; Violation of a law, standard of practice, or policy of the program, department, or hospital. Misconduct may also constitute unprofessional behavior, which may trigger action under the Academic Improvement Policy. These actions may proceed simultaneously.

IV. Process:

Allegations of Misconduct: A house officer, employee of the Hospital, attending physician, patient, or any other person who believes that a house officer has engaged in misconduct of any kind should immediately report his/her concerns to his/her supervisor, or any other supervisor in the Hospital, who in turn should communicate the allegations to the house officer's Program Director. Upon receipt of a complaint regarding the conduct of a house officer, the Program Director should conduct an initial inquiry, as follows:

i. Meet with the person complaining of misconduct
ii. Meet with the house officer to advise the house officer of the existence of the complaint, to give the house officer an opportunity to respond to the allegations, and to identify any potential witnesses to the alleged misconduct
iii. Consult with the Administrative Director of GME to determine whether the VPMA*, Department Chairman, Legal Affairs and/or Human Resources should be contacted as appropriate based on the issues and the people involved
iv. Upon request of the house officer, or if the Program Director, GME Director, VPMA*, or Human Resources decide the incident warrants more investigation, then a "Full Inquiry" must be done
v. All allegations of sexual harassment will be reported immediately to Human Resources in accordance with the Hospital's policy against harassment.
vi. Upon consensus of the Program Director and GME, the accused house staff officer can be removed from duty (with or without pay) pending the outcome of a full inquiry

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* VPMA or designated individual such as Associate Dean, CEO

S A M P L E

GME Misconduct Policy (cont'd)

IV. Process: (cont'd)

Full Inquiry: A full inquiry is an internal investigation of the allegation/incident by appropriate individuals, which may include GME, the Program Director, the Department Chairman, Human Resources, Legal, or others. The inquiry process is administered by the Administrative Director of GME and or the DIO. Factual results of the inquiry will be prepared by the GME Director and/or other responsible individuals and reported back to the program director and the house officer for appropriate action.

If the full inquiry results in a finding that no misconduct occurred, no action will be taken against the house officer. If the house officer was suspended pending the inquiry, the house officer will be reinstated with full benefits and pay.

If the full inquiry results in a finding that a house officer participated in misconduct, the Program Director shall determine, in conjunction with the VPMA*, Department Chair, GME, Human Resources, Legal, or other appropriate individuals, what action is appropriate under all the circumstances, to remedy the situation. The Program may take actions including, without limitation, the following:

a) A verbal or written warning
b) Election to not promote to the next PGY level
c) Non-renewal of contract
d) Suspension
e) Termination from the residency or fellowship program

Reportable Actions: The decision not to promote a house officer to the next PGY Level, not to renew a house officer's contract, to suspend a house officer, and/or to terminate the house officer's participation in a residency or fellowship program are each considered "reportable actions." Reportable Actions are those actions that the Program must disclose to others upon request, including without limitation, future employers, privileging hospitals, and licensing and specialty boards. House Officers who are subject to a Reportable Action may request a review of the decision as provided in this Policy.

Request for Review: A review of the decision to take a Reportable Action may be requested by the house officer. A Request for Review should be submitted to the Administrative Director of Medical Education and or the DIO within fourteen (14) days of learning of the Reportable Action. Upon receipt of a Request for Review, the Administrative Director will first determine whether the matter is reviewable under this Policy, and if so, the Administrative Director shall advise the VPMA* who will:

i. Review the complaint
ii. Meet with the house officer
Iii. Review the house officer's file
iv. Meet with the program director
v. Consider any extenuating circumstances
vi. Consult with others, as appropriate, to assist in the decision making process; and
vii. Determine whether this Policy was followed, the house officer received notice and an opportunity to be heard, and the decision to take the Reportable Action was reasonably made

* VPMA or designated individual such as Associate Dean, CEO

S A M P L E

GME Misconduct Policy (cont'd)

IV. Process: (cont'd)

The Assistant Vice President for Academic Affairs and/or the DIO and/or the Administrative Director of Medical Education will:

i. Advise the VPMA* of the request for review
ii. Assist the VPMA* to identify other potential participants, if warranted
iii. Attend all meetings held by the VPMA*
iv. Coordinate communications between the VPMA* and the house officer
v. Monitor timely completion of the review process

The decision resulting from this review is a final and binding decision. A written report will be provided to the resident and the program director, and others as appropriate.

No Retaliation: Initial and full inquiries will be conducted with due regard for confidentiality to the extent practicable. Under no circumstances may anyone retaliate against, interfere with or discourage anyone from participating in good faith in an initial inquiry or a full inquiry conducted under this policy. A house staff officer who believes he/she may have been retaliated against in violation of this policy should immediately report it to their supervisor, the Administrative Director of GME, or any other supervisor.

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* VPMA or designated individual such as Associate Dean, CEO

As in an academic case, if any decision could affect a resident's intended career development, the resident should be given an opportunity to have the decision reviewed to assure that the decision-making process was reasonable. This satisfies the second part of the requirement of due process.

MISCONDUCT ISSUES INCLUDE:

- Dishonesty
- Theft
- Fighting or violence
- Forgery or inappropriate documentation in records
- Breach of appropriate behavior/code of conduct or ethics
- Being unfit for duty

Sometimes, misconduct issues can be considered a 'lack of professionalism'. Professionalism is considered a core competency by the ACGME, and the AMA has issued a statement concerning a physician's responsibility for professionalism. It can be difficult to decipher whether a misbehavior is a misconduct or professionalism issue. Some examples of behavior that can go either way include insubordination, attendance or tardiness problems, or generally disruptive behavior, such as rudeness, or anger-management issues.

One helpful method for deciding whether to treat a behavior issue as a deficiency in professionalism or misconduct is to consider if the misbehavior was done with "malice". In this context, malice means that the resident either knew or should have known the behavior was wrong, or acted without regard for whether it was right or wrong. Intentional misbehavior or misconduct should not be considered 'remediable' under professionalism. If it seems like giving the resident notice and an opportunity to cure would amount to giving the resident another chance to cause harm, you should treat it as misconduct, and take disciplinary action sufficient to assure the behavior does not occur again.

PROFESSIONAL EXPECTATIONS

(Adapted from Duke University Hospital GME Trainee Manual)

Successful participation in graduate medical education depends upon many factors, central to which are ACGME Core Competencies, Patient Care, Medical Knowledge, Practice-based Learning and Improvement, Interpersonal and Communication Skills, Professionalism and Systems-based Practice. Professionalism includes a variety of behaviors and attitudes consistent with and understanding of, and commitment to institutional policies and procedures, departmental, divisional, and program-specific expectations. We expect trainees to:

- Treat everyone (colleagues, faculty, students, patients, families, staff, and guests) with respect as well as demonstrate integrity and honesty
- Ensure patient safety
- Regularly review performance evaluations with the program director

You may want to compare your policies with the examples provided. If you have no policy for professional expectations, you could take the opportunity to develop one. In addition, identify who in your program or institution should be included in this endeavor.

SCENARIO SUMMARY

A program director is on the phone with the Associate Dean of GME about a PGY3 resident. She is calling to report on the CCC's recommendation to dismiss the resident for falsifying information in medical records even after a previous incident where the resident was warned against it. The program director also states that she is so concerned about the risk that this resident will sue, that she wants to disregard the recommendation of the CCC, and grant the resident another chance at remediation.

DISCUSSION QUESTIONS:

- Is it a reasonable expectation that a resident understands falsification of a medical record as inappropriate?
- Should the resident have been given the opportunity to remediate the initial misconduct?
- Was the resident provided with 'notice and opportunity to respond' to the charge? Was an appropriate inquiry done prior to the CCC's recommendation to dismiss?
- How do you determine when misconduct is 'remediable'?

Inaccurate assumptions that underlie the initial scenario include the following:

- Program directors should do everything possible to keep each and every resident in the program, especially when the program director fears litigation.
- Before being dismissed, residents should be offered several chances for remediation.
- Misconduct issues should always be treated as 'remediable'.

SCENARIO RERUN

A program director is on the phone with the Associate Dean of GME about a PGY3 resident. He is calling to report on the CCC's recommendation to dismiss the resident for falsifying information in medical records even after a previous incident where the resident was warned against it. The program director states that an appropriate inquiry had been conducted, and that the behavior did occur again, even though the resident, having been previously warned, clearly knew it was wrong. Thus, he feels the decision to dismiss the resident is reasonable.

The rerun attempts to teach the following principles:

- Dishonesty, documented forgery and falsification are all misconduct issues, and are generally not "remediable".
- As long as the appropriate inquiry process has been followed, difficult decisions such as termination can successfully be defended, even if they result in serious actions against the resident.
- Program directors should not be afraid to dismiss residents who demonstrate disruptive or dishonest behavior, and especially behavior with mal intent.

ADVERSE ACTIONS

Adverse actions taken against residents are typically reported to outside agencies, regulatory bodies, and future employers. These actions can seriously jeopardize a trainee's chance at a medical career, or, per ACGME regulations, their "intended career path", and therefore they are most likely to be the actions that provoke litigation.

ADVERSE ACTIONS	
• Probation Statuses	• Denial of credit*
• Election to not promote	• Non-renewal of contract
• Requirement to repeat rotation(s)*	• Termination or dismissal

* Some institutions would not define these as adverse actions depending on the duration of the extended training and its impact on the resident's future.

There is evidence, however, that very few of these claims make it to court, and when they do, they are usually ruled in favor of the academic institution (estimated to be more than 90% of the time). *[Trouble in Academia: Ten Years of Litigation in Medical Education, Acad Med 2003; 78 (10): S13-S15]).*

Academic issues in legal cases	Misconduct issues in legal cases
• Knowledge-based	• Employment-based
• Lack of core competency	• Dishonesty, medical record forgery
• Lack of specialty training	• Harassment, disruptive behavior
• Lack of introspect (professionalism)	• Theft, violence

To defend academic decisions, a residency program must have well-developed standards for successful achievement, progress, promotion and program completion. These standards should be applied uniformly to all trainees.

There are two Supreme Court cases that program directors should be familiar with, in order to provide an appropriate legal context for academic medicine. Since both cases are decisions by the Supreme Court, they are considered the "law of the land", and apply to all states and jurisdictions.

The first, *Missouri v. Horowitz* (1978), defined minimal due process requirements. Horowitz, a medical student, was provided feedback in her rotational evaluations regarding her personal hygiene and slovenly appearance. When improvement was not demonstrated, the faculty met and decided not to promote her to her final year of medical school. She complained that this was unfair, and thus the school decided to offer her the opportunity to rotate with five independent physicians for her evaluation. The consensus (two physicians supporting her ability to be promoted, two recommending she be dismissed, and one ambivalent) provided enough information for the Dean to uphold the decision of the faculty (CCC) to dismiss her from the academic program.

