



LEARNING TO ADDRESS
IMPAIRMENT AND FATIGUE
TO ENHANCE PATIENT SAFETY

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TEACHERS GUIDE

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Office of Continuing Medical Education
DUKE SCHOOL OF MEDICINE



LEARNING TO ADDRESS IMPAIRMENT AND FATIGUE TO ENHANCE PATIENT SAFETY

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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 which 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. 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, using a "vignette" reflection may be uncoupled from the nuances of particular personalities or the frenzy of immediate decision making.

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

To our committed Advisory Board and skilled faculty, words provide insufficient thanks. The errors are mine; the kudos are all yours. To DazMedia, Barbara, and AJ, I appreciate your making our concepts come to life. To Dr. Osborn, I will always appreciate you challenging me for greater collaboration and scope and allowing this to be creative as well as content rich.

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

Let me know how we can improve.

Kathryn Andolsek, MD, MPH
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INTRODUCTION

- “Faculty and residents must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract its potential negative effects.” (**Accreditation Council for Graduate Medical Education [ACGME] Common Program Requirements VI.A.3**)
- “Providing residents with a sound didactic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents’ time and energy. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.” (**ACGME Common Program Requirements VI**)
- “Physician impairment: The Sponsoring Institution must have written policies that describe how physician impairment, including that due to substance abuse, will be handled. Sexual harassment: The Sponsoring Institution must have written policies covering sexual and other forms of harassment.” (**ACGME Institutional Requirements III.D.1.m-n**)
- “Counseling services: The Sponsoring Institution should facilitate residents’ access to appropriate and confidential counseling, medical, and psychological support services.” (**ACGME Institutional Requirements III.D.1.I**)

In June of 2002, ACGME approved new work-hour standards for residents (Accreditation Council for Graduate Medical Education. Report of the ACGME Work Group on Resident Duty Hours [Accreditation Council for Graduate Medical Education Web site]. June 11, 2002. Available at: <http://www.acgme.org/new/wkgreport602.pdf>. Accessed August 12, 2004). These requirements became effective in the United States on July 1, 2003. The attention to work hours was stimulated in large part as a response to the death of Libby Zion, a young woman admitted to a New York teaching hospital in 1984 (Asch DA, Parker RM. The Libby Zion case: one step forward or two steps backward? *N Engl J Med* 1988;318:771–775). After the report of the Bell Commission, which investigated this event, New York became the first state to legislate resident duty hours.

Numerous research studies have linked fatigue and sub-optimal performance across a variety of specialties. Not all studies show a positive correlation, perhaps because control groups often comprised residents who had not been on call the preceding night, but were chronically fatigued from work weeks of more than 100 hours. Many health care professionals and the public now believe that fatigued residents may jeopardize patient safety and may risk their own well-being (Wallack MK, Chao L. Resident work hours: the evolution of a revolution. *Arch Surg* 2001;136:1426–1432. Philibert I, Friedmann P, Williams WT. New requirements for resident duty hours. *JAMA* 2002; 288: 1112–1114).

Other studies have identified the nearly ubiquitous nature of stress and depression among interns and residents, which can impair performance and sadly, in some cases, lead to suicide.

The **L**earning to Address **I**mpairment and **F**atigue to **E**nhance Patient Safety (**LIFE**) program represents an effort to help program directors (PDs) go beyond simple compliance with ACGME mandates. Created to educate faculty and residents about the effects on performance of fatigue and other common impairments, the LIFE program is designed to identify strategies that may prevent these conditions, provide an early warning system for impairments, and manage them effectively. Many impairments appear to stem from the pressures that young physicians experience as they begin their professional life.

LIFE LEARNING PROGRAM OBJECTIVES

After completing the entirety of the LIFE program, the participant should be able to:

- Implement strategies to help prevent impairment in residents
- Identify an impaired resident
- Manage impaired residents
- Develop written policies regarding impairment
- Access appropriate referral resources

This case-based program is an educational tool to help PDs recognize and prevent problems before they occur; the program also teaches PDs how to identify, evaluate, and refer distressed residents to appropriate resources before their problems become intractable.

BASIS FOR THE LIFE PROGRAM DESIGN

We surveyed North Carolina residency programs to assess needs, and reviewed relevant literature to discover common problems encountered in residencies. An advisory board was formed to provide a broad constituency for identifying problems and approaches; we recruited board members from:

- Residents representing a variety of specialties and training programs
- Community program faculty
- Academic health center faculty
- State medical licensing boards
- Physicians from physicians health programs (PHPs)
- Medical students
- Leadership in nursing, the physician assistant community, and the hospital association
- North Carolina Area Health Education Centers
- Organized medicine
- ACGME

This teachers guide accompanies the series of case-based CD-ROM programs and Web materials that were specifically created to help teach PDs, faculty, and residents to recognize the signs and symptoms of impairment, poor performance, and undesirable resident behavior. The guide includes a review of the material contained in each program, with easy access to pedagogical content; where helpful, additional material is also provided. Discussion topics and role-playing suggestions help facilitate success in approaching the distressed resident.



HOW TO USE THE CD-ROM PROGRAMS IN WORKSHOPS

The CD-ROM materials are case-based, organized around one of eight modules.

Each of the LIFE modules is designed to support a video segment that illustrates an important impairment (as identified by our research and board members). In the initial dramatization, the faculty or fellow resident displays a less-than-ideal response. One or more experts addresses the specific issues that should be considered in such situations. A second dramatization demonstrates how one might approach the illustrated problem

in a more constructive manner. The solutions subsequently presented—and the resources identified—while certainly not all-inclusive, are meant to enhance your ability to manage problems effectively. Representative policies and procedures are also offered for you to adapt for your own.

The CD-ROM programs can be used in many ways. We describe five of the most common:

1. Programs may wish to have the CD ROMs available for self-study by residents and faculty. Programs can then use the material to stimulate a discussion at a faculty meeting or program retreat, or to serve as a stimulus for the development of a program policy.
2. A faculty member may use the material in one or more workshops, assuming the role of workshop leader. He/she can play a program module in its entirety. After viewing a particular topic, the leader can then rerun the program, stopping at individual segments to comment or to involve participants in discussions and exercises.
3. The faculty member may wish to play and stop the program wherever appropriate, according to the needs of the workshop or class sessions.
4. A workshop leader can set up a problem that the program will deal with and then, before viewing the program, discuss topics suggested, role-play situations as they are described, and ask for suggestions as to how the illustrated problems might be prevented or ameliorated.
5. A workshop can be designed to use only the vignettes, asking the participants to strategize the best options and then role-play them.

All of the topic areas can be addressed at one setting, or one or more topics can be selected, depending on the program's needs. Each topic includes experts who make useful "talking points" regarding the prevention, early identification, and management of the specific condition. Representative policies, procedures, and resources are included, with notation of key readings and Web references.

All the situations require careful, timely, and constructive feedback, which we know only too well but sometimes avoid. One scenario provides specific guidance on how to overcome our reluctance to address problems, and how to provide feedback in a more optimal manner.

The situations illustrated also suggest ways to focus the attention of faculty and PDs on *performance*, and how you can avoid the temptation to make a diagnosis of a resident,

e.g., for depression, even if this is within your medical specialty. The LIFE Curriculum reinforces separating your role of evaluator of performance from your role as a physician, and suggests referral sources that are more appropriate for a diagnostic evaluation and therapeutic intervention. In this way, PDs and faculty are helped to focus on educational remediation and support.



FATIGUE

David F. Dinges, PhD
Don K. Nakayama, MD, MBA

AIM

This module introduces participants to the problem of fatigue and the negative effects—both personal and professional—that sleep loss can have on residents. The module also suggests strategies for managing the effects of sleepiness and fatigue.

LEARNING OBJECTIVES

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

- Define fatigue and sleep inertia
- Describe how to recognize excessive sleepiness
- Discuss the physical, mental, and social consequences of fatigue (i.e., traffic violations, reduced motivation, increased cynicism, increased substance abuse)
- Understand the link between medical error and fatigue
- Identify strategies for managing fatigue, including optimal napping and prophylactic use of caffeine
- Predict times of peak and nadir performance
- Explain the night float system and explore strategies for addressing duty-hour issues
- Understand the shared responsibility of residents, faculty, and programs in managing fatigue to optimize medical care for patients, minimize errors, and enhance resident learning
- Select an appropriate evaluation for a fatigued resident

BACKGROUND

In July 2003, ACGME mandated duty hours for all residents, all specialties, and all locations. The mandate recognizes that sufficient sleep and sleep hygiene are critical for the practice of good medicine and for patient safety.

ACGME RULES

Duty Hours Restrictions

- 80 hours maximum per week (in some cases per week, on others averaged over a 4-week period)
- 24 hours maximum per shift; an added 6 hours are allowed for transfer of care
- 1 day in 7 free of patient care
- In-house call only every 3 nights
- 10-hour minimum rest period between daily duty periods and after in-house call
- Even more restrictive duty-hour policies for some specialties, such as emergency medicine

Education and Oversight

- Commit the program to high-quality education and effective patient care
- Recognize and monitor residents for signs of fatigue
- Apply preventive and operational countermeasures
- Create duty-hour assignments that recognize collective responsibility to patient care
- Provide institutional oversight
- Establish policies and procedures by the sponsoring institution
- Require justification for increases above the 80-hour limit (some residency review committees [RRCs] will accept requests for exceptions)
- Increase patient care support services to reduce resident time spent on routine activities

Accreditation Council for Graduate Medical Education. Information Related to ACGME's Effort to Address Resident Duty Hours and Other Relevant Resource Materials. http://www.acgme.org/DutyHours/dutyHrs_Index.asp. Accessed April 3, 2004.

SCENARIO SUMMARY

A resident falls asleep during a conference lecture given by the attending physician. Both the resident and the attending treat the episode as though it were impolite, a simple lapse in judgment, and not a serious symptom indicative of sleep deprivation.

DISCUSSION QUESTIONS

- Discuss your experience with residents who fall asleep on the job or manifest extreme signs of exhaustion
- Give examples of other events where residents display signs of fatigue from sleep deprivation
- Explain how you usually respond to residents who display signs of fatigue

Common myths that underlie the initial scenario include the following:

- Excessive fatigue is caused by things other than sleep deprivation (e.g., boring lectures; stuffy, warm rooms; bad habits; laziness) In fact, falling asleep in lecture is only caused by sleepiness. If a resident is bored, he/she is awake and annoyed at being bored
- Excessive daytime sleepiness means that the person in question is not getting enough sleep (recall that sleepiness can also be a sign of an underlying medical condition or disorder such as narcolepsy or sleep apnea—conditions that may need to be ruled out by appropriate evaluation)
- Sleep deprivation is not associated with health risks (on the contrary, sleep deprivation affects cognition and performance; physiologically, the effect of 24 hours of wakefulness on the body is equivalent to being legally drunk; many residents report having car accidents or near misses because of sleepiness after on-call duty)

(Jha AK, Duncan BW, Bates, DW. Fatigue, Sleepiness, and Medical Errors. Chapter 46. In: *Making Health Care Safer: A Critical Analysis of Patient Safety Practices*. Evidence Report/Technology Assessment: Number 43. AHRQ Publication No. 01-E058, July 2001. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/clinic/ptsafety/> Accessed 4/27/04; Dawson D, Reid K. Fatigue, alcohol and performance impairment. *Nature* 1997;388:235; Baldwin DC Jr, Daugherty SR. Sleep deprivation and fatigue in residency training: results of a national survey of first- and second-year residents. *Sleep* 2004;27:217–223; Steele MT, Ma OJ, Watson WA, Thomas HA Jr, Muelleman RL. The occupational risk of motor vehicle collisions for emergency medicine residents. *Acad Emerg Med* 1999;10:1050–1053).

In some states, such as New Jersey, a resident involved in a car collision can be charged with a felony. In Illinois a hospital is being sued by an individual injured in a motor vehicle collision because the hospital employed the resident, and the resident worked excessive hours.

For the above (mistaken) reasons, excessive sleepiness is treated lightly.

SCENARIO RERUN

A resident falls asleep during a conference lecture given by the attending physician. The attending questions the resident about his/her sleep hours, night float duty, and awareness of the consequences of sleep debt, convincing the resident of the importance of taking sleep seriously.

The rerun attempts to teach the following principles:

- Signs of fatigue must be taken seriously
- Residents who display signs of fatigue should be identified, evaluated, and referred to appropriate resources for fatigue management skills
- Good sleep hygiene is critical for the practice of good medicine

ROLE-PLAYING EXERCISE

Choose two participants, one to act as an attending, the other to act as a resident.

- As a resident, display signs of sleep deprivation, but justify exceeding the 80-hour work week by insisting that the extra hours constitute important opportunities for learning experiences
- As an attending, convince this person of the need for adequate sleep
- For residents, what are impediments to sleep?
- What are the responsibilities of the institution, the PD and faculty, and the resident to facilitate sleep?
- What solutions to duty hours have programs implemented and do the solutions pose risks to residents by increasing sleepiness and/or medical errors?

PROGRAM TEACHING POINTS

SLEEP AND THE EFFECTS OF SLEEP DEPRIVATION

Sleep deprivation and disruption of the normal sleep pattern can severely impair function.

SLEEP CYCLE

Text for Button C

Normal sleep is made up of two distinct, alternating states: rapid eye movement (REM) sleep and non-rapid eye movement (NREM) sleep. REM sleep is associated with dreaming and generalized muscle paralysis, excepting the eye muscles and diaphragm.

- Usually, people drift off to sleep in NREM sleep, which is made up of four distinct states; progress into deeper sleep moves from:

**Stages 1-2: theta waves
to
Stages 3-4: delta waves**

- Heart rate, respiration, and blood pressure all decline during NREM sleep. Delta sleep is the deepest and most restorative sleep.

Feirerman JR. Disordered sleep. *Emerg Med* 2: 1985;160–171.

Disruption of the normal sleep pattern can severely impair function. In humans, sleep is regulated by the circadian rhythm and homeostatic sleep drive. Circadian rhythm, which

determines the daily sleep-wake distribution, causes us to feel sleepy at night and wakeful during the day.

Sleep is regulated homeostatically; the sleep drive accumulates during waking hours and decreases during the period of sleep. (Wisor JP, O'Hara BF, Terao A, et al. A role for cryptochromes in sleep regulation. *BMC Neuroscience* 2002;3:20. Available at <http://www.biomedcentral.com/content/pdf/1471-2202-3-20.pdf> Accessed 4/29/04)

Most people, on average, require approximately 8 hours of sleep every 24 hours to satisfy their physiological needs. When people get less than 5 hours of sleep over a 24-hour period, their peak mental performance usually deteriorates. In a medical setting, or on a drive home, the consequences can be serious.

REGULATION OF SLEEP PATTERN: A TWO-PROCESS MODEL

Sleep in humans is regulated by two processes that, combined, determine sleep-wake distribution and sleep duration

- Circadian rhythm: sleep-independent process
- Homeostatic sleep drive: sleep-dependent process

Borbely AA. A two process model of sleep regulation. *Hum Neurobiol* 1982;1:195–204.

STUDIES OF EFFECTS OF SLEEP DEPRIVATION

In a study of 3602 residents, Baldwin and Dougherty found that more than 20% of all residents reported averaging about 5 or fewer hours of sleep per night, with 66% averaging 6 or fewer hours less per night. (Baldwin DC Jr, Daugherty SR.

Sleep deprivation and fatigue in residency training: results of a national survey of first- and second-year residents. *Sleep* 2004;27:217–223).

- Residents averaging 5 or fewer hours of sleep per night were more likely to report serious accidents or injuries, conflict with other professional staff, use of alcohol, use of medications to stay awake, noticeable weight change, and working in an “impaired condition”
- They were also more likely to report making significant medical errors
- Longer periods of enforced wakefulness are associated with even greater deterioration in cognitive function. After 1 night of no sleep, baseline cognitive performance in residents may decrease as much as 25%. After a second night of sleep is missed, baseline performance may decline as much as 40%

Fatigue and lack of sleep can impair a physician's attention, judgment, and reaction time; in turn, impairment in these areas can compromise patient safety and lead to medical errors.

- Even moderate levels of fatigue produce higher levels of impairment than proscribed blood levels of alcohol intoxication.

Dawson D, Reid K. Fatigue, alcohol and performance impairment. *Nature* 1997;388:235.

Impairment occurs across all specialties, including surgery, medicine, pediatrics, and anesthesiology.

- Surgery: 20% more errors and 14% more time to perform simulated laparoscopic procedures

Taffinder NJ, McManus IC, Gul Y, Russel RC, Darzi A. Effect of sleep deprivation on surgeon's dexterity on laparoscopy simulator. [Letter] *Lancet* 1998;352:1191.

Grantcharov TP, Bardram L, Funch-Jensen P, Rosenberg J. Laparoscopic performance after one night on call in a surgical department: prospective study. *BMJ* 2001;323:1222–1223.

- Medicine: ECG interpretation impaired

Lingenfelter T, Kaschel R, Weber A, Zaiser-Kaschel H, Jakober B, Kuber J. Young hospital doctors after night duty: their task-specific cognitive status and emotional condition. *Med Educ* 1994;28:566–572.

- Pediatrics: increase in time required to place an arterial catheter and to intubate

Storer JS, Floyd HH, Gill WL, Giusti CW, Ginsberg H. Effects of sleep deprivation on cognitive ability and skills of pediatrics residents. *Acad Med* 1989;64:29–32.

- Emergency Medicine: decreased reduction in comprehensiveness of physical assessment and documentation; reported toll on cognition, family life, and personal and professional relationships

Smith-Coggins R, Rosekind MR, Hurd S, Buccino KR. Relationship of day versus night sleep to physician performance and mood. *Ann Emerg Med* 1994;24:928–934.

Bertram DA. Characteristics of shifts and second-year resident performance in an emergency department. *NY State J Med* 1988;88:10–15.

- Family Medicine: in-service training exam scores correlated with pre-test sleep amounts

Jacques CH, Lynch JC, Samkoff JS. The effects of sleep loss on cognitive performance of resident physicians. *J Fam Prac* 1990;30:223–229.

- Anesthesiology: residents reported sleeping an average of 6.5 hours/day; 20% indicated sleepiness prevented them from performing clinical duties; 12% attributed errors to fatigue

Howard SK, Healzer JM, Gaba DM. Sleep and work schedules of anesthesia residents: a national survey. [Abstract] *Anesthesiology* 1997;87:932A.

Denisco RA, Drummond JN, Gravenstein JS. The effect of fatigue on the performance of a simulated anesthetic monitoring task. *J Clin Monit* 1987;3:22–24.

Taffinder NJ, McManus IC, Guy Y, Russell RC, Darzi A. Effect of sleep deprivation on surgeon's dexterity on laparoscopy simulator. [Letter] *Lancet* 1998;352:1191.

Howard SK, Keshavacharya S, Smith BE, Rosekind MR, Weinger MB, Gaba DM. Behavioral evidence of fatigue during a simulator experiment. [Abstract] *Anesthesiology* 1998;89:1236A.

Fatigue also places the health and well-being of the resident at risk:

- Needle-stick accidents that increase the risk of infection by blood-borne pathogens increase by 50% during night shifts, compared with day duty
- The risk of motor vehicle collisions increases post-call
- One study found that pediatric house officers were at higher risk than faculty to fall asleep either driving or stopped at a traffic light (49% of residents, compared with 13% of faculty)
- Another study found that nearly 60% of ER residents reported a near-miss vehicle collision, 80% of which occurred after night work. The risk increased with the number of night shifts worked per month. The study concluded that driving home after a night shift appears to be a significant occupational risk for ER residents

Howard SK, Rosekind MR, Katz JD, Berry AJ. Fatigue in anesthesia: implications and strategies for patient and provider safety. *Anesthesiology* 2002;97:1281–1294.

Parks DK. Day-night pattern in accidental exposures to blood-borne pathogens among medical students and residents. *Chronobiol Int* 2000;17:61–70.

Marcus CL, Loughlin GM. Effect of sleep deprivation on driving safety in housestaff. *Sleep* 1996;19:763–766.

Steele MT, Ma OJ, Watson WA, Thomas HA Jr, Muelleman RL. The occupational risk of motor vehicle collisions for emergency medicine residents. *Acad Emerg Med* 1999;10:1050–1053.

Kowalenko T, Hass-Kowalenko J, Rabinovich A, Grzybowski M. Emergency Medicine Residency Related MVCs—Is Sleep Deprivation a Risk Factor? [Abstract] *Acad Emerg Med*. 2000;7:451.