Horowitz appealed pursuant to the school's grievance and due process, and the decision was sustained. The Supreme Court commented that the school went beyond what was required and provided more process than was due. In essence, her written evaluations

REMEDIATION/PROBATION PROCESS

STRUCTURED FEEDBACK

Routine Feedback, verbal and written

CONCERN ARISES

DEPARTMENT REMEDIATION

Non-reportable action
Time Frame: 30 days - 6 months
Must be issued in writing and include notice of the deficiency and a specific program for improvement
No formal notification to GME
Not eligible for a Fair Hearing

INSTITUTIONAL PROBATION

Reportable to outside evaluators/agencies
Time Frame: 30 days - 6 months
Must be issued in writing
Should follow Departmental Remediation
Requires a cc: to GME for archive in file
Must offer Fair Hearing to dispute

NON-RENEWAL OF CONTRACT
TERMINATION FROM PROGRAM
EXTENSION OF CONTRACT

All of the above actions should be precipitated by Institutional Probation
Fair Hearing available for these actions

FAIR HEARING

Committee of 3 Faculty and 2 Residents,
Chaired by Dean/VPMA* or Designee
Final Decision Making Group
Majority Vote Decision

* or designated individual

LETTER OF DEFICIENCY PROCESS

STREAMLINED PROCESS

STRUCTURED FEEDBACK

Routine Feedback, verbal and written

CONCERN ARISES

"LETTER OF DEFICIENCY" (Warning)

Issued when concerns that feedback is not effecting necessary improvement
Triggers consultation with GME
Non-reportable action
Reasonable time frame determined on a case-by-case basis with specific follow up dates
Co-written/co-signed by Admin. GME Director

A "Letter of Deficiency" is not eligible for review; only if resulting actions (below) occur.

If reportable actions, i.e.,
ELECTION TO NOT PROMOTE
EXTENSION OF CONTRACT/TRAINING/
REPEAT DENIAL OF CREDIT TERMINATION

All of the above actions should be preceded by a "Letter of Deficiency"

REQUEST FOR REVIEW

GME & Physician Reviewer(s)
If either party remains aggrieved, then option for VPMA*/Dean to conduct Final Review

VPMA*/DEAN FINAL REVIEW

Final and Binding Decision
VPMA* and AVP* Administrative Affairs

* or designated individual

provided her with notice and opportunity to cure, and the decision making process, a regular meeting of the faculty, called for the purpose of discussing performance (CCC) was careful and reasonable.

The second case, *Michigan v. Ewing* (1985), went further. Ewing was dismissed as a medical student due to academic deficiency, notably failing Step 1 of the NBME. He sued alleging unfairness, noting that every other student (33 in all) who had failed the NBME had been given opportunities to retake the examination and remain in the program. However, the University of Michigan argued that Mr. Ewing's overall performance had been poor, and thus, his failure of the examination was only one of several deficiencies. The school claimed it had acted based on his entire academic record, which supported their opinion that any further opportunity for improvement would have been futile. The school provided Mr. Ewing an opportunity to personally explain why he believed his score on the exam did not fairly reflect his academic progress or potential, and after consideration, affirmed its position and removed him from the program.

This case is important because it defers to **an institution's privilege to assess the unique academic performance of each individual.** The Supreme Court again recognized that so long **as faculty are engaging in a reasonable decision making process,** the Court will not substitute its judgment on matters within the academic province of educators.

There are, however, some lower court decisions (governing only in some jurisdictions) that can serve as important examples of how things can go wrong. One case *(Ezekwo v. NYC)* recognized the limits of academic discretion in medical training. In this case, the court found that the institution had violated Dr. Ezekwo's due process rights because it retroactively changed, without notice, a policy concerning the appointment of a chief resident to deny her the title. The court did not find that the decision was unreasonable, but it did find that, because the decision was made retroactively and without notice, she was improperly deprived of an opportunity to be heard on the topic. The court was clear that the institution had the right to change the policy, and the right to deny her the title of chief resident, so long as it gave her notice of the intended change, and at least a minimal opportunity to be heard on the subject.

In another case in 2000 *(Grudzynski v. MCO),* the institution properly sought to discipline a resident for misconduct (leaving a hospital without permission), but did not follow its own policies related to resident discipline and due process. Specifically, the resident was never provided with notice of some of the charges that led to the decision to dismiss her, and thus, she had no opportunity to be heard on those charges. In addition, the hospital improperly applied its own policy, by allowing the Program Director to "review" his own decision. As a result, the court issued an injunction ordering the hospital to reinstate the resident pending further proceedings, despite her serious misconduct issues.

This case summary may serve as an important reminder for you to be familiar with your own policies and to follow them. If the policies must be changed, change them prospectively and with notice.

AREAS OF LIABILITY

Possible areas of liability other than due process for an institution include: 1) discrimination and violation of civil liberties, 2) defamation, 3) vicarious liability for actions of the resident, 4) intentional tort or intentional infliction of emotional distress, 5) breach of contract, and 6) educational malpractice.

LAWSUITS FILED OVER A TEN YEAR PERIOD (1993-2003) BY RESIDENTS AGAINST INSTITUTIONS

- Discrimination (60)
- Breach of contract (24)
- Due process (16)
- Wrong termination (10)
- Defamation (12)
- Miscellaneous (33)

Source: Nixon Peabody LLP 2003

Discrimination is the most frequently occurring claim for both resident and faculty plaintiffs. Most often, this claim is difficult for the plaintiff to prove. However, in one lower court case *(Zaklama v. Mt. Sinai),* the resident was able to produce enough evidence to justify a jury finding that he had been disciplined more harshly than other residents of different national origins. His evidence included comparative evidence that others performed as poorly as he did, but were not dismissed from the program, and the fact that the faculty member who was the most critical of his performance retracted his statements during trial.

AMERICANS WITH DISABILITIES ACT (ADA)

The Americans With Disabilities Act (ADA) was created to protect workers with disabilities from discrimination in the workplace. The definition of 'disability' can be tricky, so you should be sure to work with experts in your HR or legal department to determine specific requirements. For example, a recovered alcoholic is covered under the ADA and, if requested, program directors would need to accommodate the individual for attending AA meetings or other treatment. However, active alcoholism or intoxication in the workplace is not covered under the ADA.

RESIDENTS WITH DISABILITIES TREATED IN ACCORDANCE WITH ADA

- Residents must request accommodation **before** an institution should attempt to reasonably accommodate
- Institution must take effective measures to accommodate
- Measures can depend on the nature of the resident's disability, the specialty and the institution
- Examples of accommodations include: specialized stethoscopes, recorded lectures, extended time on exams, time off for medical treatment

It is inherently natural for program directors to want to diagnose and treat their residents. However, it is important that program directors recognize that first and foremost, they are educators, managers and agents of their employer. As such, they should refrain from diagnosing residents, and focus on assessing academic performance and workplace behavior. Failure to achieve academic requirements and/or misbehavior does not always stem from an underlying medical or psychiatric condition.

The ADA protects employees and allows workers to keep their medical information private, unless they choose to disclose it for purposes of accommodation. Therefore, program directors should not initiate discussions of a medical nature (which can be perceived as unlawful prying) with residents, and should not require psychiatric evaluations or medical treatment as a condition of employment. If a resident exhibits alarming behaviors, he or she should be sent to Employee Health for a fit-for-duty evaluation and potential treatment in accordance with institutional policies. Employee Health provides programs with an assurance that resident privacy is being respected, while giving program directors only the necessary information required for them to make effective academic and employment decisions.

In general, the less a program director knows about a resident's medical condition, the more discretion a program has to take academic and employment actions without fear of liability under the ADA. Once a program director learns information about a resident's medical condition, the program then has an obligation to provide reasonable accomodations to the resident, and to protect the resident's privacy from other faculty, staff and peers. The ADA places a stiff burden on those who possess medical information, and failure to live up to that burden can result in significant liability, even for well-intentioned acts. Focusing on academic achievement and performance, and leaving perceived diagnoses out, allows for a much more productive educational environment for the resident.

VICARIOUS LIABILITY FOR RESIDENTS

An institution or attending physician can be vicariously liable for actions of residents. It is important to keep in mind that the law imposes expectations for standards of conduct on individuals and institutions at all levels of training. However, standards and

society's expectations of medical care are constantly changing, so it is important to stay abreast of the current trends.

INTENTIONAL TORTS

Intentional torts include claims like Intentional Infliction of Emotional Distress, or Intentional Interference with a Prospective Business Relationship, or Intentional Interference with a Contract. While laws vary from state to state, these claims may arise when a Program Director initiates a conversation with a future employer or academic program and "warns" the future employer not to choose the candidate.

BREACH OF CONTRACT

Breach of contract is a serious claim that is prosecuted within the realm of employment litigation and so allows for damages to be paid if the resident is successful. Hopefully, your institution's contract has been very carefully drawn up and worded to reduce the chance of litigation in this area.

EDUCATIONAL MALPRACTICE

Educational malpractice is a relatively new area of litigation and is not recognized in all states. There are only a few issues in this area that are relatively clear cut in terms of tangible evidence. These include insufficient educational resources, such as classes that are required for proper training, or lack of support staff, services, or requisite safety procedures.

AVOIDING LITIGATION

No matter what the claim or the outcome is, litigation is an extremely expensive process. To be able to lessen the toll of litigation for any institution requires careful preemptive measures to prevent cases from forming, and if they do form, to ensure they are handled promptly.

AVOIDING LITIGATION

- Hire only residents who "fit" and meet your selection criteria
- Adhere to all policies
- Educate residents about policies
- Conduct regular and honest evaluations
- Apply necessary procedures

Remember that all evaluations, meetings, or discussions concerning residents should be documented and retained in the appropriate place, typically in each resident's file.

CONTENTS OF RESIDENTS' FILES

- Letters describing corrective action plans
- Test scores, academic evaluations, patient and procedure logs
- Proof that residents are aware of the contents of the file

The information in a resident's file may be discoverable, so if it contains employee/HR reports, personal health information, or misconduct inquiry records, it may appear that factors other than a resident's academic performance were considered in taking academic actions. Although all of those records (assuming they exist) should be maintained and may also be discoverable, they should not be included in the academic file. The files do not have to be supplied to any future employers or training programs unless subpoenaed. In some states, these documents may be considered peer review and not discoverable. Your legal department can help to clarify this.