Studies using the Epworth Sleepiness Scale (ESS), an assessment tool widely used by sleep professionals, evaluated the effects of sleep deprivation on residents. One study found that sleep-deprived residents score about the same on this scale as people with diagnosed sleep disorders (Papp KK, Stoller EP, Sage P, et al. The effects of sleep loss and fatigue on resident physicians: a multi-institutional, mixed-method study. *Acad Med* 2004;79:394–406).

- 149 residents at five US academic health centers in six specialties described multiple adverse effects of sleep loss and fatigue on learning, job performance, and professionalism
- Only 16% scored within the normal range on the ESS
- 84% scored within the range, indicating a need for clinical intervention

Sleep is not optional, but a real physiological need. Without the necessary amount, a person cannot function appropriately.

DISCUSSION TOPICS: SLEEP MYTHS

In your experience, what sleep myths are most common? The following are frequently cited:

- I don't need sleep and can get by with very little
- The more I work the better I get at what I do
- Coffee and sheer "grit" will help me overcome the need for sleep
- As long as I'm awake I can work
- Napping makes it harder to wake up and function effectively
- I can drive safely even after working 36 hours straight
- I always know when I'm too tired to work

Do any others come to mind?

The importance of sleep and sleep time needs to be understood by all members of the health care team, residents and faculty alike. Similarly, all professionals need to accept the limitations on the roles residents will play under new duty hours.

SLEEP AND SLEEPINESS

How much sleep is enough? Carskadon has put forth the following in answer to that question:

- The amount that allows the person to feel alert when rested and relaxed (e.g., during grand rounds)
- The average person requires about 8 or more hours of sleep
- One night with 2 hours fewer than the usual amount of sleep is sufficient to produce significant declines in waking performance
- After several nights of 5-hour sleep periods, most adults will not realize that they are pathologically sleepy

(Carskadon MA, Roth T. Sleep Restriction. In: Monk T, ed. *Sleep, sleepiness and performance*. Chichester, U.K.: John Wiley; 1991:155–167).

It is also critical for everyone involved to recognize the signs and symptoms of fatigue, especially those that are non-specific.

FATIGUE AND RESIDENT WELL-BEING

Text for Button F

Faculty need to accept limitations on the roles residents will play under new duty hours. This means that when residents leave “on time,” their departures should not be interpreted as a sign of laziness or disinterest. Such healthy behavior is a sign of their commitment to excellence in patient care and dedication to patient well-being. Even though the numbers of hours worked have been reduced, residents are still working twice as many hours as most US adults (i.e., an 80-hour week), and working longer than people in other stringently regulated high-risk occupations, such as commercial airline pilots.

Although they possibly will be better rested under these new work hours, residents in training will still experience periods of chronic sleep deprivation, getting less sleep than is physiologically required. For reasons such as these, strict compliance with the ACGME duty hours is a necessary, but not sufficient, strategy to prevent fatigue.

Some additional strategies include:

- Minimizing prolonged work (>24 hours of clinical duties)
- Protecting periods designed to address sleep debt (i.e., the accumulated hours of sleep needed to make up for sleep hours lost)
- Reducing non-essential tasks and enhancing learning experiences during clinical time
- Reducing non-essential interruptions (e.g., ancillary services, phone calls, pages)
- Helping residents identify co-existent medical issues that impair their sleep (e.g., undiagnosed sleep disorders, depression, stress)
- Educating residents about the need to manage fatigue
- Arranging space where naps can be taken without undue disturbance
- Exploring transportation options for residents after night shift duty

CLINICAL SIGNS OF FATIGUE

- Moodiness, depression, and irritability
- Apathy, impoverished speech, flattened affect
- Impaired memory, confusion
- Inflexible thinking and impaired planning skills (e.g., can't come up with novel solutions, unable to multitask)
- Sedentary nodding off (e.g., during conferences) or driving
- Medical errors
- Micro-sleeps (5 to 10 seconds) that cause lapses in attention and can be extremely dangerous
- Repeatedly checking work
- Difficulty focusing on tasks

Dinges DF, Barone Kribbs N. Performing while sleepy: effects of experimentally-induced sleepiness. In: Monk T, ed. *Sleep, sleepiness and performance*. Chichester, UK: John Wiley; 1991:97–128.

Rosekind MR, Gander PH, Gregory KB, Smith RM, Miller DL, Oyung R, et al. Managing fatigue in operational settings. 1: Physiological considerations and countermeasures. *Behav Med*. 1996;21:157–165.

Wu AW, Folkman S, McPhee SJ, Lo B. Do house officers learn from their mistakes? *JAMA* 1991;265:2089–2094.

Gravenstein JS, Cooper JB, Orkin FK. Work and rest cycles in anesthesia practice. *Anesthesiology* 1990;72:734–742.

Haynes DF, Schwedler M, Dyslin DC, Rice JC, Kerstein MD. Are postoperative complications related to resident sleep deprivation? *S Med J* 1995;88:283–289.

DISCUSSION QUESTION

- Are the clinical signs of fatigue overlooked in your institutions? What strategies are in place to deal with fatigue in your residents?
- Have you ever told a colleague/resident that he/she was sleep deprived?
- What would you do if you saw a colleague manifesting extreme signs of fatigue? How would you handle the situation?

DISCUSSION QUESTION (CONT'D)

- Faculty may be upset because they are working more hours (to compensate for residents working fewer); how do you address faculty morale?
- How do you monitor resident hours and fatigue?
- How do you keep residents from feeling vulnerable if they leave the hospital when they should, but are then evaluated by attendings as uncommitted or unprofessional?
- How do you manage the “culture shift” of professionalism created when a resident changes from a highly individual approach to patient care to an approach in which a team assumes responsibility?
- How do you build in assurances for patient safety if multiple handoffs are needed?
- How can other members of the health care team help with duty hours and fatigue?

Excessive sleepiness in a resident should be taken seriously, treated as a performance issue, and evaluated. Like any other individuals, residents may have conditions that have sleepiness as a symptom, e.g., a medical condition such as hypothyroidism, or a psychological disorder such as depression. Sleepiness can also occur as a side effect of a medication such as a beta blocker, or can result from a primary sleep disorder.

DISCUSSION TOPIC: EXCESSIVE DAYTIME SLEEPINESS

In your experience, what are some of the causes of excessive daytime sleepiness or fatigue? Discuss the importance of following:

- Fragmented sleep
- Too little sleep
- Disruption of the circadian rhythm
- Medical or psychological conditions that might present as fatigue
- Too little sleep (i.e., failure to meet the required amount of sleep (on average, 8.2 hours each night))

Fatigue as a normal response to enforced wakefulness cannot be eliminated from medical residencies. But it can be managed more efficiently. Sometimes program solutions can cause as many problems as they are designed to solve. For example, night float systems—or any night duty—are associated with greater risks for patient safety. Night float exposes a resident to all the risks associated with fatigue.

NIGHT SHIFT WORK AND PREVENTIVE APPROACHES TO FATIGUE

Night shift work is the most challenging component of any 24/7 industry. There are numerous ways of scheduling night shifts, but no one formula appears to work better than any other. Studies have shown that a large majority of workers—up to 95%—are unable to adjust, regardless of the divisions in hours.

NIGHT FLOATS, FATIGUE, HANDOFFS

Text for Button G

In the late 1980s, physician residency training programs developed the night float rotation, characterized by a sequence of 5–15 days of night work without any daytime duties, thereby involving an abrupt reversal of the wake-sleep schedule.

We examined the effect of the night float rotation on sleep, mood, and performance of pediatric residents. Residents completed sleep diaries daily, and tests of mood (Profile of Mood States) and attention (Conner's Continuous Performance Test) three times a week during the 2-week night float rotation and during equivalent blocks of daytime rotations.

Results show that, despite having ample opportunity to sleep during the day, while on night float rotations residents slept less than during the nights of their normal daytime rotations, 6.3 h +/- 2.5 h and 7.2 h +/- 1.7 h, respectively, $p < 0.0001$. Also, during night float compared with daytime rotations, residents had increased fatigue-inertia scores, 8.7 +/- 4.1 and 4.8 +/- 2.4, respectively, $p < 0.0001$, and decreased vigor-activity scores 10.7 +/- 5.4 and 14.8 +/- 5.3, respectively, $p = 0.02$. The scores for attention were not significantly different between night float and daytime rotations. The correlation coefficients of fatigue with measures of attention were not statistically significant for daytime rotations. However, night float fatigue correlated with omission errors, $r = 0.51$, $p = 0.001$, and with attentiveness $r = -0.36$, $p = 0.03$.

Training programs that adopt the night float rotation strategy must be aware of potential deleterious effects that may have serious consequences in resident performance and patient safety.

Cavallo A, Ris MD, Succop P. The night float paradigm to decrease sleep deprivation: good solution or a new problem? *Ergonomics* 2003;46:653–663.

HANDOFFS

As Whitcomb indicates, one of the biggest challenges is “handoffs.” He suggests that we need to study this according to specialty. We need to integrate industrial engineering techniques to isolate the components of the task, and then use the information to design a system of care to minimize risks. This has been done successfully in other high-performance, high-stakes professions such as commercial aviation. Restrictions on pilot duty hours were only part of the solution. Tremendous attention was paid to the entire airline system.

Whitcomb ME. More on resident duty-hours limits. *Acad Med* 2004;79:377–378.
http://www.academicmedicine.org/cgi/content/full/79/5/377?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=Whitcomb&fulltext=hand+offs&searchid=1090952541399_873&stord_search=&FIRSTINDEX=0&journalcode=acadmed

Prophylactic naps taken before the shift begins may be of some help. Naps ideally should occur as early as possible in the period during which there will be sleep deprivation. Emergency room residents who took a 1-hour nap before their night duty showed enhanced awake activity as documented by ECGs, reported experiencing less stress, and felt their workload was less burdensome (Frey R, Decker K, Reinfried L, Klosch G, Saletu B, Anderer Peter, et al. Effect of rest on physicians' performance in an emergency department, objectified by electroencephalographic analyses and psychometric tests. *Crit Care Med* 2002;30:2322–2329). Still, these shifts can be difficult to deal with in terms of fatigue management.

Caffeine can be helpful if used pharmacologically. Residents who wish to benefit from its effects need to avoid the social use of caffeinated beverages, using caffeine only when it is needed. Caffeine takes approximately 30 minutes for the effects to be felt and they last about 3 or 4 hours. The downside of the stimulant is that tolerance may develop and, because it is both a stimulant and a diuretic, it may interfere with subsequent sleep opportunities. Alcohol should be avoided because of its rebound effect.

NIGHT SHIFT COPING STRATEGIES

Recognize that most individuals are not able to adjust to a night shift regardless of how often they work it.

- Use caffeine pharmacologically
- Sleep prophylactically before night shifts (and again after the night shift)
- Take mid/late afternoon prophylactic naps
 - During the afternoon (natural “siesta” time)
 - During normal nocturnal sleep period (when possible)
- Shift nap
 - Should be brief (from 15 to 20 minutes), and frequent (every 2 or 3 hours)
 - Longer naps prevent sleepiness but may result in “sleep inertia”

NAPPING, SLEEP INERTIA, SLEEP DEBT

Napping when possible during on-call hours is helpful in ameliorating the effects of fatigue. Timing can also be critical. Length of the nap is important. Longer naps may result in sleep inertia, a phenomenon characterized by impaired cognition, severe disorientation, transitory hypovigilance, confusion, and difficulty in fully awakening (Dinges DF, Barone Kribbs N. Performing while sleepy: effects of experimentally-induced sleepiness. In: Monk T, ed. *Sleep, Sleepiness and Performance*. New York: John Wiley & Sons; 1991:97-128. Rosekind MR, Gander PH, Gregory KB, et al. Managing fatigue in operational set-

tings. 1: Physiological considerations and countermeasures. *Behav Med* 1996;21:157–165). Sleep inertia, which can last from a few minutes to half an hour, occurs when a person abruptly emerges from the deepest and most restorative sleep stage, delta (stage 4). Residents who manage to reach this stage are particularly vulnerable; they are often awakened by phone calls or pages, by others who share the call room, by the need for patient follow-up, or to manage junior level residents. Most people are fully aware of the grogginess and disorientation that constitutes the subjective part of sleep inertia, but many overestimate their ability to function in this state (Rosekind MR, Gander PH, Gregory KB. Managing fatigue in operational settings 2: An integrated approach. *Hosp Top* 1997;75:31–35; Bruck D, Pisani DL. The effects of sleep inertia on decision-making performance. *J Sleep Res* 1999;8:95–103; Ferrara M, De Gennaro L, Bertini M. Time-course of sleep inertia upon awakening from nighttime sleep with different sleep homeostasis conditions. *Aviat Space Environ Med* 2000;71:225–229; Jewett ME, Wyatt JK, Ritz-De Cecco A, Khalsa SB, Dijk DJ, Czeisler CA. Time course of sleep inertia dissipation in human performance and alertness. *J Sleep Res* 1999;8:1–8).

Measures that help to counter sleep inertia include standing up, turning on the lights, being physically active, showering, and enlisting the aide of metabolic activity (e.g., stimulants, exercise). Because of the mind-numbing effects of sleep inertia on cognition and function, planning recovery time from its effects—about 15 minutes—is critical.

Pre-shift and on-the-job naps may also help reduce sleep debt, which is defined as the difference between the hours of sleep a person needs and the hours of sleep a person actually gets. Sleep debts are associated with slower response times, forgetfulness, confusion, depression, lack of motivation, and decreased morale and initiative. Additionally, any awareness of being sleepy is blunted.

In an ideal setting naps should be avoided between 8PM and 10PM. However, napping at any time is better than no nap at all.

While pre-shift and on-the-job naps can help manage fatigue, they cannot take the place of time off, which is necessary to recuperate fully from the effects of enforced wakefulness. Two nocturnal sleep periods are usually necessary to recuperate from the effects of night shift work; 36 to 48 hours is an ideal period of time off.

Sleep needs require that resident moonlighting be considered very carefully. At the present time, hours spent earning extra income (outside the institution) need not be counted as part of the weekly duty hours; however, residents need to understand that hours spent moonlighting can add to their sleep debt or can prevent them from decreasing it.

The level of financial indebtedness can be staggering for a young physician: in 2004 medical students graduated with an average loan indebtedness of \$115,000. At current

interest rates this results in a \$1242 average monthly payment! The financial burdens residents face make moonlighting (and the money that can be made) quite seductive. But there are other options for debt management, and residents should be familiarized with them. (These are discussed more fully in Confusion Rains/Reigns, the LIFE segment on Burnout and Career Crisis.)

THE EFFECT OF FATIGUE ON RESIDENT SAFETY

Fatigue management leads to issues that traditionally have not been part of the educational content of residency programs. Safety is a case in point. Residents should be encouraged to think about where to live vis-à-vis the hospital in order to minimize the drive home post-call, or should consider using public transportation or taxis. Driving when sleep-deprived is dangerous and should be avoided. Very little, except pulling the car over and taking a nap, can help with fatigue.

Signs indicative of dangerous fatigue for drivers include closing the eyes at traffic lights, failure to remember driving, continuous yawning, and drifting from one lane to the other. It is a complete myth that certain activities—e.g., chewing gum, playing loud radio music, or having air blow in the face—will keep one awake. Napping before leaving the hospital after a night shift, taking a taxi, or using other modes of public transportation should be encouraged. In some states, residents who drive after a 24-hour shift and are involved in motor vehicle accidents are liable for criminal prosecution (e.g., Maggie’s Law, enacted by the state of New Jersey in 2003).

MILESTONES IN THE HISTORY OF THE PROBLEM

Text for Button K

The History Behind the New Standards

- 1984: Death of Libby Zion

- 1987: Bell Commission in NY
 - July 1, 1989 – All NY State Hospitals mandated to comply with new regulations
 - Applied to largest, highest-volume departments
 - Anesthesia
 - Emergency Medicine
 - Family Practice
 - Medicine
 - Obstetrics
 - Pediatrics
 - Surgery

- 2001: OSHA petition/Association of American Medical Colleges to limit resident working hours

- 2001: Bills in both the Senate and the House to impose work-hour limits

MILESTONES IN THE HISTORY OF THE PROBLEM (CONT'D)

Text for Button K

- 2002: ACGME proposed duty-hour standards
- 2003: ACGME approved duty-hour standards
- 2003: Maggie's Law enacted in New Jersey, establishing driving while fatigued as recklessness under vehicular homicide statute
- 2003: ACGME duty-hour standards enacted

Fatigue and sleep deprivation during residency will never be totally eliminated, even with the new ACGME standards. The best that can be done is to manage fatigue as effectively as possible. The main point is to recognize its serious effects and take steps to reduce any potential for adverse outcomes.

WEB RESOURCES

- ACGME Web site:
www.acgme.org
- ACGME resident duty hours link (July 2003)
<http://www.acgme.org/DutyHours/dutyHoursLangfinal.asp>
- ACGME discussion on OSHA petition
<http://www.acgme.org/NEW/OSHAResponse.asp>
- American Medical Association (resident duty hours)
<http://www.ama-assn.org/ama/pub/category/7064.html>
- Perspectives from ACGME workshop
<http://www.facs.org/education/gs2003/gs43flynn.pdf>
- AAMC Policy Guidance (resident duty hours)
<http://www.aamc.org/members/orr/policyguidancegme.htm>
- Sleep, Alertness and Fatigue Education in Residency (S.A.F.E.R) Program
<http://www.uphs.upenn.edu/gme/safer-sleep-prog.shtml>
(Contact Nick Jenkins in the office in the GME Office at 215-615-0501 to obtain password to view the S.A.F.E.R. Presentation)
- Wellness Resource: University of Pittsburgh Medical Center Healthy Lifestyle Program
<http://healthylifestyle.upmc.com>
<http://workhours.bwh.harvard.edu/>

FATIGUE REVIEW

- What are the new ACGME duty hours?
- Define and differentiate between REM and NREM sleep
- What two mechanisms regulate sleep in humans?
- Describe the effects of sleep deprivation as reported by Baldwin and Dougherty (2004)
- Describe the effects of fatigue and impairment on physicians in various specialties as comprehensively as you can
- Describe the effects of fatigue on resident health. What were some of the accidents that increased in sleep-deprived residents as described in this module?
- Papp, et al (2004) found that sleep-deprived residents score about the same on this scale as people with diagnosed sleep disorders. What is the significance of this finding?
- Describe some of the common myths that surround the need for sleep
- Name some of the common signs of fatigue
- According to Carskadon (1991), how much sleep is enough?
- What problems do you see with night shift work? How are your residents adopting to its requirements? Do you feel their education suffers because of the limitations now placed on their work hours?
- Describe some of the night shift coping strategies suggested in this module.
- What is sleep inertia? Do you think this is a common experience? Have you ever experienced it?
- Describe strategies that can help combat sleep inertia.
- Discuss the implications of sleep debt for night shift work. How familiar is the concept of sleep debt?
- What are some of the issues that this module raises about resident moonlighting?

FATIGUE: ADDITIONAL REFERENCES OF INTEREST

Asken M, Raham D. Resident performance and sleep deprivation: a review. *J Med Ed* 1983;58:382–388.

Barone JE, Ivy ME. Work hours: five stages of grief. *Acad Med* 2004;79:379–380.

Byusse DJ, Barzansky D, Dinges DF, et al. Sleep fatigue and medical training: setting an agenda for optimal learning and patient care. *Sleep* 2003;26:218–225.

Defoe DM, Power ML, Carpentieri A. Long hours and little sleep: work schedules of residents in obstetrics and gynecology. *Obstet Gynecol* 2001;97:1015–1018.

Fischer JE. Continuity of care: a casualty of the 80-hour work week. *Acad Med* 2004;79:381–383.

Green MJ. What (if anything) is wrong with residency overwork? *Ann Intern Med* 1995;123:512–517.

Griner PF. Residency overwork and changing paradigms of service. [Letter] *Ann Intern Med* 1995;123:547–548.

Howard SK, Gaba DM, Rosekind MR, Zarcone VP. The risks and implications of excessive daytime sleepiness in resident physicians. *Acad Medicine* 2002;77:1019–25.

Jacques CHM, Lynch JC, Samkoff JS. The effects of sleep loss on cognitive performance of resident physicians. *J Fam Prac.* 1990;30:223–227.

Lamberg L. Long hours, little sleep: bad medicine for physicians-in-training? *JAMA* 2002;287:303–306.

Landrigan CP, Rothschild JM, Cronin JW, et al. Effect of reducing interns work hours on serious medical errors in intensive care units. *N Engl J Med* 2004;351:18:1838–1848.

Lockley SW, Cronin JW, Evans EE, et al. Effect of reducing interns' weekly work hours on sleep and attention failures. *N Engl J Med* 2004;351:18:1829–1837.