According to some states, residents may have rights to copies of their files. Many program directors hesitate to give residents copies of their evaluations when requested. However, the ACGME encourages open access to academic files. So long as programs have been providing honest and frequent evaluations of residents (as required by the ACGME), nothing in the file should come as a surprise to the resident. Because a properly maintained file can only support and sustain a program's decision, discuss with your legal team the advisibility of providing the resident with copies.

SCENARIO SUMMARY

A program director is calling the previous program director about a new PGY2 resident who had recently transferred and whose performance is seemingly substandard. The current program director is accusing the previous program director of not supplying the necessary information about the resident's deficiencies.

DISCUSSION QUESTIONS

- What responsibility does the previous residency program director have to disclose academic and clinical performance?
- If a program director or faculty member is asked to provide a letter of recommendation for a resident, can that person be forthright in their letter even if the hospital has a legal obligation to be silent regarding performance?
- Can a resident's previous academic record be used as the basis for a decision by the current program /CCC?

Inaccurate assumptions that underlie the initial scenario include the following:

- Previous program directors are not obligated to provide all available information on a resident's performance when the resident transfers
- Accusation and condemnation are the best methods for obtaining information from other program directors
- All recommendation letters are accurate reflections of a resident's performance

SCENARIO RERUN

A program director is calling the previous program director about a new PGY2 resident who had recently transferred and whose performance is seemingly substandard. The current program director is requesting verbal information from the previous program director about the resident's achievement and assessment while in the program.

The rerun attempts to teach the following principles:

- Retrieving negative information about trainees is sometimes akin to a research project
- A program director has an ethical and professional obligation to accurately relay information about a resident's performance, as well as an assessment of their clinical competence
- The least amount of risk to the program or institution for disseminating information about a trainee is for the information to be an accurate reflection of the performance, and for the record to reflect such information
- A program director who is in the process of accepting a transfer resident should obtain an evaluation of the resident before offering the position

REPORTING OF CORRECTIVE ACTIONS

In addition to the resident's file containing documentation of corrective actions, be aware that certain actions, most commonly probation, must be reported to the ACGME, and/or the state licensing board. As a result, many programs avoid taking corrective action for fear of having to report, and thereby tarnish the resident's record. In fact, institutions can take any action that provides notice of deficiencies to a resident and an opportunity to cure. This includes verbal feedback, a rotational evaluation, a semi-annual evaluation, a letter of deficiency, a written warning, a remediation plan, a performance improvement plan, and so on. Each of these tools is an educational tool, and should be utilized whenever a program believes it will be useful to effect the intended improvement in performance.

Probation is another academic or disciplinary tool typically reserved for serious deficiencies or problems. The Federation of State Medical Boards has issued a policy statement recommending that residents on probation be reported to the state licensing board so the medical board can "institute safeguards to protect the public while allowing the physician to complete training". However, not every state licensing board has adopted this requirement. Significantly, there is no legal or regulatory requirement to use probation as a tool.

If an institution adopts an academic or disciplinary policy that authorizes probation, however, program directors should be aware that its use may need to be reported to third parties, and thus it qualifies as "an action that could affect the resident's intended career development." Dismissal, election to not promote, withholding credit, and nonrenewal of contract are other actions that require reporting to third parties.

Unlike licensed and privileged physicians, resident and disciplinary actions are not reported to the National Practitioner's Databank unless the state licensing board takes an action against them, and then that action is itself reported.

Reporting of impaired residents is a bit more complicated. Your state's licensing board may not require reporting of a decision to refer a resident for drug or alcohol abuse

evaluation or treatment. However, some states do require disclosure of this information to a state licensing authority. Reporting, alone, should not be construed as harmful to the resident. Generally, state medical licensing boards have replaced harsh disciplinary approaches for dealing with impaired physicians with an emphasis on rehabilitation, as long as patients are protected. In many cases, a state's physicians health program may be the most beneficial resource and may be able to preserve the trainee's privacy if he/she complies with a management plan. Contact your own legal team who will know how the programs work in your state.

It is good practice to have a release signed by the resident prior to reporting to elective agencies such as credentialing requests from other organizations. Some institutions ask for both a release of information and a release of liability. Check with your DIO and GME office for your institution's process. When residents leave a program due to termination or non-renewal, they should be aware that their performance and any subsequent action will be disclosed to other programs upon request and authorization. This information is non-negotiable, and must be reflective of the performance and the academic record. Program directors are ultimately gatekeepers of their profession, charged with the responsibility to assure that only competent physicians are graduated from their programs. Thus, the program director has a huge responsibility to relay accurate information on residents' academic performance.

SUMMARY POINTS:

Residents with Problems: Practical tips on how to manage the disciplinary process

- Use your DIO EARLY

He/she has probably had experience with these situations, and can help you learn about the resources and policies that are consistent with your own institution.

- Frame around the competencies

ACGME competencies serve as extremely helpful benchmarks, and address medical knowledge and patient care (including teamwork, patient/family counseling, as well as interpersonal communication skills and professionalism).

- Provide clear expectations of performance
- Orient towards expected behavior or performance

Consider "checklists" to assess the knowledge base of incoming residents

- Use frequent and multiple types of assessment tools and document your evaluation process
- Consider a "promotions" committee, or "progress" committee that reviews all resident evaluations

The committee, and not the single program director, can then be responsible for decisions about promotion to the next year, program completion, and remediation or termination.

LEGAL ISSUES REVIEW

- Describe the ethical responsibilities of program directors in terms of dealing with trainees with problems. What resources are called into play in these instances?

- Differentiate the two major categories of resident discipline and corrective action. What types of issues are included in each category? Who are the main governing agencies on which the requirements for each category are based?

- Identify the necessary policies and procedures for any training program. What different groups do these policies need to be consistent with? How does a well-written policy aid in the disciplinary process?

- Discuss situations in which adverse actions are warranted and utilized. What are the legal ramifications of adverse actions? Should adverse actions be avoided?

- Determine the different areas of liability for an institution. What areas are the most frequent for lawsuits filed by trainees? Is an institution liable for a trainee's actions?

- Outline preemptive measures that can aid in avoiding litigation.

- Distinguish corrective actions that need to be reported, and who they may need to be reported to.

LEGAL ISSUES: ADDITIONAL REFERENCES OF INTEREST

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AMONG THE GENERATIONS IN MEDICINE

Wayne M. Sotile, PhD
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GOAL

This module presents information about the four generational cohorts that are currently working together in the medical profession, and compares the different attitudes and values among them. The program also discusses strategies for building bridges across the generations.

LEARNING OBJECTIVES

After working through this program, you should be able to:

- Understand how resident resiliency and satisfaction is linked to the level of "cultural competence" in medical educators
- Contrast characteristics of the four generational cohorts that are currently working together in the medical profession
- Describe the impact of these generational characteristics on mentoring, communication, and resident evaluation
- Anticipate the general trends in gender, diversity, and work attitude among the generations
- Identify strategies for building bridges among the generations

SCENARIO SUMMARY

An attending physician (of the baby boomer generation) has just seen a patient who is presenting with manic symptoms. The patient had recently been prescribed an SSRI by a resident. The attending is now seeking out the resident to ask him to see the patient. The attending wants the resident to observe the effects of his SSRI prescription in this particular patient and to assist in the treatment plan. The resident (who is generation X) explains that he is too busy to see that particular patient at this time primarily because he has a personal engagement that he wants to attend. The attending is frustrated with the resident's apparent lack of concern for one of his patients, and reprimands the resident.

DISCUSSION QUESTIONS:

- What differences between the baby boomer generation and generation X values contribute to the different attitudes demonstrated in this vignette?
- How could understanding generational differences help in this situation?
- What other predictable situations could cause misunderstandings among different generations?
- How does each generation view "professionalism"?

Assumptions that underlie the initial scenario include the following:

- Individuals from the baby boomer generation tend to expect their same work attitudes from everyone else.
- Members from younger generations (generations X and Y) do not take their work as seriously as the older generations.
- Discipline is the best method for achieving an understanding between mentor and trainee.

SCENARIO RERUN

An attending physician (of the baby boomer generation) has just seen a patient who is presenting with manic symptoms. The patient had recently been prescribed an SSRI by a resident. The attending is now seeking out the resident to ask him to see the patient. The attending wants the resident to observe the effects of his SSRI prescription in this particular patient and to assist in the treatment plan. The resident (who is generation X) explains that he is too busy to see that particular patient at this time primarily because he has a personal engagement that he wants to attend. The attending explains to the resident that it would be a valuable educational opportunity for him and asks if there is a future time they could meet to discuss it.

The next day, the attending and the resident meet to discuss their actions on the previous day, and to discuss the patient's case. The attending listens to the resident's explanation of why he made the choice that he did. The attending states that he would like for the resident to follow-up with this patient.

The rerun attempts to teach the following principles:

- Acknowledging and discussing different attitudes among generations enhances working relationships
- Keeping communication lines open between mentors and trainees is important for residency programs

- Expectations for residents' behavior should be clearly identified and presented
- Focusing on the behavior of a trainee rather than on their apparent values enhances dialog and results in more productive discussions

PROGRAM TEACHING POINTS

MEDICAL DEMOGRAPHICS

- ~38% of physicians are 55 or older (varies by specialty)
- 26.7 % of physicians are women; 41.8% of medical residents are women
- 23.5% of physicians are international medical graduates (IMG)

Sources: AAMC, MHC Physician Survey 2004, AMA 2006, JAMA, 2005;294:1129-32

PHYSICIAN RESILIENCE

Resiliency is the ability for individuals to deal with change and to adapt to situations when appropriate. Some define it as the ability to come back to the original state—-to recover from shock or psychological stress. How do some adults who face incredible life or situational challenges deal with them positivtely while others "fold" when faced with similar challenges? Some say it has to do with the skills learned during our youth.

Research has shown that residents and younger physicians are less resilient than older and more experienced physicians. A critical influence necessary for promoting resilience is maintaining caring connections with other people. Therefore, a resident's resilience is influenced by relationships with faculty and other senior physicians. Put another way, a key to resident resilience is effective mentoring, modeling, and communication.

Divisive issues that can run counter to promoting resilience include work hour expectations, strategies for evaluation and promotion, and lifestyle balance. These issues often serve as a major source of distress, burnout, and ultimately of organizational dysfunction. Therefore, learning to understand and manage generational differences is both a leadership mandate and a survival skill, and this applies to both contemporary medical leaders and younger physicians alike.

Cultural competence, as it is generally discussed, usually refers to the ability to work with and care for individuals who are of a different ethnic or religious background or have a different country of origin, or represent a different cultural group. Increasingly, generations have also been recognized as having their own distinct cultures as well. Therefore, one of the main cultural competence challenges is working with the different generations that are currently in the health care work force.

CULTURAL COMPETENCE

- Ability to work with people whose beliefs, values, and histories are significantly different
- Understanding different views and perspectives of medicine in the overall scheme of life
- Developing an attitude of awareness, recognition, and understanding

GENERATIONAL COHORTS

Attitudes of a generational cohort are shaped by historical, political, and social events. People tend to resemble their generational cohort in terms of their attitudes and lifestyles, and retain those imprints throughout their lifetime.

CURRENT GENERATIONAL COHORTS IN HEALTHCARE*

- Silent Generation or Traditionalists, born between 1925 and 1945
- Baby Boomers, born between 1945 and 1965
- Generation Xers, born between 1965 and 1980
- Generation Y or Millenials, born between 1980 and 2001

The younger generations strive for flexible work hours, and flexible medical practice design. They view a balanced lifestyle as a marker of success. Many researchers have attributed this change in work ethic to the larger percentage of women who are now practicing medicine. But the desire for balance is not only in our young women; both men and women are gravitating towards "lifestyle" specialties that are associated with more regularly-scheduled work weeks, better defined boundaries between work and "off work", and fewer overall work hours.

We can group generational differences into six categories. These include 1) differences in the educational process and how people use technology to learn, 2) differences between the interest in, and the need for one's own career and financial management, 3) lifestyle orientation and views of the work/life balance, 4) perspectives towards authority, 5) demonstration of and response to leadership, and 6) relationship characteristics.

CHARACTERISTICS OF TRADITIONALISTS (1925-1945)*

- Self-discipline and denial of immediate gratification
- Hierarchical respect of authority
- Respect of age and experience
- Committed to the job
- Generally a clear division of labor by gender

CHARACTERISTICS OF BABY BOOMERS (1945-1965)*

- View children as a social fixation
- Include many single-income families
- Women worked outside the home primarily in education and nursing
- Focus on interpersonal relationships in education
- Motivated to show up early and stay late = 'workaholism'
- Question authority (early memories include Vietnam War, Women's and Civil Rights)
- Experienced changing medical economics
- Believe that they "know it all"

CHARACTERISTICS OF GENERATION X (1965-1980)*

- Dual income or single parent families
- Experienced media explosion and invasion
- Demonstrate reluctance towards commitment
- Can be easily misunderstood by other generations
- Individually directed
- Demonstrated casualness is not a lack of concern or caring

Generation X demands communication about financial issues, and appreciates constructive feedback that is direct. They seem to seek a cohesive team approach.

** Note that the years included in each cohort represent a general timeline; and every individual in a cohort does not necessarily reflect every characteristic. In addition, individuals born near either end of a cohort may express characteristics of both generational groups.*

CHARACTERISTICS OF GENERATION Y OR MILLENIALS (1980-2001)

- Held up as hope for the future
- Grew up "online"
- Lifetime learners
- Value flexibility, exciting work, their role in promoting social good
- Accept diversity

This generation has expectations that the institution will provide them with a fun and exciting career. They are more accepting of ethnic, racial, and gender diversity in the workplace than any previous generation. They expect to be able to be in relationships, get married, and have a family life, along with control of their lifestyle.

Millenials can perceive baby-boomers as hypocritical in what they claim as values compared to their behavior. At the same time, millenials can perceive Xers as selfish, materialistic, and cynical. Their revolution may be their optimism, their cheerfulness, and their positivity about marriage and family rather than cynicism.

As a quick summary, we can view the trend in Traditionalist to Generation Y work ethic as changing from dedicated and loyal, to one where each individual is their own free agent negotiating their own work/life balance. The trend in the perception of authority and leadership is changing, from respect that is based on a hierarchy to the view, in younger generations, that leadership should be based solely on competence. It is important to note that these are general trends, and not everyone in a generation strictly adheres to every characteristic. As applies to all cultural generalities, there are as many differences among individuals within a cohort as there are between cohorts.

VALUES OF YOUNGER GENERATIONS

- Collegiality
- Trust in their job
- Diversity
- Encouragement
- Stability

BRIDGING DIALOG AMONG GENERATIONS

Current medical leaders are concerned about the ability of younger generations to face the challenge of building medical communities and teams of physicians. In today's complicated medical workplace, active collaboration, and teamwork are necessary. Therefore, medical leaders should encourage young physicians to participate in medical community building.

Older physicians need to expand their inquisitiveness, and they should move beyond any notion of stereotyping or shaming young physicians for having a different work ethic. They must learn how to mentor without micromanaging. Older physicians should have an open door policy that allows free access and free flow of information while at the same time, maintaining appropriate professional boundaries.

Younger physicians should demonstrate respect towards older physicians and their values. Acceptance of the older generations view of responsibility and commitment is also helpful for younger physicians.

BUILDING BRIDGES ACROSS GENERATIONS

- Work together to implement resident work-hour limits with a mutual focus on training and patient safety
- Respect family or personal time
- Develop rewards for overtime work
- Evaluate performance with an awareness of your biases
- Identify ways to make some specialties more attractive for younger generations
- Implement alternative training methods
- Request feedback from both faculty and trainees
- Reconsider definitions of 'professionalism'
- Help trainees develop skills to build bridges among patient generations

In summary, building bridges among the generations requires effort on everyone's part. It's important to develop an attitude of curiosity and an understanding of the people that we are trying to lead. We have to be aware of, and able to identify and then manage our own biases, as well as biases of others, when dealing with generational stress. It's important to model appropriate limit-setting and psychological boundaries when dealing with generational issues. Lastly, we need to realize that this is a universal effort and we should work to develop philosophies that aid in this effort.

SCENARIO SUMMARY

A male resident (generation Y) shows up for duty early in the year in a clean t-shirt, designer blue jeans, and expensive flip-flops. The program director meets him in the hallway and tells him that he is dressed appropriately for a beach party, but not for a residency program. The resident replies that he dresses casually only on days that he doesn't see patients. The program director then blasts the resident for daring to show up in those clothes, and adds that he, himself, would have never dressed like that during his residency.

DISCUSSION QUESTIONS:

- Would the resident in this vignette have violated the dress code at your institution? Does your institution have a formal dress code and is it helpful? What would you include in a dress code if you were to write one?
- How could understanding generational differences help in this situation?
- What sorts of disciplinary actions might be associated with dress code violations?

Assumptions that underlie the initial scenario include the following:

- The dress code is a rigid requirement that has not changed since the time when the program director was in training
- Casual dress is an indicator of casual (ie slack) attitude or work style
- Millenials are always trying to get away with as much as possible and don't work as hard as the older generations

HOSPITAL POLICY ON PROFESSIONAL BUSINESS ATTIRE

Background

Appropriate good taste, good grooming, safety, and consideration for others should govern the appearance of all employees, contract employees, residents, volunteers, students, Medical Staff, and research personnel utilizing hospital facilities. Neatness and cleanliness are evidence of concern for our patients, their families, the public, and each other.

The Health Care System believes that personal neatness and appropriate attire provide an atmosphere of professionalism and inspire confidence in our ability to deliver services. The provisions of this policy apply to all personnel operating in the Health Care System. Department policies may specify additional requirements as appropriate for employee and patient safety.

Identification

All employees, staff members, volunteers, as well as visitors to the hospital shall be required to wear appropriate identification as defined in the "Identification of Employees, Staff Members, Patients and Visitors" Policy in the Health Care System Policy Manual. An employee's name and picture must be visible at eye level at all times.

Uniforms

Employees for whom uniforms are required for the job must wear the appropriate uniform. Alterations to the uniform or alternatives to uniforms are allowed only if prior approval has been obtained from a Department Head and if the intent of this policy is not violated.

Scrub Suits

Scrub suits, masks, shoe covers, and gloves should be worn only in areas designated by relevant departmental policies and only by those designated to wear them as part of their personal protective equipment. Please refer to departmental policies regarding the use of scrub suits.

SCENARIO RERUN

A male resident (generation Y) shows up for duty early in the year in a clean t-shirt, designer blue jeans, and expensive flip-flops. The program director meets him in the hallway and asks him how his orientation is going. The resident replies that the orientation is fine, except for the amount of paperwork. The program director informally mentions that the orientation should help explain the program's culture including appropriate greetings and apparel to wear to insure that patients feel at ease.

The rerun attempts to teach the following principles:

- An individual should be aware of biases before any communication or action takes place
- Mentors may determine that they can exercise more flexibility in certain situations
- Expectations for residents' behavior should be clearly identified and presented

SCENARIO SUMMARY

A female resident (generation X) is receiving her quarterly schedule of duty hours from her supervisor (baby boomer). After looking at her schedule the resident states that her religious faith requires prayer several times a day and from 1:30 to 2:00 on Fridays. She adds that she will need to be excused and have another resident cover for her during those times. The supervisor responds in a hostile manner about the resident trying to get hours off during her residency training. She states that the resident should know that medicine is a 24/7 career, and that asking her colleagues to fill in is an extreme imposition.

DISCUSSION QUESTIONS

- How does your program and staff balance accommodating religious practices of residents with practical and ethical concerns of continuity of care and obligation to patients?
- How could understanding cultural and religious differences help in this situation?
- Do you have residents or faculty on staff who would be willing to present how they have addressed their religious traditions during medical training?

Assumptions that underlie the initial scenario include the following:

- Medical training programs should not have to accommodate religious practices of residents
- Residents should not be allowed to alter an arranged on-call schedule
- The opportunities for working out cultural, generational, or any other types of differences are extremely limited in medical training programs

SCENARIO RERUN

A female resident (generation X) is receiving her quarterly schedule of duty hours from her supervisor (baby boomer). After looking at her schedule the resident states that her religious faith requires prayer several times a day and from 1:30 to 2:00 on Fridays. She adds that she will need to be excused and have another resident cover for her during those times. The supervisor replies that the resident should try to trade with another resident for the Friday time slot, and asks the resident to help come up with a plan for the daily prayer times that will maintain continuity of patient care.