Lyznicki JM, Droege TC, Davis RM, Williams MA, for the Council on Scientific Affairs, American Medical Association, et al, Sleepiness, Driving, and Motor Vehicle Accidents; *JAMA* 1998;279:1908–1913.

Mukherjee S. A precarious exchange. *N Engl J Med* 2004;351:1822–1824.

Papp KK, Stoller EP, Sage P, Aikens J, Owens J, Avidan A, et al The effects of sleep loss and fatigue on resident physicians: a multi-institutional, mixed-method study. *Acad Med* 2004;79:394–406.

Richardson GS, Wyatt JK, Sullivan JP, Orav EJ, Ward AE, Wolf MA, et al. Objective assessment of sleep and alertness in medical house staff and the impact of protected time for sleep. *Sleep* 1996;19:718–726.

Smith-Coggins R, Rosekind MR, Buccino KR, Dinges DF, Moser RP. Rotating shift work schedules: can we enhance physician adaptation to night shifts? *Acad Emerg Med* 1997;4:951–961.

Veasey S, Rosen R, Barzansk B, Ilene R, Owens J. Sleep loss and fatigue in residency training. *JAMA* 2002;288:1116–1124.

Whitcomb ME. More on resident duty hour limits. *Acad Med* 2004;377–378.

VISIT OUR WEBSITE FOR UP-TO-DATE REFERENCES

DAVID DINGES, PHD: BIBLIOGRAPHY OF RELEVANT SLEEP ARTICLES

- Chugh DK, Weaver TE, Dinges DF. Neurobehavioral consequences of arousals. *Sleep* 1996;19:S198–201.
- Dinges DF. Critical research issues in development of biomathematical models of fatigue and performance. *Aviat Space Environ Med* 2004;75(3 Suppl):A181–191.
- Dinges DF. An overview of sleepiness and accidents. *J Sleep Res* 1995;4:4–14.
- Dinges DF. Differential effects of prior wakefulness and circadian phase on nap sleep. *Electroencephalogr Clin Neurophysiol* 1986;64:224–227.
- Dinges DF. The nature and timing of sleep. *Trans Stud Coll Physicians Phila* 1984;6:177–206.
- Dinges DF, Pack F, Williams K, et al. Cumulative sleepiness, mood disturbance, and psychomotor vigilance performance decrements during a week of sleep restricted to 4-5 hours per night. *Sleep* 1997;20:267–277.
- Jewett ME, Dijk DJ, Kronauer RE, Dinges DF. Dose-response relationship between sleep duration and human psychomotor vigilance and subjective alertness. *Sleep* 1999;22:171–179.
- Kelly SM, Rosekind MR, Dinges DF, et al. Flight controller alertness and performance during spaceflight shift work operations. *Hum Perf Extrem Environ* 1998;3:100–106.
- Mallis MM, Mejdal S, Nguyen TT, Dinges DF. Summary of the key features of seven biomathematical models of human fatigue and performance. *Aviat Space Environ Med* 2004;75(3 Suppl):A4–14.
- Meier-Ewert HK, Ridker PM, Rifai N, Mullington JM. Effect of sleep loss on C-reactive protein, an inflammatory marker of cardiovascular risk. *J Am Coll Cardiol* 2004;43:678–683.
- Mitler MM, Carskadon MA, Czeisler CA, Dement WC, Dinges DF, Graeber RC. Catastrophes, sleep, and public policy: consensus report. *Sleep* 1988;11:100–109.
- Neri DF, Oyung RL, Colletti LM, Mallis MM, Tam PY, Dinges DF. Controlled breaks as a fatigue countermeasure on the flight deck. *Aviat Space Environ Med* 2002;73:654–664.
- Pack AI, Pack AM, Rodgman E, Cucchiara A, Dinges DF, Schwab CW. Characteristics of crashes attributed to the driver having fallen asleep. *Accid Anal Prev* 1995;27:769–775.
- Rogers NL, Dinges DF. Subjective surrogates of performance during night work. *Sleep* 2003;26:790–791.
- Smith-Coggins R, Rosekind MR, Buccino KR, Dinges DF, Moser RP. Rotating shift work schedules: can we enhance physician adaptation to night shifts? *Acad Emerg Med* 1997;4:951–961.
- Van Dongen HP, Baynard MD, Maislin G, Dinges DF. Systematic inter-individual differences in neurobehavioral impairment from sleep loss: evidence of trait-like differential vulnerability. *Sleep* 2004;27:423–433.
- Van Dongen HP, Dinges DF. Investigating the interaction between the homeostatic and circadian processes of sleep-wake regulation for the prediction of waking neurobehavioural performance. *J Sleep Res* 2003;12:181–187.
- Van Dongen HP, Maislin G, Dinges DF. Dealing with inter-individual differences in the temporal dynamics of fatigue and performance: importance and techniques. *Aviat Space Environ Med* 2004;75(3 Suppl):A147–154.
- Van Dongen HP, Maislin G, Mullington JM, Dinges DF. The cumulative cost of additional wakefulness: dose-response effects on neurobehavioral functions and sleep physiology from chronic sleep restriction and total sleep deprivation. *Sleep* 2003;26:117–126.
- Van Dongen HP, Price NJ, Mullington JM, Szuba MP, Kapoor SC, Dinges DF. Caffeine eliminates psychomotor vigilance deficits from sleep inertia. *Sleep* 2001;24:813–819.



AIM

This module introduces participants to the problem of stress and depression, and describes how both conditions can detrimentally and profoundly affect even model residents, their performance, and their careers. It also suggests management techniques and treatment plans that can help alleviate resident distress.

LEARNING OBJECTIVES

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

- Describe common personal and professional stressors faced by residents in training
- Predict physiologic and psychological changes as well as maladaptive behaviors that can result from chronic stress
- Identify the signs, symptoms, and behaviors associated with chronic stress
- Compare techniques for optimal stress management
- Implement strategies that can help prevent the negative consequences of stress
- Recognize signs and symptoms indicative of depression
- Anticipate suicide risk in trainees
- Outline strategies and resources for responding to the depressed resident

SCENARIO SUMMARY

A resident presents late for patient rounds and unprepared; a chart has not been updated with the most current laboratory results and the resident is oblivious to these values. Neither the attending physician nor the resident appears to recognize or acknowledge the problems that are causing poor resident performance.

DISCUSSION QUESTIONS

In terms of incidence, what is your experience with residents whose behavior and/or performance suddenly deteriorate? Do you find this to be an unusual or rare problem? Or common?

Give examples of residents whose performance suddenly fails to meet faculty expectations or undergoes an uncharacteristic decline, or a resident whose behavior or personality changes dramatically for the worse

What did you think were some of the causes of the change you observed?

How do you usually respond to residents whose performance appears to alter completely? What steps do you take to remedy the problem?

Assumptions that underlie the initial scenario include the following:

- Changes in behavior are meaningless and do not represent anything other than what they are, i.e., lateness is indicative only of tardiness; poor preparation is indicative only of being poorly prepared. These only represent lack of professionalism or character flaws, and are not potential red flags.

DISCUSSION POINT

What other assumptions might underlie this scenario?

- If a resident just “bucks up” and tries harder, things will work out.

SCENARIO RERUN

A resident presents late for patient rounds and unprepared, with charts that have not been updated with the most current laboratory results. The attending, instead of using sarcasm as a prod, appoints other team members to care for the patient, and takes the resident aside privately, suggesting that the resident make an appointment to “sort things out.”

The rerun attempts to teach the following principles:

- Potentially serious problems can underlie changes in resident behavior
- Stress may be at the root of changed resident behavior and steps should be taken to help the resident deal with it

- Feedback should be given privately
- Follow-up is necessary to “close the loop” and to assure that the resident accesses the resources needed
- The attending must stay in his/her role, not treating or evaluating, but referring for help to appropriate resources

PROGRAM TEACHING POINTS

STRESS

Physicians face enormous learning challenges during the years of their residencies. Stress during residency programs is probably inevitable. By definition, stress is not an entirely negative experience. In fact, it can work to our advantage. Stress associated with learning experiences can serve as a great motivator, can encourage and facilitate the acquisition of knowledge and clinical skills.

Responses to stressors, however, are both unpredictable and highly individual. What one resident experiences as stimulating and exciting—emergency surgery, for example—can overwhelm and intimidate another. When stress exceeds the adaptive capacity of the individual, it becomes distress, and distress can be destructive. The result is poor performance, even illness or impairment. Residents, if they are to become success-

STRESS SUMMARY

- Stress at tolerable levels can serve as a great motivator
- Responses to stress are highly individual
- Stress that exceeds the adaptive capacity of the individual becomes destructive
- What one physician experiences as stimulating, another can experience as overwhelming and intimidating
- Residents may be unable to use typical successful coping strategies (e.g., they may have moved to your community, leaving behind a network of family and friends; work schedules may interfere with exercise or a spiritual connection such as a temple, mosque, or church)

ful practitioners, must be able to cope with any number of stressors.

Generally, stressors fall into three categories: situational, personal, and professional. Situational stressors are connected with the training program and include such things as time demands and heavy workloads.

SITUATIONAL STRESSORS CONNECTED WITH THE TRAINING PROGRAM

Text for Button B

CHALLENGES	SOLUTIONS
<p>Inflexible time, sleep deprivation, fatigue, and exhaustion</p>	<p>Adhere to reasonable limits for the number of hours spent in direct patient care</p> <p>Ensure mandated and personal days off</p> <p>Guard protected time (shared responsibility of residents and programs)</p> <p>Teach principles of time management</p> <p>Teach fatigue management</p> <p>Reduce/eliminate non-educational and/or service demands on residents</p> <p>Educate staff about resident sleep time, to prevent unnecessary paging, etc.</p> <p>Urge development of personal coping skills and resources with attention to balance in resident's lifestyle: social contacts, nutrition, exercise, meditation, relaxation, spirituality, and "play"</p>
<p>Heavy workload</p>	<p>Establish reasonable maximum number of admissions and number of patients cared for per resident (some specialties have already placed limits on this)</p> <p>Establish reasonable number of outpatient visits per ambulatory session (some specialties have already placed limits on this)</p> <p>Allow for the gradually increasing complexity of patients' medical problems</p> <p>Provide adequate supervision and provide relief backup if residents get too fatigued or overwhelmed</p> <p>Add members of the team (e.g., physician assistants, nurse practitioners) to relieve service demands</p>
<p>Onerous clerical and administrative responsibilities</p>	<p>Plan for appropriate support staff and technical equipment (computers, phlebotomists, accessible medical records)</p> <p>Provide instruction on administrative roles/time Management</p>

SITUATIONAL STRESSORS CONNECTED WITH THE TRAINING PROGRAM (CONT'D)

Text for Button B

CHALLENGES	SOLUTIONS
<p>Onerous clerical and administrative responsibilities</p>	<p>Encourage other team members to work up to their capabilities and not become overly dependant on residents</p> <p>Assign clerical functions to other team members; look at restructuring work tasks</p>
<p>Shortage of other members of the health care team (nursing, social services, laboratory workers)</p>	<p>Provide appropriate number of other team members</p> <p>Provide instruction about available resources and capabilities</p> <p>Encourage other team members to work up to their capabilities and perform the duties for which they were trained; discourage overdependence on residents</p>
<p>Difficult patients (e.g., drug and alcohol abusers, abusive personalities)</p>	<p>Offer support group meetings for residents to discuss the impact of patients on them as people, and to discuss the impact on patient care of what's going on in their lives</p> <p>Establish maximum number of difficult patients per resident</p> <p>Provide adequate supervision; if they feel well-supervised, with ready access to faculty should they get "stuck," residents may feel better able to care for difficult patients</p> <p>Enhance faculty roles</p>
<p>Sub-optimal learning environment</p>	<p>Facilitate nurturing environment</p> <p>Provide formal instruction for attending staff to improve teaching skills</p> <p>Assure regular evaluation of and feedback to residents and teaching staff</p> <p>Honor protected time</p> <p>Formulate and enforce a zero-tolerance policy for harassment or hazing of residents/trainees</p> <p>Provide strategies for teaching/learning</p> <p>Identify opportunities to recognize and reward effort, competency, and caring</p>

Adapted from Aach RD, Cooney TG, Girard DE, Grob D, McCue JD, et al. Stress and impairment during residency training: strategies for reduction, identification and management. Ann Intern Med 1988;109:154-161.

Personal stressors are related to the resident and to family relationships. These include limited budgets, lack of leisure time, and the effects of the demands of the profession on important relationships, which themselves are a source of considerable stress.

PERSONAL STRESSORS RELATED TO THE RESIDENT AND HIS/HER FAMILY	
	Text for Button C
TYPE	SOLUTIONS
Family (spouse, significant other, children)	<p>Emphasize importance of social activities</p> <p>Develop adequate personal and family leave policies</p> <p>Suggest family/group meetings. Residents have many types of families, not just children; some care for older parents, siblings, or significant others</p> <p>Network with resources in the community to meet common needs (e.g., adult and child day-care)</p>
Financial strain	<p>Provide formal instructions about money management (e.g., debts, budgets, financial planning)</p> <p>Define program policies on moonlighting</p> <p>Identify sources of information on loan repayment, consolidation, management, and on forgiveness of debt</p>
Isolation; problems of relocating	<p>Conduct orientation, informational, and regular group sessions; arrange for retreats with faculty and peers</p> <p>Encourage peer interaction outside the patient care arena</p> <p>Institute “big brother/sister” mentoring programs that connect more senior residents with junior ones (formally or informally) to orient them to the community, not just to the program; families of more senior residents can play a role in orienting families of new residents as well</p> <p>Encourage active advising/mentoring system</p>

PERSONAL STRESSORS RELATED TO THE RESIDENT AND HIS/HER FAMILY (CONT'D)

Text for Button C

TYPE	SOLUTIONS
Isolation; problems of relocating	<p>Provide local community/ Chamber of Commerce material</p> <p>Suggest social activities</p> <p>Provide information about spiritual resources for interested residents</p>
Limited leisure time	<p>Teach time management</p> <p>Mandate use of personal days off/vacation</p> <p>Encourage athletics and outside interests</p>
Psychosocial problems	<p>Establish policies for early identification of impairment, and need for counseling, change of schedule, leave of absence (if required), remediation, and dismissal</p> <p>At orientation, inform residents of policies and availability of professional assistance</p> <p>Establish opportunities for group support sessions</p>
<p>Inadequate coping skills</p> <div data-bbox="111 1112 478 1242" style="background-color: #cccccc; padding: 5px;"> <p><i>Adapted from Aach RD, Cooney TG, Girard DE, Grob D, McCue JD, et al. Stress and impairment during residency training: strategies for reduction, identification and management. Ann Intern Med 1988;109:154-161.</i></p> </div>	<p>Provide opportunities for formal instruction and individual counseling in coping skills</p> <p>Anticipate need for curriculum in negotiation, conflict resolution, time management, change management, and stress management</p> <p>Build on behaviors that encourage flexibility. Residents are likely to experience life-long changes within the practice of their profession. Developing and strengthening their internal resiliency is essential</p>

Professional stressors are associated with the process of becoming a physician and include patient responsibilities and mastery of the clinical literature.

PROFESSIONAL STRESSORS	
TYPE	SOLUTIONS
Role development, professionalism, lifelong learning	<p>Match residents with faculty advisors</p> <p>Provide mentoring opportunities</p> <p>Carry out and document ongoing performance evaluations</p>
Responsibility for patient care	<p>Inform all levels of trainees about expectations</p> <p>From year to year, clarify progressive resident responsibilities and program expectations</p> <p>Make clear the promotion criteria to graduate from one year to the next and to complete training</p> <p>Normalize stresses associated with residency at orientation session and periodically during the first year</p>
Supervision of more junior residents and students	<p>Provide instruction on teaching to senior residents and faculty</p> <p>Provide leadership training to senior residents</p> <p>Define resident responsibilities and program expectations</p> <p>Match supervisors to level of residents, regarding their experience and patient acuity</p>
Difficult patients and complex medical issues	<p>Provide instruction on management of these patient and medical issues</p> <p>Consider group support meetings</p> <p>Increase the faculty role</p>

PROFESSIONAL STRESSORS (CONT'D)

TYPE	SOLUTIONS
<p>Medical literature overload</p> <p>Adapted from Aach RD, Cooney TG, Girard DE, Grob D, McCue JD, et al. Stress and impairment during residency training: strategies for reduction, identification and management. <i>Ann Intern Med</i> 1988;109:154-</p>	<p>Teach how to access and review the medical literature critically</p> <p>Form a journal club with residents and faculty</p> <p>Encourage role modeling from faculty</p> <p>Use electronic methods</p>

Personal and professional stressors can negatively affect relationships, thus causing or adding to existing stress. High achievers by definition seem particularly vulnerable to the effects of stress.

DISCUSSION: HIGH ACHIEVERS/TYPICAL TRAITS

In his book, *Managing Stress*, psychologist David Fontana compiled a list of traits characteristic of high achievers. Ask participants how many, if any, seem to apply to residents:

- Multitasks, i.e., does several things at once (e.g., telephones, converses with friends, jots notes, swivels chair back and forth, all simultaneously)
- Often feels guilty when relaxing
- Quickly tires of other people's conversations, interrupts, finishes sentences, or hurries others up
- Attempts to steer conversations towards his/her own interests instead of listening to those of others
- Usually feels anxious when engaged in a task, wants to finish it and move on to the next one
- Does not attend to anything that isn't immediately connected with what he/she is doing
- Does most things (eating, talking, walking) at full speed
- Finds people like him/herself challenging and people who "dawdle" or move more slowly very annoying

DISCUSSION: HIGH ACHIEVERS/TYPICAL TRAITS (CONT'D)

- Is physically tense and assertive
- Is more interested in winning than in enjoying him/herself
- Finds it hard to laugh at him/herself
- Finds it hard to delegate
- Finds it almost impossible to attend meetings without speaking up
- Prefers active holidays to relaxing ones
- Pushes to achieve his/her own standards without showing much interest in what he/she really wants out of life

Do you think that any of these traits are necessary to succeed as a physician? Fontana states that people who have many of these traits are prime candidates for emotional fatigue and exhaustion.

Fontana D. *Managing Stress*. London: British Psychological Study and Routedledge Ltd., 1989:70–71.

The sooner stress is recognized, the greater the chances of alleviating its effect on personal or familial relationships; in these cases, an “ounce of prevention” is surely worth

ALLEVIATING STRESS IN A RELATIONSHIP: RECOMMENDATIONS

Text for Button D

- If you are married or in a relationship, make sure to devote sufficient time/priority to marriage/relationship(s)
- Understand that relationships take work and that they go through stages
- Evaluate relationships periodically. Recognize that adjustments are necessary either because one or both members of the couple change or a situation changes. (Residency may be a life-altering experience that requires adjustment in how a couple fits together)
- Examine the quality of the commitment and how it can be demonstrated. Each person may have a different concept of what demonstrates this commitment
- Express appreciation frequently. This is one of the keys to healthy relationships and families. Appreciation helps to counter an escalation of negativity caused by small aggravations that build up over time

ALLEVIATING STRESS IN A RELATIONSHIP: RECOMMENDATIONS(CONT'D)

Text for Button D

- Accept that “the grass isn’t necessarily greener”
- Keep talking. Dialogue is more important than agreement. Most disagreements are about unsolvable issues. Discuss even if you can’t agree
- Set healthy boundaries. Typical areas are confidences, work life, and couple life

the “pound of cure.”

SIGNS OF STRESS

Basic physical, emotional, and behavioral signs of stress signal that potentially severe problems may soon occur. Obviously, no one person will manifest all the possible symptoms that indicate stress, nor is the list (see Sidebar) comprehensive. But two or three together may be enough to signal the need for intervention.

PHYSICAL, EMOTIONAL, AND BEHAVIORAL SIGNS AND SYMPTOMS OF STRESS

Physical

- Muscle tension
- Myalgia, neck pain
- Cold/sweaty hands
- Facial tics
- Fatigue
- Tension headaches
- Indigestion
- High blood pressure
- Ulcers
- Heart palpitations
- Back or joint pain

Emotional

- Anxiety
- Fear
- Irritability
- Hopelessness
- Helplessness
- Impatience
- Depression
- Nervousness
- Guilt

Behavioral

- Change in appetite
- Sleep disturbance
- Forgetfulness
- Angry outbursts
- Aggression
- Decline in productivity
- Social withdrawal
- Change in sexual interest
- Increased use of caffeine, tobacco, alcohol, or drugs
- Indecisiveness
- Loss of concentration

Worse, in an attempt to cope with the effects of stress, residents may turn to maladaptive behaviors. Unfortunately, maladaptive behaviors neither reduce the misery associated with stress nor resolve the stressful situation. In fact, they eventually may result in physician impairment due to the abuse of alcohol or other legal or illegal substances, any one of which is sufficient to hinder patient care.