The rerun attempts to teach the following principles:

- Increased diversity with more international graduates, and residents from generations that want to be able to maintain a work/life balance, brings the question of how to accommodate different religions to the forefront of residency programs
- Residency programs should provide clear guidelines for residents, and at the same time, be flexible enough to involve residents in the scheduling
- Religious accommodations in residency training are a current topic of discussion within the AMA as well as the ACGME

INTERNATIONAL MEDICAL GRADUATES AND CULTURAL COMPETENCE

Overall, an average of 26.4% of ACGME residents and fellows are international medical graduates (IMGs) *[JAMA 2005]*. This percentage varies considerably by specialty. Over half of residents in some specialties such as Geriatric Medicine are IMGs. Over 40% of residents/fellows in Clinical Neuropsychology, Pain Medicine, Child and Adolescent Psychiatry, Pulmonary and Critical Care Medicine, and Internal Medicine are IMGs, and residency programs in certain states including New York and New Jersey may comprise IMGs as a majority *[mdgreencard.com, NRMP data]*. IMGs are an increasingly important source of potential residents as residency programs seek to fill open slots and strive to help prevent future predicted physician shortages (some national groups have called for a 30% increase in the medical student pool over the next few years).

ADDRESSING POTENTIAL IMG DIVERSITY GAPS IN RESIDENCY TRAINING INVOLVES:

- Enhancing English language usage
- Avoiding the use of jargon
- Awareness of different views of medicine and education
- Clear orientation to rules, customs, and expectations of US residency programs
- Understanding and attention to "non-verbal" cues such as head nodding, smiling, indirect eye contact, etc.

Some of the strategies programs have used for IMG training include providing a clear model of how to obtain a patient history, conduct a physical examination, write chart notes, make a presentation at rounds, obtain informed consent, provide counsel for a potentially sensitive matter such as sexuality (many programs have found this strategy to be so successful that they have extended it to all residents who are starting in their program). Other strategies for promoting IMG assimilation are to identify accessible 'English as a second language' resources, incorporate 'standardized' patients, role plays and video taping of patient encounters to teach/assess physician/patient communication skills, refer to personal "coaches" to address communication skills, dress, and social interaction skills, and network with pertinent community or local college/university cultural groups.

GENERATIONAL ISSUES REVIEW

- Describe resiliency and discuss ways to promote it within your program.
- Discuss common attitudes of each generational cohort and how they may manifest within a hospital workplace. What attitudes do you have in common with your generational cohort? What are the different biases that can be associated with these attitudes?
- Describe cultural competence and discuss its impact within any workplace setting.
- Discuss the impact of generational characteristics on mentoring, communication, and how residents are evaluated. What are some strategies for dealing with these differences?
- Discuss hurdles for IMGs in residency programs and ways to bridge diversity gaps in residency training.
- Explain 'bridging dialog' between older and younger generations. Which generations should be involved in the 'building bridges' effort?

GENERATIONAL ISSUES: ADDITIONAL REFERENCES OF INTEREST

ACGME Useful Information:

Entry of Foreign-born Medical Graduates to the United States
Fifth Pathway Program
Appointment to Armed Services Graduate Medical Education Programs
Electronic Residency Application Service (ERAS)
National Resident Matching Program (NRMP)
Information on Unfilled Positions
Information on Canadian Residency Programs

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RECRUITING THE RIGHT APPLICANTS

Catherine K. Lineberger, MD

GOAL

This module presents information about recruiting and selecting applicants, not only through careful assessment of applicant credentials, but also by evaluating your own program's qualities and goals. It describes the structure of a well-designed interview process.

LEARNING OBJECTIVES

After working through this program, you should be able to:

- Recognize the importance of clearly-defined departmental and program goals in the recruitment process
- Select your most important tools for evaluating applicants
- Apply evaluative tools within your applicant selection process
- Identify strategies for a well-designed interview
- Analyze common recruiting pitfalls and develop strategies for avoiding them

PROGRAM TEACHING POINTS

Studies and experience suggest that traditional academic criteria are not sufficient for predicting the clinical performance of residents. Evaluating letters of reference is somewhat helpful, but only with a great deal of critical thinking and learning how to interpret what are frequently subtle "clues". Information gained from a well-designed and well-structured interview can frequently be the best basis for decisions.

GOALS OF RECRUITING

The goals of recruiting are to match the objectives and attributes of your department and program with those of your applicants. To accomplish this, you need to design policies and procedures for selecting your applicants as well as a process for recruiting them.

ANALYZING YOUR PROGRAM

It is important to identify the culture of your program, define the goals of your department or program, and make sure that they are broadcasted to interested applicants. Some departments have a formal mission statement that addresses these issues. This information could be included on the department website, for instance, and should begin with the overarching principles or philosophy of the residency program. The types of healthcare or procedures for which your department has been

recognized, or the types of skills and the approach to healthcare that your department is noted for should be included.

DEFINE THE SPECIFIC CHARACTERISTICS THAT BEST SUIT RESIDENTS IN YOUR PROGRAM BY CONSIDERING:

- **Success for *your* program**
  - Special Board "essential attributes"
  - ACGME RRC requirements
  - ACGME general competencies
  - Passing rate on USMLE or comparable licensing examination
  - Passing rate on Board exams
- **Accomplishments of former residents**
- **"Real culture" and behaviors promoted in your program**
  - Sound versus excellent clinicians
  - Sound versus superb teachers
  - Solid versus creative researchers
  - Developing future political leaders
  - Competent versus innovative administrators
  - What type of residents do you really want in your program
- **Knowledge, attitudes, or skills that are needed**
- **Ability to gain knowledge, attitudes, or skills**
- **Scholarship demand**
- **The "hidden" curriculum**

This can be the most difficult portion of the process. An honest self study of who succeeds in your program is beneficial. Your faculty, current residents, and recent program graduates can be extremely helpful to you, as can other departments or programs who are in contact with your residents on a regular basis. Your aim is to separate "myth" from reality. You may believe that your program is a very flexible, gentle, and adaptive residency. In truth, you may have a program that is very tightly organized, sequenced, and with limited elective time. Neither is good nor bad, however, you don't want to recruit residents whose expectations cannot be realized. You want to make your culture as transparent as possible for your applicants.

The ACGME RRC requirements for your specialty usually include eligibility requirements. Make these explicit to your potential applicants. Many programs find it useful to have "technical standards" that describe what applicants must be

able to "do" to function optimally in the program. This may be especially important for procedure-based specialties.

Program information should be provided in an enduring medium to your applicants. Some programs include information in written handouts, others use a CD-ROM or web site. It is important to retain proof that applicants received the material, such as a signed statement to that effect. Your RRC requirements may have specific items that should be included. A copy of the contract the residents will have to sign should be available. If they interview when information (such as salary) is not yet available, provide them with salary information for the current year, the typical salary increase from one year to the next, the date by which this information will be known, and how they can learn about this decision when it is made.

ASSESSING THE APPLICANT

All programs look for applicants who are enthusiastic learners and team players, and who are able to apply their knowledge in making complex decisions. Program directors seek personalities that are high-achieving, altruistic, honest, creative, innovative, amicable, flexible, resilient, respectful, compassionate, organized and professional. (Resilience is defined in the generations section, and professionalism is defined in the legal section of this CD-ROM).

Ideally, you would like to find individuals who have true insight into their career choice and ideas about how their strengths, weaknesses, abilities and liabilities would mesh with your specialty and program. It's a tall order to find all of this in one person, and it may be worthwhile for you to decide, and even prioritize, which behavioral characteristics are most important for your program before you design your strategy for a candidate search.

By attempting to identify those residents most likely to succeed, you are essentially creating a process to screen for and eliminate those candidates less likely to succeed. Alternatively, you can plan proactively for any necessary remedial process.

Anesthesiology Residency Technical Standards

Introduction

All candidates for the anesthesiology residency must possess the physical and mental skills and abilities necessary to successfully complete the anesthesiology residency program. To achieve the optimal educational experience, residents are required to participate in all phases of the training program.

The study of medicine and anesthesiology is not a pure intellectual exercise. Rather, a specific minimum set of physical, mental, emotional and social abilities are needed to be a successful resident. Residents must possess all of the abilities listed in the five categories below. The use of an intermediary who would, in effect, require a resident to rely on someone else's power of observation, communication, and/or motor skills will not be permitted.

I. Observation:

a. Visually observe materials presented in the learning environment including audiovisual presentations, written documents, tissues and gross organs in the normal and pathologic state, and diagnostic images.

b. Observe patients accurately and completely, both at a distance and directly. This requires functional vision, hearing, and sensation.

II. Communication:

a. Effectively speak, write, hear, read, and use a keyboard.

b. Perceive non-verbal communications, including facial expression, body language, and affect.

c. Communicate effectively and sensitively with patients and their families via speech as well as reading/writing.

d. Communicate in oral and written form with the healthcare team in an effective, accurate, and efficient manner.

III. Motor:

a. Elicit information from patients via palpation, auscultation, and percussion, as well as carry out diagnostic maneuvers.

b. Execute movements reasonably required to provide general medical and anesthetic care and emergency treatment to patients. These skills require coordination of gross and fine motor movements, equilibrium, and sensation.

c. Manipulate equipment and instruments to perform basic laboratory tests and procedures as required to attain residency goals (e.g. needles, stethoscope, laryngoscope, FOB, central line sets, ultrasound, anesthesia machine, syringe and infusion pumps, peripheral nerve block kits, obtain materials and equipment, etc.)

d. Respond to emergencies in the operating room and in all clinical areas when assigned, on one's own power and without reliance on equipment or mechanical devices.

IV. Intellectual/conceptual, Integrative, and Quantitative Abilities:

a. Perform calculations necessary to solve quantitative problems as required by patient care and testing needs.

b. Collect, organize, prioritize, analyze and assimilate large amounts of technically detailed and complex information in a timely fashion. This information will be presented in a variety of educational settings, including lectures, small group discussions, and individual clinical settings. The resident should be able to analyze, integrate, and apply this information for problem solving and decision-making in an appropriate and timely manner for the clinical situation.

Anesthesiology Residency Technical Standards (cont'd)

c. Apply knowledge and reasoning to solve problems as outlined by the curriculum.

d. Comprehend the three dimensional spatial relationships of structures.

e. Remain awake and alert for assigned duty periods and teaching activities.

V. Behavioral, Emotional and Social Attributes:

a. Possess the emotional health to fully apply his/her intellectual skill, exercise good judgment, and to complete all responsibilities attendant to the diagnosis and care of patients.

b. Develop a mature, sensitive and effective relationship with patients and colleagues.

c. Tolerate the physical, mental, and emotional stress experienced during training and patient care, including call nights and up to 30 hrs of clinical work.

d. Possess qualities of adaptability, flexibility, and the ability to function in the face of uncertainty.

e. Form a compassionate relationship with his/her patients while maintaining appropriate behaviors for a professional relationship.

f. Behave in an ethical and moral manner consistent with professional values and standards.

g. Exhibit sufficient interpersonal skills, knowledge, and attitudes to interact positively and sensitively with people from all parts of society, ethnic backgrounds, and belief systems.

h. Cooperate with others and work collaboratively as a team member.