RESIDENCY PROGRAMS AND STRESS MANAGEMENT

There are positive ways to deal with stress. The first step is for residency programs to acknowledge and appreciate the effects of stress; the second step is to try to prevent it; the third is to recognize the signs and symptoms of mismanaged stress. And finally, the fourth is to have policies and plans to deal with stress when intervention is required.

STRESS MANAGEMENT IN RESIDENCY PROGRAMS

Text for Button G

There are many ways for a residency program to practice prevention when it comes to helping residents manage stress.

- 1.** Identify the “culture” of your training program and what it takes to thrive. Communicate this clearly to applicants. Design an application strategy that will match residents who are congruent to your program/faculty style. For example, you may personally like the relaxed, somewhat passive, bright, quiet resident applicant, but he/she might not fit in well with a hard-driving, quick-decision-making, low-tolerance-for-uncertainty culture; therefore, find another candidate who is a better match. If you don’t already have a good feel for this, analyze the residents who have succeeded and who have been challenged within your program. Allow for new residents to adjust to the new setting. Inform incoming residents about colleagues, resources, your community, and your facility. Provide time for them to get acclimated (e.g., to move in, get utilities turned on, acquire a driver’s license, register to vote, et al). They need to know where to shop, bank, enroll their children in school, go to church, and establish resources for their families.
- 2.** Consider offering or directing residents to resources. Provide stress management training early in residency. One example of such a technique uses the acronym ERASE (see Text Button H). Within the bounds of confidentiality, residents can be encouraged to share with each other their own early warning signals for stress and show how they would prefer to be approached if colleagues take notice. There are many specific stress management techniques that can be used: breathing/relaxation, biofeedback, meditation, guided imagery and visualization, music and artistic expression, spirituality, exercise, and movement.
- 3.** Provide ongoing support mechanisms such as regular, frequent resident group meetings to discuss the many issues residents face. This is best done when the group leader is viewed as a non-threatening person by the residents. Sometimes this means arranging for a faculty member from a different program, or perhaps a counselor from your employee assistance program (EAP), or a community member not associated with the training program. This may help the residents feel better about confidentiality. The leader must be empowered by the program to keep confidences, except when a resident is suicidal or homicidal, or when patient care is being compromised. Leaderless groups are not encouraged. Consider an active process of advising and mentoring.

DISCUSSION POINT

Choose two participants, one to act as a stressed resident, the other to act as a concerned colleague. The resident displays signs of stress; the colleague tries to draw the resident out and discuss the pressure points in his/her life that are causing problems. What does the concerned colleague say to the resident? When the role-playing is over, have the group critique the presentation. What was done well? What could have been done better?

Ask participants to identify successful coping strategies they have used. What are the impediments they face to using these same coping strategies in residency?

How perfect do residents feel they need to be?

STRESS MANAGEMENT IN RESIDENCY PROGRAMS (CONT'D) Text for Button G

4. Use regularly scheduled meetings, such as curriculum meetings, where residents can have the opportunity to collaborate with peers and faculty, and can have regular review of and input into improving components of the residency.

5. Consider instituting a support group for spouses/significant others. Such groups can help residents' partners gain a better understanding of residency and form bonds with one another.

6. Model attitudes that recognize the potentially destructive impact of stress, and that demonstrate that asking for help is not a sign of weakness. Faculty need to practice modeling behaviors themselves, e.g., the ERASE guidelines (see below). Faculty who appear to have no other interest in life other than medicine or who do not take care of their own physical/emotional/spiritual needs convey the impression that residents should behave in the same way.

7. Facilitate mentoring relationships, which are very important. Connect residents with faculty mentors, ideally ones they themselves choose. Faculty should have regularly scheduled meetings with their advisees, in addition to having an open-door policy. Pairing new residents with senior residents can be helpful, as some residents will be more comfortable relating to a peer.

8. Develop self-reflective practice. Encourage residents to analyze their own strengths and weaknesses, to set realistic short- and long-term goals, and to identify measures of their progress.

9. Conduct ongoing faculty professional development in these and related areas. How well programs mentor, support, and care for faculty is frequently mirrored in how well faculty mentor, support, and care for residents.

ERASE

- Exercise
- Relaxation
- Other Enjoyable Activities
- Supportive Relationships
- Emotional Expression

How can a resident get adequate exercise? Residents may find it challenging to get to a gym or sports club on a regular basis. Consider sharing exercise time with significant others and family. Look for gyms that have off-hours that accommodate resident schedules. Consider activities that can be done at home or in the hospital setting. Stairs offer opportunities for vigorous aerobic exercise, pipes can be used for chin-ups, and floors are readily available for push-ups. Even a brisk 10-minute walk around the hospital (if safe) can be invigorating and provide a sense of getting away for a moment. Some hospitals have put treadmills, free weights, and a few machines in a lounge area for residents, and many residency programs offer intramural team sports. Some offer residents free or reduced memberships in local fitness facilities; ask if a personal trainer can help with a 20-minute routine, one that alternates between aerobic exercise and a short strength-training workout.

Relaxation techniques are proven stress relievers and could be included in the curriculum for residents, family members, and even patients. These include deep-breathing exercises, meditation, and imagery. Bathrooms, lounge areas, or call rooms can be used for a 5-minute meditation break. Settings don't have to be elaborate. Another simple method is to put on a CD with soothing music or sounds of nature for 5 minutes. Use earphones to drown out noise. A 6-minute power nap is another option.

Outside activities are very important. Residents need to nurture a healthy life outside of medicine and maintain non-medical interests. Ask residents what they enjoyed doing before medical school. Sometimes it is useful to encourage residents to maintain outside interests that remain relatively stable to contrast the instability and ever-changing status of the patients they care for. An example of this is photography. Every time you look at a picture you've taken, it is the same. Unlike a patient, a photo won't crash on you overnight. Look for something concrete to balance the ambiguity of medicine. Examples include arts and crafts, hobbies, religious affiliations, humor, vacations, sex, music, fishing, and other pleasurable activities.

Support systems are another important source of stress relief. Family, significant others, and friends can all help alleviate pressure. Short phone calls and emails reinforce relationships and ease strain. Forming alliances with other residents reduces the competitive atmosphere that pervades most training settings and emphasizes the spirit of cooperation. Residents can help each other out, volunteering on busy services when possible. Making friends with staff such as emergency medical technicians, nurses, and physician assistants can make life on the floor easier. These professionals are enormous resources. Encourage residents to have some of their support people be those who won't talk medicine with them.

A strong spiritual relationship can also be helpful. Many residents manage stress from the perspective of spirituality, within either the structure of a formal faith or a world view that acknowledges something greater and beyond themselves. Spiritual directors can be a resource.

Counseling, too, can be important. Counseling should be considered or recommended any time the effects of stress interfere with the resident's performance or the function of the medical system. Residents can frequently access free counseling through an EAP.

Finally, emotional expression is vital. Emotions are normal, healthy responses to life events. Residents need to express their feelings in safe and appropriate ways. People who express emotions are better able to understand and cope with them, and can be more effective in coping with other peoples' feelings. Speaking with close friends, family members, and faculty, and keeping a journal (e.g., narratives or poems) can help to satisfy the need for emotional clarity and expression. Helping with emotional expression is another role that counseling plays.

Every program would be wise to adapt and teach stress management strategies early on in the residency as a way to help physicians through the rigors of the training period. Time, finances, and conflicts are common sources of stress for residents; therefore, other curricular components that may be useful are time management, financial management, and conflict management.

Faculty and PDs should resist the urge to diagnose and manage resident stress—which could blur the teaching relationship—even if capable of managing similar symptoms in a patient. The obligation of those in charge is not to treat the resident but to help the resident access appropriate resources. Finally, and very importantly, the resident should meet with the PD, and the reporting physician/colleague should request confirmation that an appointment has been scheduled.

Beyond stress management, residency programs must address mental health problems of physicians, particularly depression. All supervisory personnel need to be alert to its potential presence. If any faculty member suspects that a resident is depressed, steps should be taken immediately to intervene before the problem spirals out of control.

Begin by arranging a private meeting. Provide as much emotional support as possible and assess for any suicidal ideation.

HELPING THE STRESSED RESIDENT: INTERVENTION PRINCIPLES

- Address issues directly and privately with the resident
- Arrange for a meeting
- Inform the PD
- Inquire as to what the resident sees as the issues
- Be supportive, empathic; normalize and instill hope
- Assess for immediate risk of suicide/homicide
- Avoid diagnosing and/or treating what is thought to be the problem
- Introduce the idea of an outside evaluation
- Arrange for meeting between resident and PD
- Follow up with resident to confirm that all steps are taken

Sometimes the resident will benefit from counseling, a change of rotation, or even a leave of absence. This is especially true if the resident's suffering is severe, as can be the case with depression. Know your RRC and board's policies on resident leave of absence; clarify what time is allowable, and what needs to be "made up" after the leave.

DEPRESSION

Depression is as common in physicians as it is in the rest of society. It is also a major risk factor for suicide. Physicians commit suicide at higher rates than the general population. Women physicians are at particular risk.

SUICIDE STATISTICS

Suicide ranks as the leading cause of premature death among physicians.

Relative risk for suicide in male physicians increased from 1.1 to 3.4 from 1963 to 1991.

The relative risk for suicide in female physicians increased from 2.5 to 5.7 during the same period.

Lindeman S, Laara E, Hakko H, Lonnqvist J. A systematic review on gender-specific suicidemortality in medical doctors. *Br J Psychiatry* 1996 Mar;168:274–279.

Center C, Davis M, Detre T, Ford DE, Hansbrough W, Hendin H, et al. Confronting depression and suicide in physicians: a consensus statement. *JAMA* 2003;289:3161–3166.

Medical culture does not invest a great deal in physician mental health. Educate residents and encourage them to establish their own source of care for both their physical and psychological well-being.

Educate residents about depression and its consequences. They should know and understand the kind of protection they can expect in terms of confidentiality if they decide to seek help for themselves or their colleagues. (The module on burnout and career crisis has other suggestions and can be recommended at this point.)

Identifying or diagnosing depression is not always simple and, as a consequence, it often goes unrecognized. Certain factors can mask the clinical presentation. Depression can also hide behind physical symptoms. And, finally, it can cause social and sexual problems, sleep disturbance, and substance abuse.

DSM-IV CRITERIA FOR MAJOR DEPRESSIVE EPISODE*

Text for Button I

Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure:

Note: Do not include symptoms that are clearly due to a general medical condition, mood-incongruent delusions, or hallucinations.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful)

Note: In children and adolescents, can be irritable mood

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day

Note: In children, consider failure to make expected weight gains

4. Insomnia or hypersomnia nearly every day

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

DSM-IV CRITERIA FOR MAJOR DEPRESSIVE EPISODE* (CONT'D)

Text for Button I

6. Fatigue or loss of energy nearly every day
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

The symptoms do not meet criteria for a Mixed Episode.

The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism)

The symptoms are not better accounted for by bereavement; i.e., after the loss of a loved one; the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

*These criteria are provided only to help recognize the signs and symptoms of depression. Program directors, faculty, or residents should not attempt to diagnose and manage depression in colleagues. The potentially depressed resident should be referred to and evaluated by a professional in the context of a physician-patient relationship; the PD should remain in an educational, evaluative role.

Except in an emergency, no physician should treat a colleague or family member, for depression or anything else. The following make excellent discussion questions on this point:

Judgment can never remain neutral when the person being treated is close to the physician.

Residents are colleagues and the mentoring relationship can make them seem almost like family members. Boundaries then risk becoming blurred because of the multiple roles faculty members must play with residents.

Treaters cannot be effective evaluators, and evaluators, if they are to remain effective as such, cannot be treaters. This is true even when the disorder in question falls well within the normal scope of the senior physician's practice.

Outside resources should always be used to identify and treat any medical or psychological condition affecting any resident.

After the resident has had an outside evaluation, use the information provided to develop an education modification plan. Although the program won't be treating the resident, it is essential that it ensures that he/she gets time off to keep doctor appointments, gets frequent feedback on job performance, and takes care of him/herself. Maintaining confidentiality is also very important.

Finally, if the resident is not returning to a service where he/she can be directly monitored by program faculty aware of his/her situation, permission must be granted to inform supervisors on any other rotation the resident joins so that close supervision of the resident can be maintained.

Fortunately, the prognosis for depression is excellent. With appropriate care, most physicians recover completely and go on to resume normal and productive lives.

STRESS AND DEPRESSION REVIEW

- Discuss the positive impact of stress on resident performance; how can it sometimes work advantageously? What are good sources of stress? How is useful stress distinguished from distress?
- Discuss some of the situational, personal, and professional stressors connected with resident training programs suggested in this module. In terms of challenges and solutions described here, how do they fit in with the pressures and attempts to alleviate those pressures at your institution? How proactive would you describe your program?
- Discuss steps that can be taken to alleviate stress as suggested in this module. How realistic do you think the suggestions are?
- Describe some of the physical, emotional, and behavioral signs of stress
- Describe some of the methods residency programs can put in place to help reduce stress
- Discuss how faculty can help model behaviors that might be useful in reducing resident stress
- Describe the incidence of depression as presented in this module. How common do you find it in residents and other physicians in your institution?
- Give reasons why no physician should provide medical treatment to a colleague or family member

STRESS AND DEPRESSION: ADDITIONAL REFERENCES OF INTEREST

- Bellini LM, Abbuhl S, Grisso JA, Lavizzo-Mourey R, Shea JA. Stresses and workplace resources for academic junior faculty: track and gender comparisons. *Acad Med* 2001;76(10 Suppl):S62–S64.
- Center C, Davis M, Detre T, et al. Confronting depression and suicide in physicians: a consensus statement. *JAMA* 2003;289:3161–3166.
- Cohen JJ. Heeding the plea to deal with resident stress. *Ann Intern Med* 2002;136:394–395.
- Collier VU, McCue JD, Markus A, Smith L. Stress in medical residency: status quo after a decade of reform? *Ann Intern Med* 2002;136:384–390.
- Epstein RM. Mindful Practice. *JAMA* 1999;282:833–839.
- Firth-Cozens J. Doctors, their well-being and their stress. *BMJ* 2003;326:671–672.
- Firth-Cozens J, Greenhalgh J. Doctors' perceptions of the links between stress and lowered clinical care. *Soc Sci Med* 1997;44:1017–1022.
- Frank E, Breyan J, Elon L. Physician disclosure of healthy personal behaviors improves credibility and ability to motivate. *Arch Fam Med* 2000;9:287–290.
- Glass RM. Awareness about depression: important for all physicians. *JAMA* 2003;289:3169–3170.
- Horiguchi T, Kaga M, Inagaki M, Uno A, Lasky R, Hecos K. An assessment of the mental health of physicians specializing in the field of child neurology. *J Pediatr Nurs* 2003;18:70–74.
- Kivimäki M, Sutinen R, Elovainio M, Vahtera J, Räsänen K, Töyry S, Ferrie JE, et al. Sickness absence in hospital physicians: 2-year follow-up study on determinants. *Occup Environ Med* 2001;58:361–366.
- Mareiniss DP. Decreasing GME training stress to foster residents' professionalism. *Acad Med* 2004;79:825–831.
- Meier DE, Back AL, Morrison RS. The inner life of physicians and care of the seriously ill. *JAMA* 2001;286:3007–3014.
- Petersen-Crair P, Marangell L, Flack J, Harper R, Soety E, Gabbard GO. An impaired physician with complex comorbidity. *Am J Psychiatry* 2003;160:850–854.
- Pitt E, Rosenthal MM, Gay TL, Lewton E. Mental health services for residents: more important than ever. *Acad Med* 2004;79: 840–844.
- Rahe RH, Taylor CB, Tolles RL, Newhall LM, Veach TL, Bryson S. A novel stress and coping workplace program reduces illness and healthcare utilization. *Psychosom Med* 2002;64:278–286.
- Robinson GE. Stresses on women physicians: consequences and coping techniques. *Depress Anxiety* 2003;17:180–189.
- Smith R. Why are doctors so unhappy? There are probably many causes, some of them deep. *BMJ* 2001;322:1073–1074.
- Yao DC, Wright SM. National survey of internal medicine residency program directors regarding problem residents. *JAMA* 2000;284:1099–1104.
- Zare SM, Galanko J, Behrns KE, et al. Psychological well-being of surgery residents before the 80-hour work week: a multiinstitutional study. *J Am Coll Surg* 2004; 198:633–640.

VISIT OUR WEBSITE FOR UP-TO-DATE REFERENCES



SUBSTANCE ABUSE

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AIM

This module presents information on substance abuse, its risk factors, and its effects on professional lives. The program presents strategies helpful in rehabilitating addicted residents, and describes the legal issues that pertain to both the addicted physicians and the institution.

LEARNING OBJECTIVES

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

- List the five substances most commonly abused by physicians
- Cite the recovery rate for physicians with substance abuse or dependence who enter treatment and are monitored for 5 years
- Recognize common indicators, signs, and symptoms of substance abuse in residents
- Describe the medico-cultural factors relative to substance abuse in physicians (e.g., conspiracy of silence, denial, etc.)
- Anticipate the favorable treatment outcomes of substance abuse in physicians
- Outline the types of policies and procedures PDs should have in place for prevention, identification, and management of substance abuse
- List resources available for residents with substance abuse problems
- Discuss strategies for creating a non-punitive, collegial culture

SCENARIO SUMMARY

A resident with back pain asks one of his colleagues to prescribe an opioid for pain relief; she has been prescribing the opioid for him for the past few months, but is now very reluctant to do so. She argues with him about the addictive nature of the drug he is taking. Ultimately, however, she agrees to write the prescription for him.

DISCUSSION QUESTIONS

- In your experience, how widespread is the problem of alcohol and substance abuse among your residents/colleagues?
- What types of behavior(s) typically indicated to you that one of your residents/colleagues had an alcohol/substance abuse problem?
- Have any of you had experiences with addicted colleagues? If so, describe the experiences.
- How have you typically reacted or responded to an addicted colleague? How willing are you to insist that he/she see an appropriate person to deal with the addiction?

Assumptions that underlie the initial scenario include the following:

Drug addicts look and act differently than non-addicted people

If a person can function effectively while taking drugs, then obviously, there is no addiction

Helping out a friend in need is the ethically appropriate thing to do

DISCUSSION POINT

What other assumptions might underlie this scenario?

SCENARIO RERUN

A resident with back pain asks one of his colleagues to prescribe an opioid for pain relief; she has been prescribing the opioid for him for the past few months. She gently refuses to be complicit in his addiction and insists that he see his PD to obtain help.

The rerun attempts to teach the following principles:

Stereotypical images of addicts are precisely that: stereotypes

An individual can be an addict and still function, at least, up to a point: doctors notoriously function well at work. Usually their professional performance is the last thing to decay.

Enabling an addicted colleague by prescribing—covering up drug or alcohol abuse in any way—is not an act of friendship.

Addicted colleagues need help. There are resources to help them overcome any addictions. A true friend insists that the addicted physician avail him/herself of them.

PROGRAM TEACHING POINTS

INCIDENCE AND RISK FACTORS

Studies estimate that the prevalence of chemical and alcohol abuse for physicians in the US is similar to that of the general public. Alcohol is the number one substance abused by physicians, as it is in society as a whole. Alcohol is, followed by marijuana, opiates—mostly prescription opiates (i.e., hydrocodone), not illicit opiates (i.e., heroin)—stimulants (i.e., Ritalin, Adderall, other amphetamines), and cocaine. The prevalence of prescription opioid addiction in physicians is related to how easily physicians can access and divert the drugs.

PHYSICIAN ADDICTION SIMILAR TO GENERAL US PUBLIC

- 6% suffer substance use disorder
- 14% suffer alcohol use disorder

Regier DA, Farmer ME, Rae DS, Locke BZ, Keith SJ, Judd LL, et al. Comorbidity of mental disorders with alcohol and other drug abuse. Results from the Epidemiologic Catchment Area (ECA) Study. *JAMA* 1990; 264:2511–2518.

Aach RD, Girard DE, Humphrey H, McCue JD, Reuben DB, Smith JW, et al. Alcohol and other substance abuse and impairment among physicians in residency training. *Ann Intern Med* 1992; 116:245–254.

The risk factors for substance abuse in physicians are also similar to those for the general population. Perhaps the most important risk factor for physicians is their easy access to pharmaceuticals either through diverting sample medications, self-prescribing, falsifying prescriptions, or obtaining prescriptions from colleagues.

RISK FACTORS FOR PHYSICIAN ALCOHOL AND SUBSTANCE ABUSE

- Stress at home and/or at work
- Emotional problems, self-treatment of pain, abnormal sleep patterns, and chronic fatigue
- Psychic stimulation
- Family history of substance abuse (genetic)
- Easy access to pharmaceuticals (availability)

McAuliffe W. Risk factors of drug impairment in random samples of physicians and medical students. *Int J Addiction* 1987;22:825–841.

RECOGNIZING ADDICTION IN PHYSICIANS

Unfortunately, early detection of physician addiction is difficult. Addicted physicians can continue to function at high levels for a long time, and problems are usually only identified at a late stage, when performance becomes markedly impaired. Work is usually the last area to suffer. Alcohol addiction is especially hard to determine. Not only is alcohol a legal substance, but its use is, generally, socially acceptable and even encouraged through medical traditions such as “liver rounds.” The difficulty resides in separating use from misuse or abuse.

DSM-IV CRITERIA FOR SUBSTANCE ABUSE AND SUBSTANCE DEPENDENCE*

The top five substances used by physicians are alcohol, marijuana, opiates—mostly prescription opiates (i.e., hydrocodone), not illicit opiates (i.e., heroin)—stimulants (i.e., Ritalin, Adderrall, other amphetamines), and cocaine.

SUBSTANCE ABUSE:

A maladaptive pattern of substance use leading to clinically significant impairment or distress is manifested by one or more of the following, occurring within a 12-month period:

- Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
- Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired)

DSM-IV CRITERIA FOR SUBSTANCE ABUSE AND SUBSTANCE DEPENDENCE* (CONT'D)

- Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
- Continued substance use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

Additionally, the symptoms for substance abuse have never met the criteria for substance dependence.

SUBSTANCE DEPENDENCE:

A maladaptive pattern of substance use leading to clinically significant impairment or distress is manifested by three or more of the following, occurring at any time in the same 12-month period:

- Tolerance, as defined by either of the following:
 - A need for markedly increased amounts of the substance to achieve intoxication or desired effect
 - Markedly diminished effect with continued use of the same amount of the substance
- Withdrawal, as manifested by either of the following:
 - The characteristic withdrawal syndrome for the substance
 - Taking the same (or a closely related) substance to relieve or avoid withdrawal symptoms
- Taking the substance often in larger amounts or over a longer period than was intended
- Having a persistent desire or unsuccessful efforts to cut down or control substance use

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV). American Psychiatric Association, Washington D.C., 1994.

*The DSM criteria are presented as a reference to PDs to help them identify at-risk residents. The criteria are intended to trigger a referral for an evaluation, and do not imply that PDs should themselves evaluate and/or attempt to diagnose or manage a resident with substance abuse or substance dependence. We recommend PDs and faculty remain in their educational and evaluative roles, and avoid seeing the resident in a physician-patient relationship, which risks blurring the boundaries of both relationships.

DISCUSSION QUESTION MISUSE

Are these two categories—abuse versus dependence—critical to the way you define an addiction problem? How important is the difference between *abuse* versus *dependence* to your decision to report an addicted physician to appropriate faculty?

Are there any ways in which your program enables the misuse of alcohol and other substances of abuse?

What are your state medical board's rules on prescribing for friends, colleagues, and family members—not just opioids or controlled substances, but even prescriptions such as antibiotics or contraceptives? Are your state board's rules the same as in most other states? How do residents in your program become aware of these policies?

Most commonly, a physician's alcohol abuse is identified as a result of complaints. A typical situation is one or more phone calls from other people, usually colleagues or family members of patients, reporting a suspicious odor of alcohol detected on a resident's breath. Although such an allegation is not a confirmation, it should be taken seriously and prompt a thorough evaluation.

ALCOHOL ADDICTION

- A single episode may be the tip-off to a real issue of dependency or abuse
- A pattern of behavior is sought, but patterns start with a single episode
- Complaints about residents (as with any clinicians) and alcohol use should be taken seriously

Early signs of substance abuse should raise the index of suspicion: alterations in professional behavior, dress, and general behavior (e.g., a punctual person is routinely late for appointments). Signs also include any cavalier prescribing of controlled substances (e.g., evaluate carefully any resident who prescribes a relatively large quantity of opioids for a patient with a self-limiting condition).

SIGNS AND SYMPTOMS INDICATIVE OF SUBSTANCE ABUSE

Text for Button C

PERSONAL/FAMILY BEHAVIOR

- Isolation and withdrawal from family, friends, church, leisure activities
- Erratic or violent behavior in the home
- Sexual dysfunction and/or promiscuity (e.g., multiple sexual partners)
- Legal problems, especially driving convictions
- Separation or divorce from partner
- Compulsions (e.g., excessive spending, gambling)

SOCIAL BEHAVIOR

- Inappropriate behavior at social functions
- Citation for driving while intoxicated (DWI)
- Citation for “careless and reckless driving” plea-bargained down from DWI
- Deterioration in personal hygiene, clothing, and dressing habits
- Accidents, falls, motor vehicle collisions

PROFESSIONAL BEHAVIOR (OFTEN THE LAST TO DETERIORATE)

- Recurrent tardiness
- Rounds very early or very late (to avoid others and escape scrutiny)
- Behaves inappropriately during rounds
- Shows diminished performance (poor quality of presentations, charting, dictations)
- Absent, often without a viable excuse
- Over-prescribes medicines, especially controlled substances
- Wears long-sleeved scrubs and/or has track marks or injection sites
- Requests drug samples from colleagues or nurses
- Alters behavior (becomes less compulsive when typically conscientious; has rapid changes in quality of dress, hygiene, timeliness, attention to detail)
- Becomes the subject of “hospital gossip”
- Has alcohol on breath
- Slurs speech and/or has pinpoint pupils

SIGNS AND SYMPTOMS INDICATIVE OF SUBSTANCE ABUSE (CONT'D)

Text for Button C

- Repeatedly fails to answer pages or home phone calls
- Diverts medicines
 - Medications on unit disappear
 - Patients complain that the resident “keeps my medicines” or requests that “I give him/her any unused medicine”

Deterioration in personal life or in family relationships may be more subtle and difficult to detect. While substance abuse certainly affects both, unless the spouse or significant other is forthcoming with information, abuse will probably remain unidentified until work function begins to decline or social/legal problems result. A DWI and other repeated traffic violations—speeding tickets or reckless driving, for example—are significant red flags.

OTHER PROBLEMS IN IDENTIFICATION OF PHYSICIANS AT RISK

Identifying doctors at risk is difficult for a number of other reasons. Denial of an addiction problem is high. In our medical culture, it is often “hear no evil, see no evil, speak no evil, and maybe the whole thing will just go away.” Denial occurs on all levels: the institution, the resident, peers, and the family/significant others.

On the institutional level (the first part of our scenario is exemplary), colleagues—or even supervisors, for that matter—can become enmeshed in a “conspiracy of silence.” They may make excuses for a colleague’s behavior and dismiss the accuracy of their diagnosis or intuition. They may even fear retribution if they come forward and share what they know. As well, they may be sincerely afraid of causing legal problems; they may believe—like most others in the general population—that physicians either don’t get ill or that they are able to heal themselves. They may also fear risking a friendship or alienating a person they value. More critically, they may be afraid that reporting a colleague’s addiction will end his/her career. Unfortunately, many professionals remain unaware of the potential resources that allow physicians to continue to practice after getting the treatment help they need.

DISCUSSION QUESTIONS

- In your experience, do you find that colleagues too often cover for a physician with a drug or alcohol problem?
- What is the policy on tolerance of use or abuse at your institution?

Denial also exists on the level of the addicted individual. So entrenched are their defenses that addicted doctors may be unable to recognize that they have a problem.

Family members and friends also have difficulty dealing with the reality of the situation. Many may feel a great sense of failure with respect to the person's addiction, because they are unable to rescue the person or to convince him/her to get help. Family members may be dependent on the physician's salary and fear losing it if he/she enters treatment.

The peer relationship is particularly complex. Peers, too, may feel failure because of an inability to get the physician the necessary help. But they also may be involved by writing prescriptions for the physician, or even by being asked to write prescriptions.

Residents who do recognize that they are alcohol- or drug-dependant often believe they can deal with it on their own.

If denial exacerbates the problem of dealing with addiction, so does a punitive approach.

Traditionally, substance abuse has been treated as if it were a moral or ethical failure instead of a disease. Physicians who became addicted faced extreme disciplinary measures, including loss of the medical license. As a result, doctors who desired treatment faced substantial hurdles. Now, addiction is viewed as a disease. There are medical societies and programs in every state designed to help physicians deal with substance impairment.

PRINCIPLES OF INTERVENTION

All institutions should have a clearly articulated administrative and therapeutic pathway to deal with substance use or abuse. The administrative pathway requires defined policies and procedures outlining the steps to be taken once a resident (or other physician) with a potential substance abuse problem has been identified. Hospital by-laws constitute one mechanism that can spell out acceptable versus unacceptable behavior, the necessary documentation needed to avoid legal exposure, and the consequences or, "due process" if you will, if those by-laws are violated. All should be treated the same and all should be offered help.

Once a resident with a substance abuse problem has been identified and the problem is documented, he/she should be confronted with the facts. Intervention should take place with the help of a team. Depending on your system, this team may consist of the physician associated with your employee health program, director of your hospital physician wellness committee, or the PHP in your state. You may benefit from investigating what services these groups provide so you will be knowledgeable when the situation arises.

- Use a trained, experienced leader for the team. Consider the most experienced resource in your institution, head of human relations, the designated institutional official (DIO), chair, chief of medical staff, head of occupational health/employee health, or your state PHP
- Select, train, and coach team members from the most significant persons in the resident's life. Training and coaching should emphasize knowledge and objectivity
- Select the site of the confrontation carefully (e.g., choose a quiet, non-threatening, neutral space)
- Determine goals—all members of team must agree on the choices to be given to the resident (e.g., leave of absence, required evaluation, immediate drug testing)
- Present documented information (e.g., dates, time, places, events)
- Rehearse the confrontation, if possible (have each team member practice a role)
- Plan for all outcomes (e.g., options, transportation, action plans, and consequences for non-compliance are agreed on in advance and executed immediately)

Revised from Aach RD, Girard DE, Humphrey H, McCue JD, Reuben DB, Smith JW, et al: Alcohol and other substance abuse and impairment among physicians in residency training. *Ann Intern Med* 1992;116:245–254.

The therapeutic pathway consists of physicians and/or programs in the area that can provide substance abuse treatment once the resident with the alcohol- or drug-related problem has been identified. A physician who is aware of a resident with alcohol or drug problems should without hesitation contact the PD. The PD can, in turn, access the appropriate resources including the DIO. Other resources may include the medical society, the state PHP, or the institution's employee health service. The PHP may protect physician confidentiality and be able to allow physicians in recovery to return to practice without jeopardizing their medical license. (State laws vary, so know your state!)

Residents who are aware of a substance abuse problem in a colleague should contact the PD and not be deterred by a misguided sense of loyalty to the colleague. Contact should be made as soon as possible. The prognosis is usually extremely good for residents with alcohol and other substance abuse disorders. But the earlier they get help, the better!

COMMON ISSUES INVOLVING RESIDENTS SUSPECTED OF SUBSTANCE ABUSE

Text for Button E

The recovery rate for physicians who enter treatment and then are monitored for 5 years is over 90%. Success correlates with intensity of monitoring and drug screening. Therefore, intervention is worthwhile, even if a resident is in denial about having a substance problem.

Example of language a PD might use when confronting a resident:

"I am concerned about your health and safety, as well as that of your patients. I am removing you from patient care immediately and want you to accompany me to the employee health service for evaluation. I have already spoken to the people there and Dr. _____ will see you as soon as we arrive."

Consider walking the resident over to employee health or emergency medicine to obtain a blood alcohol level or to test for other substances.

LEGAL CONCERNS OF PROGRAM DIRECTORS:

Some PDs express concern that if they insist on an evaluation, a trainee might sue. A good-faith referral for evaluation based on commonsense concern is not likely to constitute grounds for litigation. However, check with your own hospital or institution's legal counsel, then:

- Start from a clinical perspective and state the concern regarding the resident's safety and/or that of the patients under his/her care; then cover the legal bases as necessary with appropriate documentation
- Avoid diagnosis; describe the behavior. Commonly, PDs and faculty run a risk by excusing or explaining everything based on a diagnosis (i.e., personality disorder or ADD), without confronting and/or attempting to define the specific problematic/unsafe behavior
- Let another resource (e.g., the employee health service) do the evaluation and determine a diagnosis

The obligation to report an addicted colleague has both legal and ethical dimensions. In some states, the law requires that substance abuse be reported. Physicians who have substance abuse problems risk harming a patient, and patients must be protected from even potential harm. In addition, our professional ethics require us to help our addicted colleagues. If residents aren't appropriately identified and successfully treated they risk an inevitable loss of license and their profession.

REPORTING TO THE NATIONAL PRACTITIONER DATA BANK (NPDB): WHEN IS IT REQUIRED?

Text for Button F

PROGRAM DIRECTORS

PDs are referred to their own hospital or institution's legal counsel for state-specific regulations. A reporting requirement may only apply if a physician's hospital privileges are revoked or restricted.

HOSPITALS AND OTHER HEALTH CARE ENTITIES

A report is required for professional review action—based on reasons related to professional competence or conduct—that adversely affects clinical privileges for a period longer than 30 days, or voluntary surrender or restriction of clinical privileges while under investigation or to avoid investigation. Reports must be submitted to the NPDB and appropriate state licensing board within 15 days of the action.

There is no reporting requirement for obtaining an evaluation or getting treatment.

<http://www.npdb-hipdb.com/npdbguidebook.html>

Accessed May 14, 2004

Further, the professional life of the resident in question—or any physician—will generally not be compromised legally because of the addiction if he/she consents to and successfully participates in treatment. Most PHPs have agreements with medical societies: if they identify the problem and can assure that the physician receives appropriate treatment and monitoring to prevent a recurrence or relapse, the licensing board will usually not revoke the license and will preserve confidentiality about the issue.

REPORTING ADDICTED PHYSICIANS

- Reporting to state authorities should be limited to the extent required by state law
- Circumstances that are reported are usually limited to refusal of treatment, non compliance with a treatment plan, unsatisfactory progress towards recovery, risk to patient safety, or criminal activities such as selling drugs

Aach RD, Girard DE, Humphrey H, McCue JD, Reuben DB, Smith JW, et al: Alcohol and other substance abuse and impairment among physicians in residency training. *Ann Intern Med* 1992;116:245–254.

PHYSICIANS HEALTH PROGRAMS

Physicians health programs can be of enormous help. The key components of a PHP consist of evaluation, referral for treatment, aftercare, and monitoring of the physician.

Once the individual has been evaluated and referred by the PHP, treatment proceeds on an individual level of need. For example, some addicted physicians may require referral

for detoxification, which calls for inpatient care. That is then followed by a program—conducted either on an inpatient or outpatient basis—that deals with the issues of addiction, including denial and rationalization. Program resources range from groups like Alcoholics Anonymous to Women for Sobriety to individual therapy sessions. Success rates appear to be higher when the physician is treated within his/her peer group, with other physicians. Otherwise they tend to take over the groups and act as physician, not patient.

When a resident does not need inpatient treatment, he/she is treated on an outpatient basis until the addiction is resolved satisfactorily.

In some settings, a PHP may communicate directly with the PD. In others, it may report to an intermediary group, such as a hospital employee health service that, in turn, communicates to the PD any decisions regarding fitness for duty and oversees any necessary monitoring.

The program may wish to place the resident on a leave of absence until a determination is made that the resident is safe to return for full duty. A program may also be able to arrange a reading elective or non-clinical experience with appropriate supervision.

TREATMENT OPTIONS	
<p>TREATMENT: SHORT-VERSUS LONG-TERM</p> <ul style="list-style-type: none"> • Short-term treatment—28 days • Long-term treatment—29–90 days • Participation in self-help organizations <p>Alcoholics Anonymous http://www.alcoholics-anonymous.org/</p> <p>Women for Sobriety http://www.womenforsobriety.org/</p> <p>Narcotics Anonymous http://www.na.org/</p>	<p>Alanon http://www.al-anon-alateen.org/</p> <p>OTHER</p> <ul style="list-style-type: none"> • Caduceus groups • Family therapy • Individual therapy

DISCUSSION POINT

- **Have any of you had any experience referring residents to any of the organizations that help with rehabilitation (e.g., Alcoholics Anonymous)?**
- **How would you rate the organization in terms of success in restoring the addicted individual to health?**
- **What is the phone number/address of your own state PHP? What are their policies about confidentiality? Must your PHP routinely report to the state licensing board any physician they evaluate?**

Once the physician is rehabilitated and able to resume his/her duties safely, devise an outpatient aftercare program for monitoring. This includes a contract that outlines the recovering physician's intervention goals, continued meetings, and counseling sessions, as well as random or scheduled drug screens.

Modifications of the resident's schedule may be desirable upon return to duty. Close supervision and monitoring are essential as outlined in the contract.

PROGNOSIS FOR ADDICTED PHYSICIANS

The prognosis for addicted physicians is good. They are usually highly motivated because of licensing issues and commitment to their profession. Once a resident returns to the residency program, monitoring should be aimed not only at the resident but also at the specific resident performance measures, which include the quality of patient care the resident delivers.

PROGNOSIS FOR REHABILITATION

Oregon Experience With Impaired Physicians on Probation.

- Good prognosis for physicians
- High motivation because of licensing and other professional issues
- Support for extensive and thorough treatment
- 96% abstinence rate with 8-year follow-up of impaired physicians placed on probation and monitored by random urine drug screens, versus 64% for treated but unmonitored physicians

Outcome studies show 75–95% success rate at 2–5 years, which increases with monitoring.

Shore JH. The Oregon experience with impaired physicians on probation. *JAMA* 1987; 257:2931–2934.

Ganley OH, Pendergast WJ, Wilkerson MW, Mattingly DE. Outcome study of substance impaired physicians and physician assistants under contract with North Carolina Physicians Health Program for the period 1995–2000. *J Addic Dis* 2005;24:1–12.

Re-entry may offer particular challenges to the resident in addition to resumption of duties and staying substance-free. Many experience guilt because of their absences and humiliation because of their addiction. Thus, it is important that the PD maintains a therapeutic and non-punitive environment.

Residents may want their problems to remain confidential. Others may want to share their experience with their colleagues. Either option should be supported.

In summary, substance abuse can occur in residents during their training. It is important that institutions have strategies in place to help identify and treat residents with problems. An organized plan to address the issue is imperative. A clear policy on substance use and a defined process to assist addicted residents in their recovery will ensure that they can resume training as drug-free professionals.

STEPS PROGRAMS CAN TAKE TO HELP COMBAT SUBSTANCE ABUSE

Text for Button G

- Educate residents to raise awareness about stress, fatigue, and other conditions that contribute to substance abuse
- Recognize the prevalence of substance abuse. Be proactive; establish procedures to address the problem and assist in recovery
- Educate graduate medical trainees (i.e., residents and fellows) and attending faculty about your program/institution's substance abuse policies
- Increase awareness of the resident's professional and ethical responsibility to physician colleagues with substance-abuse issues, including how to find assistance for a colleague they suspect is addicted
- Differentiate myths from reality regarding substance abuse for residents, their families, and attending physicians
- Define a clear, confidential process for referral and self-referral of residents and faculty with substance problems
- Consider the program's modeling of the social use of drugs, such as alcohol, at "liver rounds" or at social events. How is responsible alcohol use modeled and supported? Are there alcohol-free social events? Who is responsible for providing a designated driver for residents who drink at these events?
- Have a low threshold for referral for evaluation/management (this is particularly relevant to PDs who provide medical care for patients with these conditions). It is easy to blur the boundaries of the PD/faculty member's teaching and evaluative role with that of a treating physician. Stay within your role. Use an outside source for referral and evaluation
- Think carefully through who needs to know the information regarding the resident. It is important to preserve the trainee's confidentiality and to allow him/her the opportunity to get the needed help without everyone in the residency knowing about the problem. Many residency programs are like families or small communities. It is often useful to have a discussion to confront the group's perceived "need to know" directly, reminding them of their responsibility as professionals to respect the medical confidentiality of others. Refer them to their resident colleague for answers. Restrict confidential information; give it out only to those who need to be informed. You may check with human resources or your legal department if you are uncertain

STEPS PROGRAMS CAN TAKE TO HELP COMBAT SUBSTANCE ABUSE

Text for Button G

- Anticipate a possible query from the local press if anything is a matter of public record (a DWI, a listing of investigations of the state medical board, etc.)
- Know the policies on substance abuse and prescribing from the state medical boards. Integrate these policies into residency education as part of the ACGME competency, *professionalism*. Orient new residents to prescribing policies from your state licensing board, on such situations as:
 - “Hallway prescribing” is inappropriate for a colleague or team member whom you are not seeing formally as a patient and without a documented medical record
 - Prescribing medications (even antibiotics) for self, colleagues, friends, and family members may be specifically prohibited if done outside the boundaries of an established patient-physician relationship. In some states, the consequences may include loss of your medical license

SUBSTANCE ABUSE REVIEW

- Describe the incidence and risk factors of alcohol and drug abuse with respect to physicians. How common do you think it is in your programs?
- Describe the signs of addiction as presented in this module. Do you find them helpful? How difficult do you think it is to recognize addiction of any kind in residents or colleagues?
- How is alcoholism defined in this module? Is the definition congruent with the way you would define it?
- What reasons are described in this module to show that denial works to prevent addicted residents from getting the help they need?
- Describe some of the principles of intervention in addiction as presented in this module
- When is reporting an addicted physician to the National Practitioner Data Bank required?
- Describe the function of PHPs; what is your PHP like? What are its rules and policies regarding confidentiality? Consider inviting someone from your PHP to present a lecture for your program.
- Describe steps that residency programs can take to help combat addiction in their residents

SUBSTANCE ABUSE: ADDITIONAL REFERENCES OF INTEREST

Ahmad T, Wallace J, Peterman J, Desbiens NA. Doctors' perceptions of drinking alcohol while on call: questionnaire survey. *Student BMJ* 2002;10:421–422.