The faculty of the Department of Anesthesiology recognizes their responsibilities to present candidates for board certification verifying that they have the knowledge, attitudes, and skills to function in a broad variety of clinical situations and to render the complete spectrum of anesthesia care independently.

The Resident Selection Committee is responsible for adhering to these technical standards during the selection of residents. Any applicant to the program, or resident matched or hired by the program, is responsible for notifying the program director of any condition that would affect full and independent participation in required residency activities.

If you have any questions about this document or whether you meet the standards described above, please contact the Anesthesia Education Office.

My signature below indicates that I have received a copy of and read this document.

Signature Date

Printed name

MATERIALS FOR EVALUATION:

- **Application**
  - Provides opportunity for your program to ask about values, perspectives, and attitudes necessary for success in your field
- **Personal Statement**
  - Assesses insight into specialty choices
  - Identifies earlier career choices
  - Reflects how career choice supports what is valued/important to the applicant
  - Identifies potential clues such as "balance" and "lifestyle" and the expectations of the applicant can be compared to the expectations of the training program
- **Curriculum Vitae**
  - Pay attention to any unexplained time lapses
  - Check for accuracy of dates by matching to other sources (ie. dates of attendance, graduation)
- **Letters of reference**
  - If any of these are written by someone you know, don't hesitate to follow-up and inquire about details
  - Lukewarm or bland letters are red flags
  - Consider what the writer doesn't say, as well as what he/she does say
  - Consider what the association is between the writer and the applicant
- **Dean's letter/Medical Student Performance Evaluation**
  - Any negative comment is important-investigate thoroughly
  - Look for mention of comparative objective data (grades, percentiles, etc.)
  - Are all rotation comments included in entirety, or are they selected/edited?
- **Scores from key 3rd year clerkship exam**
- **Competency verification from prior GME training**
- **Certifications**
- **Results of USMLE, COMLEX, or other comparable exams**
- **ECFMG results if applicable**
- **Chronology of education and training, specifically accounting for any gaps other than vacation**
- **Any past disciplinary action (school, employment, civil, criminal)**
- **Visiting electives (good source of information, and a test of "fit")**

Of these, the letters of reference, CV, and results from the clerkship may provide some insight into characteristics of the applicant, however, letters of reference frequently suffer 'grade inflation'. Therefore, it's not so much what the recommendation letters say, it's also what they don't say, that deserves attention.

Discover whether or not the applicant gave permission for the letter to be submitted without his/her seeing it. If the applicant didn't waive their right to this review, consider the letter more "suspect" than if he/she did.

If the applicant provided a list of people who were submitting letters of reference, and you received letters from different individuals, ask the applicant to provide you with a written explanation of the change. Ask if you can contact the individuals on the original list.

You may want to specify the qualifications of those writing the letters (a faculty member who had actually worked with and supervised the applicant, for a specified period of time, for example). Define what constitutes an unacceptable or less desirable source for letters of recommendation (personal friend, family member, etc). Consider having your own short form on which the applicant describes his or her relationship to the letter writers, as well as a method of contact.

CRITERIA FOR EVALUATING LETTERS OF REFERENCE

- Is the letter from someone the applicant indicated would be submitting a letter?
- Is the letter written to address issues specific to your program? Or is it a generic letter?
- In what capacity does the reviewer know the applicant (faculty member, friend, family member, colleague, student)?
- What benchmark data do you have about this reviewer (other letters of recommendation, acquaintance of your faculty, or residents) to determine how this letter compares to others he/she has written, i.e., is he/she frequently or always overly positive?

Within the CV, look for mention of leadership or volunteer/public service activities in which the applicant may have been involved. While these items serve as plusses for the applicant, any breaks or lapses in training or employment can be considered red flags. Results from the third-year clerkship or "Sub-I" can be used as an indication of clinical competence especially if the preceptor was able to directly observe each student during their patient interactions, and provide comparisons among students.

THE INTERVIEW

The interview and the process leading up to it can be the source of the most useful information about your candidates' behaviors and attributes. Therefore, it is critical to

have your interviews carefully designed to be able to glean the most information. Your goal is find out as much as you can about past behavior and attitudes of your applicants. The premise for this is that past ability predicts future success, or on the flip side, that past misbehavior can predict future problems. Studies confirm that physicians with disciplinary issues at the level of the state licensing board had issues much earlier in their training, even as early as medical school. *[N Engl J Med. 2005; 353(25):2673-2682]*

INTERVIEW METHODS:

- Structured or unstructured
- Group or individual
- Behavior-focused questions
- Gathering feedback

Your interview method will depend on the information you want to obtain. For example, if you want to know how well your applicant functions in a team, then the group interview might be the most revealing method. If you want to know how well your applicant deals with personally difficult situations, then you might want to choose an individual interview.

GROUP INTERVIEW METHOD IS ALSO USED FOR:

- Limited time and multiple interviewers
- Less formal settings

The structured interview is rare in GME, and the unstructured interview has very low predictive value. The semistructured is the most common residency interview type and can be made more reliable by:

- Using consistent interviewers; this allows each interviewer to compare and contrast a large percentage of the applicants
- Including behavioral descriptive interview style questions
- Asking consistent questions of each applicant

Asking consistent questions of every applicant definitely saves time, and allows each interviewer the ability to directly compare applicants. However, the less formal group interviews probably stay "fresher" and more enjoyable if they are unstructured where each member of the group comes up with a question of interest.

It is important to be aware that applicants may show a different aspect of themselves to resident interviewers than they do to faculty interviewers. Applicants may tend to let their guard down a little more with those they perceive as peers. Therefore, it is very important to include interactions with the residents, and with no faculty involvement.

Many departments have instituted a "night before the interview" social event that can maximise applicant-resident interactions. [R. Strauss, UNC] Afterwards, the resident interviewers should be given an opportunity to voice opinions about each applicant. Comments from the administrative staff should also be solicited.

INTERVIEW METHODS: QUESTIONS

All interviewers, whether they are faculty or residents, should be coached on the types of questions they should ask, as well as the types of questions that are inappropriate to ask. The types of questions that have been demonstrated to be the most revealing are behavior-focused questions. The following two models provide some examples of the types of behaviors you may want to learn more about during the interview, as well as the types of questions you may find useful to identify these behaviors. Your HR department can provide your institution's requirements if there is any uncertainty.

The following table presents some candidate behaviors that many programs might find desirable. Examples of "main questions" within each behavior are listed. For one of these questions, examples of follow-up probe questions are given that may allow the interviewer to obtain further information from the applicant. A rating scale is also presented as an example by which the program can grade the applicant's answers.

BEHAVIOR-FOCUSED QUESTIONS	MAIN QUESTION	FOLLOW-UP PROBE	ANSWER RATING
Team player/Altruism	"Tell me about a time when you went out of your way to help a team member."	"What was the minimum expectation in this setting?" "Why did you behave the way you did?" "What reward(s) did you receive for this?" "Why did you choose to do more than what was expected?" "What did your friend (colleague) think about this?" "Did you tell anyone else about it?"	Excellent (4 points): sacrificed significant amounts of personal time/energy to help; incurred some personal risk and received no external award or compensation Acceptable (3 points): volunteered to help but only in free time; placed significant limits on amount/time of assistance; put effort "in the bank" for future payback Poor (2 points): reluctant to help; was coerced or convinced; minimal time or effort expended; drew attention to efforts as deserving of acknowledgement Unacceptable (1 point): did little to help; situation was part of usual expectations; motivated by potential for self reward

BEHAVIOR-FOCUSED QUESTIONS	MAIN QUESTION	FOLLOW-UP PROBE	ANSWER RATING
Communication Skills	"Give me an example of the most difficult interaction you've had with a supervising resident."		
Honesty	"Tell me how you would answer a question that a patient asks you, if you are unsure of the answer."		
Ambition	"Give me an example of a time when you exceeded your own expectations."		
Work Ethic	"Tell me about the hardest thing you've ever done."	"What do hard work and sacrifice mean to you?"	
Conflict Resolution	"Give me the best example, in the last few years, of your ability to resolve a conflict."		
Self-reflection/Insight	"What learning skills have you developed?" "How do you best learn?"	"Tell me about something you failed at." "Imagine yourself a week into this residency. What is something you wish you would have known?"	

Consider having interview teams of faculty and residents design their own questions and rating scale during a pre-interview season "retreat".

The key to asking these questions is to follow up with further probe questions if the answer you receive is incomplete, theoretical, or vague. Follow-up questions should be phrased as asking for more explanation of a situation, the action that the person took

within that situation, and then, what was the outcome or the result of that person's actions. Some programs may wish to make this a very quantitative process; others will find it acceptable just to explore the issues with applicants in some detail.
The STAR process is another method for generating consistent interview questions about behaviors such as communication, team player ability, and self-motivation. STARs are discussed in the following tables. *[Source: UNC OB/GYN Program]*

Communication **STAR**s

Situation or Task	Action	Result
Tell me about an interaction with a team member, nurse, or patient that you wished you had handled differently.	How did you rectify the relationship/situation?	What was the outcome of your actions?
Tell me about a recent incident when you lost your temper.	Walk me through the steps you took after you lost your temper.	What was the outcome of your actions?
What is the most difficult thing that you have ever had to teach to someone?	How did you accomplish it?	Is there anything that you would have done differently?

Team Player **STAR**s

Situation or Task	Action	Result
Describe a situation where you had to work out an agreement with a peer or team member.	Walk me through the steps you took.	What was the outcome of your actions?
Describe a time when you should have been more of a collaborator.	What impeded your efforts?	Is there anything you would do differently next time?
Has there ever been a time at work or in medical school that you took a leadership role?	What were your duties in that role? What did the team do?	What was the outcome of your actions?
Describe a time when you were a member of a team and you faced some type of problem or dilemma.	How did the team approach problem	What was the outcome of your actions?
Tell me about a time when you went out of your way to help a team member.	How did you go about making this decision?	What was the impact on your relationship with the team member?

Self-Motivation STARs

Situation or Task	Action	Result
Was there ever a situation during medical school that made you question your desire to be a doctor?	Describe the circumstances surrounding that situation.	What made you stay interested in medicine
Give me an example of a time when you saw something that you thought was being done poorly.	Describe the circumstances surrounding that situation.	What did you do about it?
Can you think of a situation where a supervisor's evaluation of your performance differed from your own perception?	Describe the circumstances surrounding that situation.	What did you do about it?
Has there ever been something you have worked hard to achieve, but failed?	Describe the circumstances surrounding that situation.	What did you do about it?
Was there ever a time when you did something without being asked or without expecting recognition for it?	What did you do first….. second?	What was the result?

Both approaches to interview questions are similar. They attempt to identify the applicant's behaviors. You can design questions that help you gain information about whether the applicant demonstrates behaviors deemed to promote success in your program. These may be behaviors that the applicant has already displayed in some situations, or predicts behaviors that the applicant might exhibit if put in certain situations.

Of course there are many questions that are entirely inappropriate to ask in an interview. These include questions regarding family planning, marital status, or birth control. Obviously, there should be no questions about race, religion, or sexual orientation. Questions about medical history or disability are also unacceptable, and interviewers may not ask if applicants have previously requested or received reasonable accommodations. However, it is appropriate for the applicant to offer information within any of these areas.

It is legitimate for you to know if the applicant is able to perform with or without reasonable accommodation the essential requirements and/or functions of the residency program, or if the applicant has any condition that would keep him/her from completing the program. You cannot ask if the applicant is disabled or if they have certain medical conditions. Instead, you will need to have already developed essential requirements or technical standards for your program, and ask each and every applicant the same question about their ability to perform these requirements.

You may consider having a workshop for all those involved in recruitment at the start of applicant season. These workshops would provide opportunities to role play some situations and compare typical questions. Many groups can be very creative at coming up with their own list of behavior specific questions. You will want to define the type of feedback you need from your interviewers at the end of the day. In the workshop, you might include practicing that type of feedback.

Some programs split up assignments for the interview day. One interviewer may focus on academic skills, another the interpersonal skills. Residents may take applicants to lunch or dinner in a casual setting to determine whether each individual will be a team player, or fit in well with the other residents.

The interview is valuable time and can provide a coordinated approach for assessing your applicants. Being organized at the beginning can help you more successfully mine the most useful information.

INTERVIEW METHODS: FEEDBACK

- Obtain immediate feedback from interviewers
- Employ standardized method for rating applicants
- Include key faculty, current residents and staff

In summary, these methods for recruiting and interviewing residents should assist in recruiting the right applicants and avoiding future problem residents. They maximize your chance for success.

However, sometimes it just isn't possible to avoid recruiting residents who have problems. Sometimes, cognitive problems including insufficient knowledge base, test-taking difficulties, or learning disabilities are so subtle that they may be difficult to detect during the interview process. Other problems that can be imperceptible at first are affective problems such as unacceptable work ethic, lack of compassion, or respect, impairment, or psychomotor problems that prevent attaining the proper level of technical skill or stamina. Sometimes individuals may perform well as a student, but lack the "right stuff" for making the leap to the independence and specific competencies required of residents. Sometimes the person has simply made the wrong career choice. These problems may be detected as substandard performance, or the inability to progress.

If these problems do occur, there should be clear policies for corrective action (discussed in further detail in the "Legal" section of this CD-ROM). Situational issues such as change in marital status, child-rearing, or restrictive health conditions can lead to stress that can impair performance, at least for a while. Many of these can be anticipated and can be prevented or ameliorated by identifying your resources (see the "Stress and Depression" section of the first CD-ROM).

POTENTIAL PROBLEMS COULD TAKE THE FORM OF:

- **Poor career choice/insight**
- **Cognitive issues**
    - Inadequate knowledge base
    - Learning disability
    - Test-taking abilities (written, oral, or both)
- **Affective problems**
    - Poor coping skills
    - Professionalism issues
        - — *Motivation*
        - — *Honesty/integrity*
        - — *Work ethic*
        - — *Compassion*
        - — *Respect*
        - — *Altruism*
        - — *Disruptive behavior*
    - Burnout
    - Impairment
        - — *Substance abuse*
        - — *Medical condition*
        - — *Psychiatric illness*
        - — *Learning issue*
    - Situational issue(s)/stressor(s)
    - Psychomotor problems
        - — *Lack of technical skill*
        - — *Inadequate stamina*

SCENARIO SUMMARY

A faculty member is interviewing a resident applicant in her office. The faculty member is disorganized and at times disrespectful, not only in the questions she asks, but also in the way she conducts the interview. By doing this, she decreases her chances of obtaining useful information from her applicant. The mistakes of the interviewer include that she doesn't reply to the applicant's inquiries, but goes on with her next question, she doesn't follow through with her questions to get all of the possible information out of each one, and she asks inappropriate questions. The next day the faculty member learns about some of her mistakes as she talks with the program director.

DISCUSSION QUESTIONS:

- What are some interviewing skills that might have helped the interviewer in the preceding vignette?
- Is it possible to have the wrong impression about an applicant based on an improperly conducted interview?
- How could your program benefit from a training session or workshop focusing on interview strategies?

Assumptions that underlie the initial scenario include the following:

- The amount of information that can be obtained from an interview is very limited.
- There are no "bad questions" that an interviewer can ask.
- Interviewing skills are always intuitive, and training will not help.

SCENARIO RERUN

A faculty member is interviewing a resident applicant in her office. The faculty member is conducting a much better interview. First, she allows the social interaction to go on a little further at the beginning, then, she is not dissuaded by an incomplete answer to her question, but prods for further information and follow-up. She also asks multiple questions about each situation to see if the described behavior was an isolated incident or if it was part of a pattern. By following these steps, she increases her chances of obtaining useful information from her applicant.

The rerun attempts to teach the following principles:

- Interviewing techniques are not intuitive, but can be learned.
- Interview questions can be planned ahead of time, but the interviewer also has to be flexible enough to base follow-up questions on the applicant's responses.
- It is only through a well-designed and carefully structured interview that the interviewer can obtain the most valuable information from each candidate.

APPLICANTS REVIEW

- Define the goals of recruiting and name the steps for accomplishing those goals.
- Characterize the "culture" of your program.
- Compare the materials used for candidate evaluation, and describe the types of information that can be gleaned from each one.
- Contrast the different interview methods.
- Discuss the elements of a well-designed interview process. What types of questions can produce the most valuable information about each applicant? How should each question be structured? What questions must be avoided?

APPLICANTS: ADDITIONAL REFERENCES OF INTEREST

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STAYING IN THE PROGRAM DIRECTOR ROLE

Joseph Kertesz, MA
Warren J. Pendergast, MD
Judith C. Holder-Cooper, PhD

GOAL

This module presents information on responsibilities and challenges for program directors, management strategies for common challenging resident situations, and avenues for potential rewards.

LEARNING OBJECTIVES

After working through this program, you should be able to:

- Understand the main challenges that program directors face as well as ways to manage them
- Explain what is involved in "the rock" and "the hard place"
- Describe educational "boundary" issues and assess the appropriate level of program director and trainee involvement
- Identify program director "rewards"

SCENARIO SUMMARY

A program director is in his office fielding multiple calls and visits from various staff. The program director's administrative assistant comes in his door with some urgency to inform him that one of the residents is there to see him. He hangs up the phone, and reprimands the administrative assistant for having interrupted him during a time that he was very busy. He also complains about the majority of the residents' issues as being petty and not worth his effort discussing.

DISCUSSION QUESTIONS:

- For what issues involving residents is the program director responsible?
- What issues should the program director delegate to another professional to address?
- What stress management programs are available to residents at your institution?
- What are the "job requirements" included in the program director's role?
- Is there an appropriate forum for divulging personal information about a resident?

Assumptions that underlie the initial scenario include the following:

- Program directors are extremely busy people
- Personal meetings with residents are generally considered an imposition by program directors
- Program directors have to handle all issues dealing with residents by themselves

SCENARIO RERUN

A program director is in his office fielding multiple calls and visits from various staff. The program director's administrative assistant comes in his door with some urgency to inform him that one of the residents is there to see him.

After some time passes, the program director is seen talking on the phone with another program director. He is asking the other program director how he/she handles residents who he believes are constantly seeking advice.

The rerun attempts to teach the following principles:

- Program Directors should be knowledgeable of and consult objective resources for assistance
- Resident confidentiality should be maintained, and personal information about a resident should only be divulged to those individuals with "the need to know"
- One of the best ways of dealing with the role of Program Director is to develop a network of other program directors that allows for sharing experiences and discussions

PROGRAM TEACHING POINTS

Program Directors often work autonomously as the only person in a division or department with their type of specialized knowledge or expertise. Much of that expertise has been gained from on the job training.

Often the program director (PD) is promoted into the role without having the opportunity for any focused preparation, training, or gradual development. Yet, the role of PD requires a delicate balancing act between senior/experienced physician, teacher, evaluator, manager, administrator, mentor, and coach. Essential competencies include adult teaching and learning, curriculum design and evaluation, as well as formulating individualized learning plans, human resources, managerial skills, accreditation, and legal issues. The program director manages residents, staff, faculty, and often the division chief chair or dean. There are a myriad of academic as well as administrative duties that the PD is responsible for, and they all have to be performed well on an as-needed, and usually urgent, basis.

Rewards associated with the role of PD involve serving as teacher and mentor for the residents, and developing life-long relationships and appreciation from residents. Surveys of PDs show that the most enjoyable activities associated with the job are teaching and mentoring, and these rank far above all other duties. Attracting and selecting resident applicants also ranks as one of the more enjoyable activities. Some enjoy faculty development and helping more junior faculty progress. Others love curriculum development, or the challenge of figuring out ever better assessment tools in their specialty.

Nonetheless, PDs have a high turnover rate. According to a 2001 survey of internal medicine PDs, 40 to 45% of PDs stay in the position 3 years or less. *[Acad Med. 2001 Nov;76(11):1127-35].*

REASONS FOR HIGH TURNOVER INCLUDE:

- Overwhelming administrative duties and time demands
- Difficult colleague relationships
- Inadequate resources
- Lack of recognition
- Lack of preparedness

The PD's role can be one of the most rewarding as well as one of the most difficult jobs in medical education. It can easily be viewed as being caught between a 'rock' and a 'hard place'.