Boisaubin EV, Levine RE. Identifying and assisting the impaired physician. *Am J Med Sci* 2001;332:31–36.

Carlson HB, Dilts SL, Radcliff S. Physicians with substance abuse problems and their recovery environment: a survey. *J Subs Abuse Treatment* 1994;11:113–119.

Centrella M. Physician addiction and impairment—current thinking: a review. *J Addic Dis* 1994;13:91–105.

Collins GB. New hope for impaired physicians: helping the physician while protecting patients. *Cleve Clin J Med* 1998;65:101–106.

Herrington RE, Benzer DG, Jacobson GR, Hawkins MK. Treating substance abuse disorders among physicians. *JAMA* 1982;247:2253–2257.

Jex SM, Hughes P, Storr C, Conard S, Baldwin DC Jr, Sheehan DV. Relations among stressors, strains, and substance use among resident physicians. *Int J Addic* 1992;27:979–994.

Khantzian EJ. The injured self, addiction, and our call to medicine. Understanding and managing addicted physicians. *JAMA* 1985;254:249–253.

Lohr KM, Engbring NH. Institution-wide program for impaired residents at a major teaching hospital. *J Med Ed* 1988;63:182–188.

Petersen-Crair P, Marangell L, Flack J, Harper R, Soety E, Gabbard GO. An impaired physician with complex comorbidity. *Am J Psychiatry* 2003;160:850–854.

Sansone RA, Wiederman MW, Sansone LA. Physician mental health and substance abuse. What are state medical licensure applications asking? *Arch Fam Med* 1999;8:448–451.

Winter RO, Birnberg B. Working with impaired residents: trials, tribulations, and successes. *Fam Med* 2002;34:190–196.

VISIT OUR WEBSITE FOR UP-TO-DATE REFERENCES



AIM

This module presents information on professionals who engage in disruptive behavior and suggests strategies for the institution for handling it appropriately.

LEARNING OBJECTIVES

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

- Define disruptive behavior
- Describe the impact of disruptive behavior on the medical environment and the health care team
- Recognize the signs and symptoms of disruptive behavior
- Outline strategies to identify, intervene, and manage disruptive behavior
- Access resources to develop effective tools and responses (e.g., the institution's human resources unit or equity/harassment office, or your state's PHP)

SCENARIO SUMMARY

A resident physician verbally abuses a nurse in the context of demanding medical care for a patient. A chief resident (or junior faculty member) who happens to pass by interrupts the interaction and counsels the nurse to ignore the behavior.

DISCUSSION QUESTIONS

- In your experience, how prevalent is disruptive behavior in your institution?
- Verbal aggression is one manifestation of disruptive behavior; what other types have you encountered?
- What are the penalties for disruptive behavior in your setting? How would you provide feedback on someone else's behavior? A resident colleague? A faculty member?
- If you risk feedback, what happens?

Assumptions that underlie this scenario include the following:

- Aggressive outbursts are just part and parcel of the stress and strain physicians are under and are simply signs of “blowing off steam”
- Disruptive behavior should be tolerated as long as the person who is disruptive is a “good doctor”
- Disruptive behavior has no consequences other than its immediate unpleasant effect

DISCUSSION POINT

What other assumptions might underlie this scenario?

SCENARIO RERUN

A resident physician verbally abuses a young nurse in the context of demanding medical care for a patient. A chief resident (or junior faculty member) who happens to pass by interrupts the interaction, and tells the physician in no uncertain terms that the behavior is unacceptable. He/she arranges for the physician to see the PD for help in communicating needs to staff more effectively.

The rerun attempts to teach the following principles:

- Disruptive behavior is no longer tolerated
- Disruptive behavior impedes good communication
- Disruptive behavior does not represent a desire for good patient care; instead, it may mask the unacceptable use of power by one individual who is in a position of authority over another individual
- Disruptive behavior is common in physicians who are overly perfectionistic, and may have low self esteem. It is also common in those with personality disorders, often narcissistic personality disorders
- Disruptive behavior may be enabled in a culture in which this behavior is tolerated in senior physicians who in turn verbally abuse younger ones. This cycle may be similar to the cycle of abuse seen in abusive families and needs to be interrupted
- Disruptive behavior often violates standards of conduct spelled out by policies

PROGRAM TEACHING POINTS

DISRUPTIVE BEHAVIOR DEFINED

Disruptive behavior has been defined as any pattern of behavior that causes conflict, chaos, disharmony, dysfunction, and/or anxiety in the medical environment. It is best characterized by a power imbalance between different parties, a physician and a nurse, for example, or a senior versus a junior member of a team. The imbalance of power is then exploited and abused. Disruptive behavior can infect the workplace to such a degree that others are unable to fulfill their duties or care effectively for patients; it can also increase staff absenteeism and turnover markedly. Hospitals, physician practices, and other employers may have difficulty hiring other members of the health care team to work with physicians with disruptive behaviors. Increasingly there is less tolerance for this behavior even among brilliant professionals. Disruptive behavior may be insidious, and must be addressed quickly and directly. Tolerating or excusing the behavior risks encouraging and perpetuating it.

Workplace “bullying” is a relatively new and legally somewhat vague area, not already covered by abusive behavior, harassment, and discrimination. However, an Indiana court recently awarded a hospital employee \$325,000 due to alleged bullying on the part of a physician. Indicators of workplace bullying include persistent hostility, behavior that occurs on more than one occasion and continues over time, aggressive behavior (by a physician) that interferes with an employee’s work production, regular verbal attacks toward one employee but not others, physical threats, and yelling or shouting in a hostile manner.

DISRUPTIVE BEHAVIOR: A NEW TAKE ON AN OLD BEHAVIOR

In the past, a physician’s disruptive behavior was often tolerated. Faculty role models themselves may have behaved in a disruptive manner, making it even more difficult to manage. However, disruptive behavior has become increasingly unacceptable because of its adverse impact on patient care, on the institution, and on employee morale. Patient care is at risk when a nurse’s fear of a physician reduces his/her willingness to communicate vital information, and when nurses must shift their focus from caring for patients to managing physicians. Disruptive behavior can lead to charges of a hostile work environment, harassment, and racism, all of which can have severe legal and financial consequences for the institution. Coworkers and patients may make direct reports to the state medical board, which can result in licensing restrictions or revocation.

DISCUSSION POINT

Describe instances of disruptive behavior that you have witnessed and depict how they were dealt with

Disruptive behavior is a symptom of an underlying condition, much like congestive heart failure is a symptom of cardiovascular disease. Disruptive behavior can signal sleep deprivation, a work load that is too heavy, stress in the work place or personal life, poor impulse control, low self-esteem, concrete thinking, or intolerance. When it is elicited by factors such as these, the behavior can often be stopped with a quick, firm, and authoritative response: identify the offending behavior, describe it as unacceptable, outline the consequences of its recurrence, and document the incident. If the individual recognizes that the behavior is inappropriate, understands its negative impact on the health care team, apologizes, and moves on, no further disciplinary action may be required. However, if the egregious behavior recurs and becomes an identifiable pattern, then it usually indicates that the physician is affected by a much more serious condition and will require a comprehensive evaluation. Narcissistic personality disorder or trait is one of the most common etiologies of disruptive behavior. Others etiologies include borderline personality disorder or traits, obsessive compulsive disorder or traits, bipolar disorder, substance abuse, and depression.

DESCRIPTIONS OF DISRUPTIVE BEHAVIOR

Disruptive behavior includes inappropriate expressions of anger or resentment, inappropriate words or actions directed toward another person, and inappropriate responses to patient needs or staff requests. It can also take the form of pejorative body language and tone of voice.

COMMON SIGNS AND SYMPTOMS OF DISRUPTIVE BEHAVIORS IN PHYSICIANS

Disruptive behavior may occur as a response to an important event, for instance, a delay in receiving a test result. Although the resident may have a legitimate concern for patient safety, disruptive behavior is disproportional to the incident, and it results in polarization of a situation rather than constructive problem resolution.

Common manifestations of disruptive behavior include:

ANGRY OUTBURSTS

- Use intimidating, abusive, condescending, or degrading language (e.g., insults, profanity)

COMMON SIGNS AND SYMPTOMS OF DISRUPTIVE BEHAVIORS IN PHYSICIANS (CONT'D)

- Display body language and tone of voice that is pejorative and insulting (e.g., sarcastic attitude; one that is perceived as threatening by others)
- Make verbal threats of violence, reprisal, or legal action

DEGRADING OR DEMEANING WORDS OR BEHAVIOR TOWARDS OTHERS

- Harass others sexually (e.g., sexually explicit comments, innuendos)
- Use racial or ethnic slurs
- Engage in inappropriate humor

DISREGARD FOR EFFECTIVE COMMUNICATION WITH PATIENTS OR STAFF

- Fail to answer pages or calls in a timely manner
- Demonstrate unprofessional demeanor (raise voice, use sarcasm, plan reprisals)
- Blame staff for adverse outcomes
- Act in an uncooperative, defiant, or rude manner
- Refuse requests for help

Programs usually tolerate disruptive behavior far too long, most with the mistaken hope that the behavior will resolve spontaneously. In today's health care environment, however, ignoring or tolerating it is not a viable option. Institutions need to develop a clearly stated code of conduct, as well as policies and procedures for dealing with violations of institutional standards. While no code can be exhaustive and catalogue every possible situation, it should—as clearly as possible—describe unacceptable behavior and outline the consequences if professional standards are violated. The ACGME competencies in these situations can help a great deal because they emphasize interpersonal and communication skills, professionalism, and team work.

MEDICAL STAFF CODE OF CONDUCT POLICY AND PROCEDURES TO DEAL WITH VIOLATIONS

Text for Button C

Example: Medical Staff Code of Conduct Policy and Procedures (this is presented as an example of one institution's policy on disruptive behaviors. You will want to work with your own medical staff office, human resources, and counsel's office to develop your own policies)

POLICY STATEMENT

This policy emphasizes the need for all individuals working in the _____ hospital to treat others with respect, courtesy, and dignity, and to conduct themselves in a professional and cooperative manner.

This policy is intended to address conduct that does not meet that standard. Incidents of inappropriate conduct must be dealt with for the safety and well-being of patients, employees, physicians, and others in the hospital so that the hospital can perform in an orderly manner.

For purposes of this policy, examples of inappropriate conduct include, but are not limited to the following:

- Threatening or abusive language directed at nurses, hospital personnel, or other physicians (e.g., belittling, berating, and/or intimidating another individual)
- Degrading or demeaning comments regarding patients, families, nurses, physicians, hospital personnel, or the hospital
- Profanity or similarly offensive language in the hospital, while speaking with patients, nurses, or other hospital personnel
- Inappropriate physical contact with another individual that is threatening or intimidating
- Public derogatory comments about the quality of care being provided by other physicians, nursing personnel, or the hospital
- Inappropriate medical record entries concerning the quality of care being provided by the hospital or any other individual

Employees, including residents, who engage in inappropriate conduct will be dealt with in accordance with the _____ hospital's human resources policies. Conduct that may constitute sexual harassment shall be addressed pursuant to _____ hospital's harassment policy.

MEDICAL STAFF CODE OF CONDUCT POLICY AND PROCEDURES TO DEAL WITH VIOLATIONS (CONT'D)

Text for Button C

In the event of any apparent or actual conflict between this policy and any other bylaws, rules, regulations, or other policies of the hospital or medical staff, the provisions of this policy supersede all others.

This policy outlines collegial steps (e.g., warnings and meetings with a resident) that can be taken in an attempt to resolve complaints about inappropriate conduct. However, there may be a single incident of inappropriate conduct—or a continuation of conduct—that is so unacceptable as to necessitate immediate disciplinary action. Therefore, nothing in this policy precludes immediate referral to the executive committee and dismissal of the resident.

PROCEDURE

1. Nurses and other hospital employees who observe, or are subjected to, inappropriate conduct by a resident shall notify their supervisor about the incident or, if their supervisor's behavior is at issue, they shall notify the chief executive officer (CEO). Any physician who observes such behavior shall notify the CEO directly.
2. The documentation shall include:
 - The date(s) and time(s) of the questionable behavior
 - Factual description of the questionable behavior
 - The name of any employee, patient, or patient's family member who was involved in the incident, including any employee, patient, or family member who witnessed the incident
 - The circumstances that precipitated the incident
 - The names of other witnesses to the incident
 - Consequences, if any, of the inappropriate conduct as it relates to patient care, personnel, or hospital operations
 - Any action taken to intervene in, or remedy, the incident.
3. The supervisor shall forward a documented report to the PD and the CEO, who shall review the report; the CEO may meet with the individual who prepared it and/or any witnesses to the incident to ascertain the details of the incident. After a determination that an incident of inappropriate conduct has occurred, the chief of staff (CS) shall proceed as set forth in Paragraph 4.

MEDICAL STAFF CODE OF CONDUCT POLICY AND PROCEDURES TO DEAL WITH VIOLATIONS (CONT'D)

Text for Button C

4. The CS (or his/her respective designees) shall meet with the resident:
 - This initial meeting shall be collegial. It is designed to help the resident understand that certain conduct is inappropriate and unacceptable
 - During the meeting, the resident shall be advised of the nature of the incident that was reported and shall be requested to provide his/her response and/or perspective concerning the incident
 - The resident shall be advised that if the incident occurred as reported, his/her conduct was inappropriate and inconsistent with the hospital's standards
 - The identity of the individual preparing the report of inappropriate conduct will not be disclosed at this time. The resident shall be advised that any retaliation against the person suspected of reporting the incident will be grounds for immediate dismissal
 - The meeting will be used to educate the resident about administrative channels that are available for registering complaints or concerns about quality or services
 - Other sources of support or counseling will be identified for the resident (e.g., the state PHP, personal assistance plan, or EAP as appropriate) with a strong recommendation made to pursue assistance

5. The resident shall be advised that a summary of the meeting will be prepared and a copy provided to him/her. The resident may prepare a written response to the summary. The summary and any response that is received shall be kept in the confidential portion of the resident's credentials file. The resident shall be made aware that a corrective action plan will be developed for the remainder of his/her training. The plan should clearly state that a second event may result in immediate dismissal.

6. If another report of inappropriate conduct involving the resident is received, a second meeting shall be held. It is advisable that at least three people (e.g., the CS, the PD, and another medical staff leader) be present to meet with the resident. The resident may be allowed an advocate, such as a faculty member or a chief resident, to attend as a support.
 - At this meeting, the resident shall be informed of the nature of the incident and be advised that such conduct is unacceptable. Based on the seriousness of the issue, termination may be considered

MEDICAL STAFF CODE OF CONDUCT POLICY AND PROCEDURES TO DEAL WITH VIOLATIONS (CONT'D)

Text for Button C

- The resident should be referred to employee and occupational health and/or the state PHP for an evaluation
 - If not immediately terminated, the resident shall be advised that if there is a future complaint about inappropriate conduct, there will be a recommendation for termination of training/employment
 - A letter shall be sent to the resident confirming the substance of the meeting. A copy shall be kept in the confidential portion of the resident's credentials file (along with any response that he/she may submit)
 - The resident shall be required to sign the letter acknowledging receipt
7. In the event there is a third reported incident of inappropriate conduct, the PD, the CS, and another medical staff leader will initiate a formal action for termination pursuant to the medical staff bylaws. Any further action, including any hearing or appeal, shall then be conducted under the direction of the board.
8. The resident may be excluded from the hospital's facilities pending any formal investigations and any related hearing and appeal that may result. Such exclusion is not a suspension of clinical privileges, even though the effect is the same. Rather, the action is taken to protect patients, employees, physicians, and others on the hospital's premises from inappropriate conduct and to emphasize to the resident the most serious nature of the problem created by such conduct. Before any such exclusion, the resident shall be notified of the event or events precipitating the exclusion and shall be given an opportunity to respond in writing and to demonstrate that acceptable standards of conduct have not been violated. However, to ensure that there is no inappropriate delay in addressing the concerns, the resident must submit any response within three (3) days of being notified.

Recommended by the _____ Committee this _____ day of _____, 200__.

*Adapted from the policy of the:
Tennessee Medical Foundation*

*216 Centerview Drive
Suite 304*

Brentwood, TN 37027-3226

Accessed 1/30/04 <http://www.e-tmf.org/sys-tmpl/modelstaffcodeofconductpolicy/>

It is essential that lines of communication with faculty, nurses, and all members of the health care team be kept open. These people can frequently provide the most accurate feedback on the professionalism and communication skills of trainees. Any complaints of temper tantrums (e.g., angry outbursts or instrument throwing), or of personal and/or sexual innuendo, sarcasm, profanity, or denigration should be investigated carefully and documented meticulously.

STEPS TOWARDS REHABILITATING A DISRUPTIVE PERSONALITY

Once a pattern of disruptive behavior has been identified and a confidential investigation has confirmed the veracity of the complaint, the next step is to speak formally to the resident. The PD is best positioned to take control of this intervention, usually in collaboration with the DIO. This should then be followed by referral for evaluation. Treatment, if needed, can be recommended and carried out either by a resource such as the hospital's employee health program or a PHP. A state PHP has the advantage of working exclusively with clinicians. Peers are better positioned than a non-medical person to challenge any instances of denial on the part of the resident.

When the PD meets with the resident, problem behaviors should be described carefully and their effect on others clearly explained. Focus must be on the behavior in question, not on why it occurred. Emphasize the unacceptable nature of the behavior and stress the seriousness of the incident.

ROLE MODELING EXERCISE

Arrange for this ahead of time, if possible.

- Chose two participants. Have one play a PD who is confronting a physician reported for verbally abusing a subordinate and using threatening body language. In their interaction, have the physician attempt to force explanations and reasons for why the behavior occurred
- Ask participants to explain how the PD might better handle this situation. Attempt to get them to see that the focus needs to be on the behavior itself, not on why it occurred
- Once this is clear, have the two replay the interaction in an appropriate way

Develop and draw up a plan consisting of a learning contract, corrective action, probation, or whatever is consistent with your own policy. The contract should clearly describe what behaviors will not be tolerated and the consequences if they recur. Consequences may include dismissal from the training program. This written document helps to communicate clearly to the resident the various issues relating to professional conduct. The contract also helps if efforts fail in assisting to modify the resident's behavior and if disciplinary measures become unavoidable. Having a document in place provides evidence for any subsequent disciplinary action taken as a result of the resident's unprofessional behavior.

NORTH CAROLINA MEDICAL BOARD STATEMENT ON HARASSMENT: AN EXAMPLE

Text for Button D

One form of disruptive behavior is that displayed by faculty against trainees, or by senior residents against junior residents or students.

It is the position of the North Carolina Medical Board that the relationship between medical supervisors and their trainees in medical schools and other medical training programs is one of the most valuable aspects of medical education. We note, however, that this relationship involves inherent inequalities in status and power that, if abused, may adversely affect the educational experience and, ultimately, patient care. Abusive behavior in the medical supervisor-trainee relationship, whether physical or verbal, is a form of unprofessional conduct. However, criticism and/or negative feedback that is offered with the aim of improving the educational experience and patient care should not be construed as abusive behavior.