'THE ROCK'

COMPLIANCE AND ACCREDITATION

- Administrator's expectations and demands
- Hospital, departmental and institutional requirements
- Compliance with RRC, Board, and GMEC requirements
- Regulations from state medical board, JCAHO, DEA, OIG, CMS, FDA
- Increasingly rigorous documentation requirements

POLICIES

- Code of conduct for residents
- Policies for patient safety and employee health and safety
- Adherence to policies when assigning outside rotations
- Provisions for due process

FUNDING

- Financial realities
- Shrinking federal GME funds and hospital resources
- More demands on departments for program activities
- Having to do more with less
- Fewer financial resources for faculty who may be working "harder"
- Limited administrative support for managing duties

RESIDENT EVALUATION

- Closely regulated (usually a minimum of every 6 months)
- Assessment of 6 core competencies and specialty-specific procedures
- RRC requirements for specialties
- Problem residents require more attention

DUTY HOURS

- Handling of increased patient volume and need for acute care
- Uncoupling learning from clinical service
- Juggling schedules for classroom teaching while "off duty"

THE 'HARD PLACE'

The PD must also address the needs and expectations of the residents and faculty, or the "hard place" which encompasses all aspects of resident training and education. This area is frequently the preferred area of focus for the PD when compared to "the rock."

Working with residents can be very rewarding. However, there are also important restrictions and guidelines in this area that PDs need to be aware of. First of all, in order to educate residents about the practice of medicine, the PD has to stay current with the trends in healthcare as well as the trends in medical education.

CURRENT TRENDS IN HEALTHCARE

- Evidence-based medicine
- Advances in technology
- Increased acute patient volume
- Managed care guidelines
- Cultural diversity in patient population and healthcare work force
- Diminishing reimbursement

CURRENT TRENDS IN MEDICAL EDUCATION

- Competency-based system
- Portfolio accrual
- Need for self-reflection
- Development of personal plans for life-long learning
- "Feminization" of medicine
- Grade "inflation"
- Maintaining up-to-date certification
- Remediation of problem situations
- Simulation training
- Balancing patient care and training

RESIDENT AND FACULTY NEEDS

- PD hears residents' complaints or requests for change
- Faculty's needs often run counter to system or residents' needs
- PD caught in crossfire

RESIDENT TRANSITION

- From student to physician
- Requires clear goals and a directed curriculum
- Melding of individual differences
- Providing flexibility for change if needed

RESIDENT MENTORING

- Mentoring alleviates stress and promotes effective training
- Complicated if PD serves as a formal mentor

IMPORTANT BOUNDARIES

- Temptation is to be all things to all people
- WARNING: Maintain appropriate boundaries by avoiding the temptation to "treat" personal problems from residents or faculty
- PD cannot serve as mentor, advisor, or physician for residents
- PD must remain an evaluator of performance and professional behavior

SCENARIO SUMMARY

A resident is meeting with a PD in her office. The PD is asking the resident how she is doing after 6 weeks of leave to deal with her father's health problems. The resident replies that she still feels like she needs some more time off because thinking about seeing patients is too stress-provoking. She asks the PD if the past 6 weeks could be documented as an elective period so she could still receive full credit and pay. The PD replies that he believes he has helped enough and he would not be able to change what is already documented in the resident's file. The resident pleads with the PD, saying that she needs the financial support for her father. After receiving a repeat of the first reply from the PD, the resident starts to blast the PD for not sufficiently supporting and warning her.

DISCUSSION QUESTIONS:

- How could this scenario have played out if the PD had maintained the proper boundaries from the beginning?
- What professional resources could the PD have referred the resident to in this scenario?
- What are the potential legal implications associated with this situation?

Assumptions that underlie the initial scenario include the following:

- The temptation is for PDs to be all things to all people
- Boundary violations can escalate quickly and become extremely problematic
- Ultimately, it is the PD's decision about how to manage residents with problems

SCENARIO RERUN

A resident is meeting with a PD in her office. The PD is asking the resident how she is doing after 6 weeks of leave to deal with her father's health problems. The resident

replies that she still feels like she needs some more time off because thinking about seeing patients is too stress-provoking. She asks the PD if the past 6 weeks could be documented as an elective period so she could still receive full credit and pay. The PD replies that he is definitely concerned but diverts the request to ask about the resident's progress in working with the Physicians' Health Program (PHP). The resident replies that she feels her progress is slow with the independent psychiatrist that she has been referred to. The PD reiterates that the PHP has the authority to determine when an individual is ready to return to rotations, and that everyone including the resident, herself, her patients, and the residency program would benefit the most by having her back as a healthy individual.

The rerun attempts to teach the following principles:

- When a PD becomes aware of a resident who may be impaired for whatever reason, he/she should be aware of the advantages and disadvantages of resources such as the local EAP or counseling resources, or the state PHP
- Even though it is often difficult, the PD must maintain appropriate boundaries to be able to continue as an objective evaluator
- Any type of intervention should be handled by an objective party who is not formally associated with the residency program

OBJECTIVE REFERRAL RESOURCES

REFERRAL HEALTH RESOURCES
• State Physicians Health Program (PHP)
• Institution Employee Assistance Program (EAP)
• Institution Employee Occupational Health (EOH)
• Referral source for learning disabilities
• Network of primary care and specialty physicians
• Disability office
• Human Resources

OTHER REFERRAL RESOURCES
• Faculty from another department
• Independent counselors and therapists
• Executive "coaches"
• Community programs

Career coaching is one such professional resource available to residents to assist them with their development. Career coaching may be available, along with other mental

health resources within a dedicated office at your institution; a division of the employee assistance program, for example, or, through a professional coaching practice that the employee assistance program recommends.

Unlike therapy, which addresses past issues revolving around emotional healing or relief from psychological pain, career coaching addresses the present through action planning with an emphasis on the future. Career coaching can take place concurrently with psychotherapy, but it is not a substitute for therapy when it is needed. Career coaches can be licensed psychologists, social workers, or professional counselors with specialized training in coaching; coaches can also be certified and members of the International Coaching Federation (ICF). You can obtain further information about coaching from the ICF website at www.coachfederation.org.

CAREER COACHING

- Underutilized resource for the medical field
- Residents may have pursued medicine without deep consideration
- Extreme mismatch may exist between personal vision and reality
- Objective is to align personal goals and current career path

CAREER COACHING IS ALSO VALUABLE FOR:

- Performance challenges
- Leadership effectiveness
- Workplace conflict resolution
- Strategic planning

Referring residents to objective professionals is one way to maintain appropriate boundaries. Carefully designing, writing, and adhering to policies and guidelines is another. Each program must have policies for time off or leave of absence, for rotation schedule changes, for moonlighting, for remediation, probation, and dismissal.

THE PD ROLE

The nature of the PD role and the necessity of maintaining boundaries can produce a sense of isolation for the PD, which in itself can be a form of stress. For this reason, PDs need to be aware of the network opportunities that are safe from conflicts of interest. These include creating a professional network with other PDs, either within a geographic region, or within a specialty. Sometimes, peer support from a faculty member is helpful as long as that faculty member is removed from the situations and has good boundary sense.

Networking through professional development opportunities is another option. There are opportunities through graduate medical education groups such as the ACGME,

AHME, AAMC (especially the GEA and GRA), and the AMA. Many of these are regional and easier to attend on limited time and budget. Specialty societies have a section for PDs and/or academic faculty. If your specialty society does not yet have a GME group, then consider starting one. These groups may have an established website, listserv, and chat rooms for networking. PDs may find it easier to network with other PDs within their specialty.

GME-ASSOCIATED WEBSITES

- ACGME www.acgme.org
- AHME www.ahme.org
- AAMC GEA www.aamc.org/members/gea
- AAMC GRA www.aamc.org/members/gra

The ACGME's Parker Palmer award is given to 10 residency program directors each year who demonstrate commitment to teaching and development of innovative approaches for educating physicians in training.

FINDING REWARDS

- Faculty development within or outside of your institution
- Medical education society within specialty
- Professional development courses (ex. ELAM)
- Work with division/department for recognition of teaching and PD role within the promotion and tenure process
- Develop relationships with DIO, GME, and within institution
- Network with program directors in your specialty, city, state, or region
- Identify and train associate PDs

STRESS MANAGEMENT

- Private support systems
- ERASE (Disk 1 of LIFE Curriculum)
- Professional writing or speaking
- Serving as clinical practitioner or research scientist

Finally, it is important to work to support the program coordinator(s) in the same way that the PD needs to work at identifying ways to develop and sustain him or herself. As with the PD role, there is a lot of knowledge and skills unique to the program coordinator role. Also, few people in the institution may have this job, the job requirements are difficult to categorize, and it isn't usually transferred automatically from one coordinator to the next.

The program coordinator's role can be better characterized by requesting HR to help develop a realistic job description that includes the necessary skills/requirements. HR may also be able to help assess if an individual program coordinator needs assistance with developing the necessary skills, or if their position is appropriately reimbursed.

Some of the medical specialties have developed or are in the process of developing certification for program coordinators (refer to www.tagme.org). If your specialty has this type of certification, encourage your program coordinator(s) to obtain it. If not, collaborate with other PDs to see if it would be possible to create.

Programs who invest in program coordinator(s) gain tremendous benefits. Program coordinators who understand their role are often happier, more productive and have less attrition.

PD ROLE REVIEW

- Compare the challenges and the rewards associated with the program director role.
- Name the administrative duties associated with 'the rock'.
- Name the academic responsibilities associated with 'the hard place'. What restrictions does the PD need to be aware of?
- Identify objective referral resources for residency training programs. Which resources could be involved with resident health issues, with resident performance issues?
- Discuss why it is important for program directors to maintain appropriate boundaries when interacting with residents?
- Describe potential avenues for program director rewards.

PD ROLE: ADDITIONAL REFERENCES OF INTEREST

AMA. Guidebook for GME program directors. 2005. Available at: www.ama-assn.org/ama1/pub/upload/mm/410/gme_handbook-2005new.pdf.

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Castiglioni A, Bellini LM, Shea JA. Program directors' views of the importance and prevalence of mentoring in internal medicine residencies. *J Gen Intern Med.* 2004 Jul;19(7):779-82.

Heard JK, Allen RM, Clardy J. Assessing the needs of residency program directors to meet the ACGME general competencies. *Acad Med.* 2002 Jul;77(7):750.

Hoffman CE. Boundaries with barbs: dual relationships with self and significant others. Paper presented at: Capella University; 2004; Minneapolis, MN.

The Residency Program Directors Council. Time, money, and the brave new world of residency education. Ophthalmology. 2005 Oct;112(10):1647-8.

Schindler BA, Novack DH, Cohen DG, et al. The impact of the changing health care environment on the health and well-being of faculty at four medical schools. *Acad Med.* 2006 Jan;81(1):27-34.

Career coaching websites:

ACP http://www.acponline.org/counseling/index.html

AAMC http://www.aamc.org/students/cim/start.htm

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