Adopted April 2004

Program directors also need to be aware that residents who have anger management problems at work may engage in similar behaviors at home. They should ask the resident directly about whether he/she displays abusive behavior toward spouse, partner, or children. Residents are highly unlikely to admit to such behavior but at least the PD has planted a seed of awareness.

The Americans with Disabilities Act, discussed in another segment of the LIFE program, protects individuals with personality and bipolar disorders. However these individuals must still be able to perform according to a program's established standards of conduct. A diagnosis of either of these conditions does not require that unprofessional behavior be accepted.

HOW TO INTERVENE

The intervention with the resident should be planned carefully. Define the acceptable outcomes of the meeting ahead of time. Decide if an independent evaluation will be required such as by the employee and occupational health unit or the state PHP. Ideally, the physician will take responsibility for the behavior and acknowledge the need for its modification. Offer help in obtaining treatment for the problem. There are several treatment programs that include a two- to three-month inpatient stay followed by intensive individual and group work modeled after successful substance abuse programs. Taking this seriously may require a major intervention. If the resident physician can expect financial or emotional support during the rehabilitation period, identify and define it.

However, if the resident refuses to acknowledge the disruptive behavior or follow any recommendations provided, emphasize that dismissal is a very real consequence for this unprofessional behavior.

If the resident accepts the need for treatment, assign a mentor who can guide and assist in recovery. Some treatment may consist of intensive inpatient intervention. The impact of treatment should be carefully monitored.

Plans for re-entry to the residency should be made well in advance of the resident's return to the work environment, and should probably be developed in consultation with the mentor. Modifications to the rotation may be necessary. A contract outlining expectations of behavior is usually very useful. Consequences for repeat episodes should be clearly outlined. Residents will usually require ongoing counseling and monitoring; their schedules should be adapted to those needs, accordingly.

Sometimes a resident will be more likely to succeed if he/she transfers to a different specialty or career.

Unfortunately, many physicians with disruptive behavior have personality disorders. These are not easily treated, and the success rate is less than it is for physicians with chemical dependence. Nonetheless, it is important to determine if an attempt at rehabilitation is appropriate, and to have a clear, fair, and well-documented process for termination from the program for those cases where rehabilitation fails.

Program directors and institutions will need to be realistic in their expectations. If the medical environment is to function optimally, collegiality and mutual respect must be fostered and cherished.

DISRUPTIVE BEHAVIOR REVIEW

- Define disruptive behavior and describe its different manifestations
- Disruptive behavior has been defined as a potential symptom of underlying conditions; discuss them
- At what point should a disruptive physician be referred for treatment for adverse behavior?
- Describe the steps needed to document episodes of disruptive behavior effectively
- Describe strategies to rehabilitate the disruptive personality

ADDITIONAL REFERENCES OF INTEREST

Boon K, Turner J. Ethical and professional conduct of medical students: review of current assessment measures and controversies. *J Med Ethics* 2004;30:221–226.

Knox GE. Doctors behaving badly and the people who let them. *Trustee* 1999;52:18–19.

Linney BJ. Confronting the disruptive physician. *Physician Exec* 1997;23:55–58.

Pfifferling JH. The disruptive physician: a quality of professional life factor. *Physician Exec* 1999;25:56–61.

Shanafelt TD, Sloan JA, Habermann TM. The well-being of physicians. *Am J Med* 2003;114:513–519.

Sotile WM, Sotile MO. Managing yourself while managing others. *Physician Exec* 1996;22:39–42.

VISIT OUR WEBSITE FOR UP-TO-DATE REFERENCES



BURNOUT

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AIM

This module introduces participants to the problem of burnout. Burnout can lead to symptoms of poor performance, attitudinal changes that can be interpreted as a lack of motivation, as disinterest, and as cynicism. If a resident presents with a career crisis, it can be challenging to determine whether he/she is suffering from burnout, and would really benefit from a change of specialties or even a departure from medicine entirely. The program also discusses strategies to reduce the effects of stress and the strain it puts on a medical career.

LEARNING OBJECTIVES

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

- Describe the signs, symptoms, and consequences of burnout
- Identify characteristics in the individual, the work environment, and the family that increase the risk of burnout
- Select management techniques to help prevent, identify, or alleviate burnout
- Contrast the challenges residents face in life with those they face in residency programs
- Identify the signs and symptoms of career uncertainty in a resident
- Compare management strategies appropriate for residents with career uncertainty

SCENARIO SUMMARY

Two residents, one sarcastically complaining of exhaustion, the other expressing anger with the profession as a whole, exchange comments in front of a faculty member who dismisses the import of what the residents express, regarding the remarks as indicative only of poor time management.

DISCUSSION QUESTIONS

- Do you find that residents complain often about their residency experiences?
- How do you react to these complaints? Do you think the residents are whining, and that their comments are indicative of a crisis in career choice?
- How would you respond to these residents?

Assumptions that underlie the initial scenario include the following:

- Remarks made by residents that express unhappiness or dissatisfaction with their work need not be taken seriously. The remarks don't represent anything except a way of simply blowing off steam
- If these two residents could only "get it together," things would be fine

DISCUSSION POINT

What other assumptions might underlie this scenario?

SCENARIO RERUN

Two residents, one complaining of exhaustion, the other expressing anger with the profession as a whole, exchange comments in front of a faculty member. Instead of dismissing the remarks, the supervising physician recognizes that they mask stress. He recommends that one resident immediately see her program director (PD) to sort things out, and that the other discuss his frustrations so that they can work together to come up with constructive approaches.

The rerun tries to teach the following:

- Sarcasm and humor can mask extreme stress
- Stress under certain conditions indicates burnout and needs to be taken seriously; left untreated, it can end in undesirable outcomes

PROGRAM TEACHING POINTS

BURNOUT

Burnout is defined as a syndrome that combines emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness. It can lead to depression and substance abuse, two outcomes that, along with stress, are covered in other segments of the LIFE program. A career crisis can take the form of doubt about specialty choice or even an aversion to continuing the practice of medicine.

Burnout typically occurs in professionals where employment conditions are characterized by prolonged stress combined with high performance expectations. These types of jobs are usually open-ended, and are without any defined structure or limit to the amount of work involved. Because residents bring to the practice of medicine enormous dedication to both their patients and their profession, they are highly vulnerable. Residents also frequently have little control over their working environment. Unfortunately, as the saying goes, the line between profession and obsession is often blurred.

BURNOUT SUMMARY

PROFILE

- Burnout typically occurs in professionals whose working conditions are characterized by prolonged stress and high performance expectations
- Physicians are highly vulnerable
- Obsessive/compulsive personality traits
- Unrealistically high expectations
- Addiction to work

Residents most likely to succumb to burnout are those with obsessive/compulsive personality traits, unrealistically high expectations, or “workaholism.” In those personalities, burnout stems from inability to balance work, rest, and recreation.

ADDITIONAL STRESSORS

- Escalating demands of others (patients, supervisors, staff)
- Competition to do better than others
- Financial pressures
- Limited time to engage in non-work “outlets”
- Sense of being deprived of something they perceive they deserve
- “Compassion fatigue”
- Family pressures and expectations

Adapted from Farber, 2000

The conditions of medical practice change constantly. Increasingly, the practice of medicine has become an uncertain and anxiety-provoking experience. Residents experience deterioration in their sense of personal autonomy, an increase in patient workload, a reduction in financial remuneration, and a decline in respect. Perhaps worse, what was once a profession, a vocation, and a calling has become to many simply a *business*.

Burnout may be even more prevalent in women. A nationally representative sample of nearly 6,000 physicians in primary care and specialty non-surgical care found that women physicians were 60% more likely than men to report burnout. For each additional 5 hours over 40 hours worked per week, the odds of burnout in women increased 12–15%.

PROFILE OF WOMEN PHYSICIANS

- Women physicians are 60% more likely than male physicians to report burnout
- Odds of burnout in women increased 12–15% for each additional 5 hours worked per week over 40 hours
- Women are more likely than men to experience sexual harassment
- Women manage domestic responsibilities more often than men do
- Children intensify the pressures women experience
- Women lack sufficient numbers of role models

McMurray JE, Linzer M, Konrad TR, Douglas J, Shugerman R, Nelson K. The work lives of women physicians. *J Gen Intern Med* 2000; 15:372-80. Gautam M. Women in medicine: stresses and solutions. *West J Med*. January 2001; Vol 174:37-41.

Additional pressures appear to play a role. Women physicians are more likely to experience sexual harassment. At home, they frequently bear a disproportionately greater responsibility for managing domestic chores and, if they have children, the pressures are intensified. Unfortunately, there seems to be a dearth of role models or mentors for these young physicians—that is, older women doctors who have balanced their personal and professional lives successfully.

DISCUSSION QUESTIONS

- Do you believe that the pressures on men and women in residency programs differ?
- Define the different types of stressors that might specifically affect each
- Do you think men and women react differently to stress?

Burnout: Identifiable Stages

Burnout characteristically proceeds in identifiable stages. Recognizing these stages may help to identify them early. The first or honeymoon stage is characterized by boundless energy and enthusiasm, a period where all things seem possible. During this phase, an individual loves the job, and feels that the job loves the person. All possible needs, desires, and problems will be met and resolved by the job. The pleasure of the job, the delight with co-workers, and the happiness engendered by the organization are palpable.

STAGES OF BURNOUT

Stage I

Honeymoon

Stage II

The Awakening

Stage III

The Brownout

Adapted from Miller LH et al. The stress solution: an action plan to manage the stress in your life. Pocket Star, 1993.

During the awakening or second stage, the honeymoon experience fades and people begin to realize that their initial impressions were unrealistic. The job doesn't meet every need, and both co-workers and the organization appear to be less than perfect. Worse, rewards and recognition are few and far between.

WORKING HARDER: THE VICIOUS CYCLE OF BURNOUT

Text for Button B

A vicious cycle sets the stage for burnout

- Increasing fatigue results in reduced efficiency and productivity
- Denial of fatigue results in an attempt to work harder and increase the time spent working
- Working harder reduces time available for rest and recuperation
- Lack of rest and recuperation increases fatigue and reduces efficiency and productivity

WORKING HARDER: THE VICIOUS CYCLE OF BURNOUT (CONT'D)

Text for Button B

- Increased fatigue distorts the resident's ability to have insight into the quality of his/her work and interferes with his/her perspective
- Lack of insight increases any tension and anxiety a resident feels; the resident might believe he/she can improve the situation with more work, rather than by getting a fresh perception of the system/situation
- Unrealistic expectations of perfection—by patients, society, the residency program, and most harshly, the resident—create the impression the resident can never be good enough, further diminishing self-esteem and self-worth

Adapted from Betts WC. NCPH Program. Burnout: Overwork Syndrome. Spring, 1993

As disillusionment and disappointment grow, confusion reigns. Something appears to be out of place, although the individual may not quite be able to pinpoint exactly what that is. Typically, the person then works even harder to attain his or her goals, but working harder doesn't change anything. Boredom and frustration become commonplace, as do feelings of incompetence. At this point, the person so affected begins to lose self-confidence, direction, and passion.

DISCUSSION QUESTIONS

- Do you think that the different stages of burnout as defined by this paradigm fit your experience or observations of the phenomena?
- Give examples from your own experience of the vicious cycle of burnout as it affected you, your colleagues, or residents in your institutions

The third stage is *brownout*. The enthusiasm and energy once experienced now give way to symptoms that include chronic fatigue and irritability. Eating and sleeping patterns change, and indulgence in escapist behaviors such as drinking and using drugs can occur. Productivity falls off and work deteriorates.

SIGNS AND SYMPTOMS OF BURNOUT

Text for Button C

- Inefficiency
- Edginess, irritability, and low tolerance for frustration
- Cynicism (in an individual previously not cynical)
- Increased anxiety and self-criticism
- Lack of perspective, insight, and sense of humor
- Depression
- Isolation
- Lack of enjoyment; few pleasurable activities
- Guilt
- Alterations in eating and sleeping patterns
- Disturbances in family and work relationships
- Physical complaints (gastrointestinal, cardiovascular, neuromuscular)
- Substance and alcohol abuse

Early identification of the beginning of a career crisis is essential. Ideally, the problems that produce burnout and lead to such extreme dissatisfaction with the profession should be prevented in the first place, before it reaches end stage.

APPEARANCE VERSUS REALITY: THE RESIDENCY AND MEDICINE AS A CAREER

Overall, about 80% of physicians are satisfied with their choice of a career in medicine. However, about 20% experience either severe doubts about practicing medicine or have critical reservations about their chosen specialty. Interestingly, 87% of doctors believe the overall morale of the profession has declined and nearly 60% state their own morale has declined (Henry J. Kaiser Foundation survey; quoted in USA News.com January 31, 2005 "Doctors Vanish from View").

Factors that lead to career crisis arise from a contradiction between appearance and reality, expectation and actuality; this contradiction often results in unhappiness, dissatisfaction and, eventually, burnout. How does this come about?

First, many residents select a specialty because they think it will give them independence of action with respect to treatment approaches, and allow them to have input into treatment decisions that affect patients. Because of that, they can take pride in both their professional growth and personal contribution. It is important to remember that a passion for medicine is often driven by tremendous altruism, the desire to have an impact on a patient's life and make a real difference.

DISCUSSION QUESTIONS

- How difficult was your residency?
- Were your expectations realistic in terms of your ideas about autonomy and self-determination of the residency?
- Were there ever times when you felt you had too much autonomy?

In fact, however, residents—especially first-year—have very little authority or autonomy. But they have tremendous responsibility, a burden they never experienced as medical students. The burden grows heavier with each program year. Heavy responsibility combines with little control, and long arduous hours, even considering the reduction in duty hours. Little or no time is left for personal life, a veritable recipe for burnout and career misgivings.

RESIDENCY PROGRAMS: APPROPRIATE RESPONSE TO RESIDENT STRESS

How can programs respond? The LIFE program on stress discusses the importance of a good orientation, the importance of connecting residents to one another and the community, of teaching coping skills, negotiation techniques, and conflict resolution. For starters, all of these can be applied to burnout.

Second, faculty can do a better job with mentoring by pairing career-satisfied alumni from the residency program or colleagues in the community with residents to help them learn what the real world is like—in other words what professional life is like once residency training has ended.

DISCUSSION QUESTIONS

- What stress management programs do you have in your institution to help residents?
- Does your institution provide mentoring programs for your residencies? If so, how are your faculty trained and evaluated as mentors?
- How do you think your residents feel they are treated? If one could appear here anonymously and speak to you, what do you think he/she would say?
- What are the benefits for residents training in your programs?
- What are the disadvantages?

Other issues are involved as well. Most physicians take professional satisfaction for granted. Some of the main sources of satisfaction residents derive come from relationships with their colleagues and other healthcare professionals. Unfortunately, these relationships are not always positive. Many report a lack of respect. This can be disheartening, even to the most impervious!

Mistreatment, verbal attacks, and being belittled or threatened about their careers also contribute to dissatisfaction and demoralization. Programs must have clear policies that protect residents from any kind of harassment by senior residents and faculty, which should be regarded as unacceptable. All evaluation systems should ask about feedback and whether it is provided in a constructive manner. The policies should outline specific consequences for those who are unprofessional in their conduct and who make unhelpful and derogatory remarks to trainees. These policies must then be enforced.

HARASSMENT POLICY— NORTH CAROLINA MEDICAL BOARD

Text for Button F

THE MEDICAL SUPERVISOR—TRAINEE RELATIONSHIP

It is the position of the North Carolina Medical Board that the relationship between medical supervisors and their trainees in medical schools and other medical training programs is one of the most valuable aspects of medical education. We note, however, that this relationship involves inherent inequalities in status and power that, if abused, may adversely affect the educational experience and, ultimately, patient care. Abusive behavior in the medical supervisor-trainee relationship, whether physical or verbal, is a form of unprofessional conduct. However, criticism and/or instructive feedback offered with the aim of improving the educational experience and patient care should not be construed as abusive behavior.

Consider an active advising/mentoring system; let residents choose advisor, if possible

- Initiate policies that make residents feel part of the decision-making processes
- Involve residents in ongoing evaluations of the curricula, rotations, and faculty
- Hold regular group meetings, both with and without residency leadership present
- Include residents on the curriculum committee and important task forces that involve resident roles and responsibilities
- Encourage resident input in design and implementation of the evaluation system (ACGME requires residents and faculty to be involved in an annual program review)
- Use resident input to develop policies on harassment (or to review policies that have already been developed)
- Survey residents regarding their perception of well-being and the attitudes toward them of their faculty and co-workers
- Engage residents in decisions regarding frequency and manner of resident social events

FINANCIAL CONCERNS

Residents also worry about their finances. Many graduate from medical school with an average debt of over \$110,000.00. At this point in their lives, they are also taking on marriage, family, car payments, and home mortgages. In a climate of decline in physician earnings, of having to work harder for much less, they worry about their future financial security.

FINANCIAL CONCERNS

- 42% of residents have an educational debt of at least \$50,000
- 25% of residents have an educational debt of around \$150,000 or more
- Average medical school debt is over \$110,000
- Physician income has declined over time
- Many residents live in poor housing conditions
- Most have little disposable income
- Many report strains on marriage, especially if both are MDs

Association of American Medical Colleges. Student Questionnaire

Residents may benefit from access to a financial planner. Ultimately, they will be among the top wage earners in the country. But most start with a large debt load. They often don't want to put off the purchase of a nice car, a nice house. If married with children, they may have other costs associated with day care and education. Some residents need help learning how to draw up a budget and live within it, how to prioritize, and how to reasonably delay some gratification, rather than increase the strain that comes with increased indebtedness. Information about how to manage loans and loan repayment may also be helpful.

RESOURCES FOR MONEY MANAGEMENT AND LOAN REPAYMENT

Text for Button E

Finances are a common stressor for residents, who may benefit from basic financial information and planning. Programs may want to identify neutral resources, perhaps through human resources or hospital administration. Some programs tap into a collaboration of local lending institutions for a joint presentation of a resident workshop. This avoids pressure from a single proprietary group to get the resident to purchase a particular product or service. The following includes information on some national and regional resources:

American Medical Association

Student Loan Resources

<http://www.ama-assn.org/ama/pub/category/12478.html>

American Medical Student Association Loan Consolidation

<http://easnetwork.com/eas/associations/amsa.asp>

RESOURCES FOR MONEY MANAGEMENT AND LOAN REPAYMENT (CONT'D)

Text for Button E

American Medical Women's Association Foundation

Student Loan Program

<http://www.amwa-doc.org/index.cfm?objectid=DE510983-D567-0B25-55DB67A37916AA10>

Association of American Medical Colleges

Educational Debt Management Services for Residents

<http://www.aamc.org/students/financing/debthelp/>

Strategies for Managing Your Student Loans

<http://www.aamc.org/students/financing/debthelp/laymansguide/contents.htm>

State Loan Repayment Program

<http://www.aamc.org/students/financing/repayment/start.htm>

MEDLOANS Program

<http://www.aamc.org/students/medloans/start.htm>

National Health Service Corps

Information On Loan Repayment and Scholars Program

<http://nhsc.bhpr.hrsa.gov/>

National Institutes of Health

Loan Repayment Programs

<http://www.lrp.nih.gov/about/studentloans.htm>

Physicians/Post-Doc Program

http://www.lrp.nih.gov/about/intramural/biomed_training.htm#PPRProg

Loan Repayment/Debt Management

<http://www.training.nih.gov/careers/careercenter/debt.html>

Southern Medical Association

Resident Resources

<http://www.sma.org/residents/index.cfm>

The educational experience is critical to resident satisfaction. Time and again, this comes up in surveys. But the learning experience is critically affected by the training experience. And this all ties in with the way residents feel they are treated—or mistreated. Certainly, not all of the discomforts associated with a residency training program can be eliminated, but a conscious effort at reducing a resident's sense of mistreatment should enhance their experience greatly.

MEDICINE AND IDEALISM

In addition to all of these strains, some residents are highly vulnerable because of their idealism. It is important to listen carefully to them, to respond most effectively. This will not be accomplished in one meeting. Instead, enact policies that will reduce their sense of mistreatment and make them feel part of the system, not simply a cog in its wheel.

WEB RESOURCES

Diffusing stress and avoiding burnout

<http://www.ama-assn.org/ama/pub/category/10971.html>

Wellness Resource: University of Pittsburgh Medical Center Healthy Lifestyle Program

<http://healthylifestyle.upmc.com>

In addition to reducing the potential for stress and mistreatment, PDs can help in other ways. Ensure that all residents are aware of stress management strategies.

DISCUSSION QUESTIONS

- What strategies do you think are most helpful to assist residents in managing stress?
- Do you think that stress management programs are helpful?
- Did you make use of them during your residencies?
- Are they available at your institution?

Encourage residents to practice stress management strategies on a routine basis. Also, the importance of self-care, routine exercise, rest, and a healthful diet cannot be overemphasized. However, do not exclude the possibility that the resident may not have made the right career choice. In this case, referral to human resources, a career counseling resource, or the employee assistance program may be of help.

NON TRADITIONAL OR ALTERNATE CAREERS FOR CLINICIANS

Text for Button H

- Non-patient-oriented areas (eg, pathology)
- Research
- Administration
- Informatics and computer science
- Engineering
- Industry (e.g., advertising/promotion, medical education)
- Non-profit organizations
- The arts (many authors, playwrights, and poets began their careers with medical degrees)
- Public health
- Clinical trials (pharmaceutical industry)
- Consulting
- Volunteer work (see examples at: www.vistastaff.com/physician/volunteer.php)
- Locum tenens
- Journalism/medical reporter/advertising
- Media/film/TV
- Politics (e.g., think-tanks, non-profit organizations, congressional offices, agencies)
- Work with medically related organizations, medical boards
- State licensing boards
- State, PHP
- Occupational and environmental health
- “Concierge” or “boutique” practices advertising

It may be awkward for PDs, faculty, and even mentors to steer residents in other directions when so much time (and money) has already been invested, but it is important to do so if it is warranted. Be aware though, that the resident may feel pressured to please; therefore, the advice might be better considered if it comes from a more neutral source.

Some careers may require additional training, a second degree, such as an MBA, and a different residency. For physicians potentially interested in administration, consider the American College of Physician Executives “Career Choice” courses and career counseling options (www.acpe.org).

BURNOUT AND CAREER CRISIS: ADDITIONAL REFERENCES OF INTEREST

Abrass CK, Ballweg R, Gilshannon M, Coombs JB. A process for reducing workload and enhancing residents’ education at an academic medical center. *Acad Med* 2001;76:798–805.

American Medical Association. Leaving the bedside: the search for a nonclinical medical career. American Medical Association 1996;139 pp. www.ama-assn.org
Anonymous. Burnished or burnt out: the delights and dangers of working in health. [Editorial] *Lancet* 1994;344:1583–1585.

Chopra SS, Sotile WM, Sotile MO. Physician burnout. *JAMA* 2004;291:633.

Clever LH. Who is sicker: patients—or residents? Residents’ distress and the care of patients. [Editorial] *Ann Intern Med* 2002;136:391–393.

Frey JJ 3rd. A piece of my mind. Time to myself. *JAMA* 2003;289:2185–2186.

Gabbe SG, Melville J, Mandel L, Walker E. Burnout in chairs of obstetrics and gynecology: diagnosis, treatment, and prevention. *Am J Obstet Gynecol* 2002;186:601–612.

Gundersen L. Physician burnout. *Ann Intern Med* 2001;135:145–148.

Lim JK, Golub RM. Graduate medical education research in the 21st century and JAMA on call. *JAMA* 2004;292:2913–2915.

Linzer M, Visser MR, Oort FJ, Smets EM. Predicting and preventing physician burnout: results from the United States and the Netherlands. *Am J Med.* 2001;111:170–175.

Parshuram CS, Dhanani S, Kirsh JA, Cox PN. Fellowship training, workload, fatigue and physical stress: a prospective observational study. *CMAJ* 2004;170:965–970.

Shanafelt TD, Bradley KA, Wipf JE, Back AL. Burnout and self-reported patient care in an internal medicine residency program. *Ann Intern Med* 2002;136:358–367.

Spickard A Jr, Gabbe SG, Christensen JF. Mid-career burnout in generalist and specialist physicians. *JAMA* 2002;288:1447–1450.

Thomas NK. Resident burnout. *JAMA* 2004;292:2880–2889.

Wright SM, Beasley BW. Motivating factors for academic physicians within departments of medicine. *Mayo Clin Proc* 2004;79:1145–1150.

VISIT OUR WEBSITE FOR UP-TO-DATE REFERENCES

BURNOUT REVIEW

- Define burnout and any potential outcomes discussed in this module
- What are some of the manifestations of career crisis?
- What kinds of employment conditions are especially stressful and invite burnout?
- Describe the profile or personality characteristics of the resident most likely to succumb to burnout
- Describe the particular risk factors women might experience that would lead to burnout
- Name and define the stages of burnout
- What are the signs and symptoms of burnout?
- What are the factors discussed in this module that lead to career crisis?
- What experiences contribute to or exacerbate resident stress?
- What techniques can programs use to help residents deal with stress?
- Describe some of the financial concerns that worry residents. Cite dollar numbers from the program
- Describe stress management techniques discussed here
- Name alternate career choices for people with medical degrees



BOUNDARY VIOLATIONS

Victoria Green MD, JD, MBA, MHSA

AIM

This module presents information on boundary violations. Because of the nature of the medical encounter, these violations can be difficult to define. Blatant transgressions are easy to discern; however, there are more subtle breaches that all professionals should be able to recognize. The module, in addition to attempting to define the more difficult instances, also presents information on how to handle a range of these infractions, from reprimands to policy directives.

LEARNING OBJECTIVES

Text for Button A

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

- Outline strategies for prevention, detection, and intervention for boundary violations
- Contrast sexual violation and sexual impropriety
- Describe the inherent power differences that constitute the primary factor in boundary violations
- Analyze the role that the perceptions of both participants play in boundary violations
- Identify cultural diversity issues as they relate to the potential for misunderstanding in the physician patient encounter
- Recognize that boundary violations can occur in same gender as well as mixed gender relationships
- Assist residents in understanding the difference between healthy demonstrations of empathy and actions that might be construed as boundary violations

SCENARIO SUMMARY

A resident who has just examined a female patient asks his supervisor to confirm his diagnosis of a benign mole on the woman's breast. As the two conduct the examination, the resident exposes more of the woman's breast than necessary and, at the same time, places his hand on her shoulder. The two appear to be flirting with one another. The supervising physician, noticing the interaction, dismisses the resident, telling him that he will conclude the examination.

DISCUSSION QUESTIONS

- This scenario demonstrates an inadvertent boundary violation. Do you think this happens often in residencies?
- How large a problem are boundary violations, in your experience? What kinds occur most often?
- How do you handle boundary violations?

Assumptions that underlie the initial scenario include the following:

- It is acceptable for patients and physicians to interact in the manner portrayed in this scenario
- The resident need not be reprimanded for his behavior
- The only concern is in the intent—if the resident didn't mean to be flirtatious then no change is needed in his behavior

DISCUSSION POINT

What other assumptions might underlie this scenario?

- Boundary violations only occur between physicians and patients

SCENARIO RERUN

A resident who has just examined a female patient asks his supervisor to confirm his diagnosis of a benign mole on the woman's breast. As the two conduct the examination, the resident exposes more of the woman's breast than need be and, at the same time, places his hand on her shoulder. The two appear to be flirting with one another. The supervisor, noticing the interaction, dismisses the resident, telling him that he will conclude the examination can catch up with him later. When he does, he uses the opportunity to educate the resident about proper physician behavior.

The rerun attempts to teach the following principles:

- Boundary violations, unless they are blatant, are not always clear-cut
- The resident's inappropriate behavior needs to be confronted calmly and directly by the supervising physician and used as an opportunity to educate the resident in training about appropriate professional behavior
- Intention, no matter how benign in origin, can be easily misinterpreted
- Physicians must avoid relationships with patients

PROGRAM TEACHING POINTS

BOUNDARY VIOLATIONS: IMPRECISE IN CHARACTER

Professional boundaries are often imprecise in their nature. Unless they are the blatant violations of standards and are perpetuated by sexual predators (relatively rare occurrences), breaches in professional conduct can be difficult to define. Appropriate behavior is not always black and white, which can pose problems for the inexperienced physician in training. Residents must learn the difference between an empathetic relationship with a patient, one that attempts to build rapport and put the patient at ease, and one that may create difficulties and lead to the “slippery slope” of inappropriate behavior.

DISCUSSION QUESTIONS

- Where do you think the line is crossed in trying to establish an empathetic relationship with a patient?
- Do the benefits outweigh the risks in attempting to establish patient rapport?
- Have any of you ever had your intentions misunderstood by a patient? If so, how did you deal with it?
- Does everyone agree that the resident’s behavior was inappropriate? If there is disagreement, why?
- What does a program do when there is a lack of consensus about the appropriateness (or lack of appropriateness) of a given behavior?

Boundary violations can occur any time there is an imbalance of power, and that imbalance can manifest in a variety of relations: in relations between doctors and patients, between attendings and residents or students, between residents and more junior residents and students, and between physicians and staff. In deciding whether a behavior violates a boundary, the interpretation of that behavior is just as important

DISCUSSION QUESTION

Comment on the statement, “The interpretation of behavior is just as important as the intention that motivates it.” Do you agree with that?

as the intention that motivates it.

BOUNDARY VIOLATIONS DEFINED

Professional boundaries are limitations that define the physician-patient relationship and are based upon physical and psychological distance that must exist between patients and their doctors so that care can occur safely. This relationship is fiduciary,

Past experiences, especially those from early childhood, affect the way people view and react to one another.

“Transference” is the unconscious displacement or projection of feelings, attitudes, and expectations of significant people in the patient’s early childhood, especially parents, to current relationships. For example, if a patient was raised by parents perceived to be overly critical, the patient might view and react to his or her physician as overly critical.

“Countertransference” is the physician’s displacement of feelings and attitudes onto the patient in reaction to a patient’s episode of transference or other actions. These feelings and attitudes also arise from situations and conflicts in the doctor’s past or experiences with other patients.

Residency is an ideal time to facilitate the skill of self-reflection in trainees, so long as time is set aside to process these feelings. Caring for patients frequently involves powerful emotions and feelings. The pressures of residency conversely offer a unique environment to uncover feelings arising from past conflicts due to vulnerabilities exposed by stress and fatigue. Residents may benefit from opportunities to discuss these feelings and to learn to channel them more therapeutically.

For instance, a diabetic patient may have an underlying alcohol use disorder and be non compliant or non adherent with a doctor’s recommendations. The physician may respond to this patient in a variety of ways: anger and/or frustration; overlooking or avoiding the alcohol issue; or making excessive efforts to rescue the patient and keep him/her from taking responsibility for his/her decisions. The physician’s response may be rooted in his/her own personal experiences. A physician may unconsciously respond to patients as he/she either responded or wishes he/she had responded to a close relative or friend with a substance use problem.

Programs should provide opportunities to enhance the insights of residents on why they feel certain ways when encountering particular types of patients. This will lessen the emotional toll on the resident, and help him/her to develop better therapeutic responses to his/her patients.

Portions of definitions adapted from Laplanche J, Pontalis J-B. *The Language of Psychoanalysis*. Tr. Nicholson-Smith D. New York: WW Norton, 1974.

entailing mutual trust, confidence, and respect for the parties involved.

Boundary violations exist on a continuum, ranging from minor to extreme. Gift-giving is a good example. Patients frequently offer their doctors small gifts, such as a basket of home-grown vegetables or baked goods, to show gratitude for professional services. A small token of appreciation is relatively innocuous. However, gifts can grow in significance, from financial rewards such as lucrative stock tips, to expensive gifts, to sexual favors. Valuable gifts should serve as a red flag to the physician, indicating that the patient may think there is more to the relationship than what

Patients frequently want to express gratitude to their physicians, sometimes with gifts. Physicians need to balance acceptance of legitimate gratitude, while avoiding any perception that a gift affects the physician-patient relationship and results in preferential treatment (e.g., longer visits than are typical or off-hours appointment times).

Common advice to physicians is to decline valuable gifts. Of course, value is relative. A gift certificate to a nice restaurant may be financially trivial to a wealthy patient, yet the same gift may be quite significant to a patient making only the minimum wage.

Consider discussions about gift-giving with all trainees and faculty to develop reasonable policies, or refer residents to the pertinent policies of the sponsoring institution. Provide opportunities for residents to reflect on the many issues involved and to rehearse ways to respond to the gratitude of patients.

Gifts can be accepted graciously on behalf of the entire team. This acknowledges that the patient experience is usually a group effort. For instance:

Thank you for your thoughtful gift of chocolates (or flowers). I am going to put them in our lounge so that all of the doctors and nurses who worked with you can enjoy them. I am glad you were pleased with your care.

Or:

I am glad you were pleased with your care. Our hospital policy is not to accept individual gifts, but let me give you the address and phone number of our development office so that you may send this as a contribution to our new children's wing, if you would like to do so. In this way many other children can receive the same good care as your child in the future.

the physician intends.

It is necessary to differentiate boundary violations from boundary crossings, although even these call for caution and good judgment. Boundary crossings involve transgressions that are minor and, in some ways, might be seen as appropriate. They might involve attending a patient's wedding or a family funeral, putting a hand on the shoulder of a colleague in distress, or inviting a student out for lunch. These are behaviors that physicians commonly regard as indicative of humaneness and caring on the part of the physician. It is often best to inquire whether these behaviors are construed as helpful and wanted.

DISCUSSION QUESTIONS

- How common, in your experience, are boundary crossings?
- How does your institution direct you to handle boundary crossings?
- Do you see boundary crossings as creating potential problems in the physician-patient relationship?
- Do you see boundary crossings as creating potential problems in the teacher-learner relationship?

It is the physician's responsibility to understand and evaluate the potential meaning of any interaction to a patient or learner. For example, touching might signal support or consolation to one person; but for another, it might constitute an intimate approach. Because of the potential variability of interpretation, it is critical that the physician refrain from any behavior that might be interpreted as provocative and/or likely to cause confusion.

COMMUNICATION AND CULTURAL DIFFERENCES

Nonverbal communication is heavily influenced by cultural differences. For example, the experience of body—or personal—space and its invasion varies greatly. Sitting in close proximity may be experienced as friendly by a person from one culture, but as

CULTURAL DIFFERENCES

Cultural differences impact communication

- Body space
- Eye contact
- Smiling/nodding
- Touching

Purnell LD, Paulanka BJ. *Transcultural health care: a culturally competent approach*. Philadelphia, PA. FA Davis Company, 1998.

Andrews MM, Boyle JS. *Transcultural concepts in nursing care*. 3rd Edition. Philadelphia, PA. Lippincott, 1999.

threatening by other.

Eye contact is another area of difference. In some cultures, direct eye contact is considered impolite or aggressive, so it is avoided. Other cultures regard it as an expression of openness and honesty. Smiling and nodding may mean agreement, understanding, and assent, or it may only indicate respect.

DISCUSSION QUESTIONS

- How large a role does cultural difference play in your practices?
- Have you ever had problems due to cultural misinterpretations?
- Do you see a need for education in cultural differences?

Touching must be carefully considered because physical contact can convey a wide variety of different meanings. Because of the growing cultural diversity in the US population, physicians and other members of the health care team are increasingly likely to differ in cultural backgrounds. The physician who is knowledgeable about cultural differences and who, therefore, can avoid potential pitfalls is wise, indeed. Although it is impossible to be fully culturally competent, physicians should strive for awareness

CULTURAL ASPECTS OF CARE

Text for Button D

The physician's message is conveyed through both verbal and nonverbal communication, which are heavily influenced by culture. Physicians who are not aware of cultural differences can inadvertently convey a different message from what they intended.

Consider how frequently we physicians say something will happen (a hospital discharge, a lab test) right now. The Spanish word "horita" means "right now" in Mexico, but in Puerto Rico the word means "in about an hour or so." The English phrase "just now" means "later" in South Africa. Words may create a different expectation for the patient from what the physician intends, leading patients to be frustrated or even angry.

In many cultures there are different meanings associated with touch or the amount of physical space between two individuals. Touching a small child or even paying significant attention to him/her in some cultures may be interpreted as friendly. In others cultures, it is considered an indication of bad luck.

Physicians should learn the common cultural norms of the patients with whom they interact, but avoid making assumptions based on stereotypes. In addition, they should have a very low threshold for asking patients and families directly what is acceptable to them. For instance, "I have some important news I need to communicate. With whom would you like me to discuss this?"

Adapted from Galanti GA. *Caring for patients from different cultures: case studies from American hospitals*. 2nd ed. Philadelphia, PA: University of Pennsylvania Press, 1997.

and to enhance their perception of verbal and non verbal cues.

Sexual Misconduct

Sexual misconduct, one of the most extreme boundary violations, is defined as behavior that takes advantage of the physician-patient or physician-learner relationship in a sexual way. Sexual misconduct severely exploits the imbalance of power that exists between the two, an imbalance heightened by the differences in status, education, and/or author-

SEX AND POWER

Text for Button E

- There is an inherent power imbalance between patients and physicians. A patient sees the physician in the professional role of healer, and assumes the physician knows more or has more skill in a particular area. This is why patients seek care and guidance, and are often willing to be a great deal more honest, much more emotionally intimate, and vulnerable far more quickly to the physician than to anyone else. The patient (or his/her insurance) contracts with and pays the physician for services. These elements convey power to the physician and set up the boundaries of the physician-patient relationship
- Changing any of the elements in the physician-patient relationship affects the boundaries, and may weaken them
- Sexual contact of any nature between a physician and a patient is the most egregious boundary violation. It is unacceptable, can lead to professional censure, and to a permanent loss of a medical license and a career
- Residents may not see themselves as powerful figures to patients, may strive to develop egalitarian relationships with their patients, and may behave as friendly in ways that can be misconstrued (e.g., suggesting the use one of another's first names)
- A resident may not feel that he/she is the patient's "real" doctor. Instead, he/she may feel that he/she can be friends with the patient, because the attending is the "real" physician. Therefore, the resident may believe that boundary issues aren't applicable to him/her. However, in the patient's view, the resident is part of the treating team and is in a position of power similar to the attending faculty physician

ity that commonly exist between doctor and patient and/or doctor and learner.

VIOLATIONS VERSUS IMPROPRIETIES

The Federation of State Medical Boards defines two levels of sexual misconduct: sexual violation and sexual impropriety. Sexual violation includes physician-patient sex or any conduct with a patient that is sexual or may be reasonably interpreted as sexual. Sexual impropriety includes behavior, gestures, or expressions that are seductive, sexually suggestive, or sexually demeaning to a patient. These violations are associated with professional and legal ramifications. Abuse can result in loss of

SEXUAL VIOLATION VERSUS SEXUAL IMPROPRIETY

Text for Button F

Sexual violations are so egregious they are fairly easy to identify. They are engaged in by a minority of individuals who are often sexual predators. Even though such violations are rare, they tend to receive significant publicity when they occur.

Sexual Violation may include physician-patient sex or any conduct with a patient that is sexual or may be reasonably interpreted as sexual, including but not limited to:

- Kissing
- Touching breasts, genitals, or any sexualized body part for any purpose other than appropriate examination or treatment, especially for sexual gratification of the physician, or in a situation in which the patient has not consented, has refused, or has withdrawn consent
- Encouraging the patient to masturbate in the presence of the physician or masturbation by the physician while the patient is present
- Offering to provide practice-related services, such as drugs, in exchange for sexual favors
- Engaging in sexual intercourse: genital, oral, or anal

Sexual Impropriety, which is more common but often more difficult to define, includes behavior, gestures, or expressions that are seductive, sexually suggestive, or sexually demeaning to a patient, including but not limited to:

- Disrobing or draping practices that reflect a lack of respect for the patient's privacy
- Deliberately watching a patient dress or undress, instead of providing privacy for disrobing
- Subjecting a patient to an intimate examination in the presence of medical students or other parties without the explicit consent of the patient or when consent has been withdrawn
- Examining or touching of genitals without the use of gloves
- Making inappropriate comments about or to the patient, including but not limited to making sexual comments about a patient's body or underclothing; making sexualized or sexually demeaning comments to a patient; criticizing the patient's sexual orientation (homosexual, heterosexual, transsexual, or bisexual); making comments about potential sexual performance during an examination or consultation except when the examination or consultation is pertinent to the issue of sexual function or dysfunction; requesting details of sexual history or sexual likes or dislikes when not clinically indicated for the type of consultation
- Using the physician-patient relationship to solicit a date

SEXUAL VIOLATION VERSUS SEXUAL IMPROPRIETY (CONT'D)

Text for Button F

- Initiating or encouraging conversation regarding the sexual problems, preferences, or fantasies of the physician
- Examining the patient intimately without consent

Revised from the Ad Hoc Committee on Physician Impairment. Report on Sexual Boundary Issues By The Ad Hoc Committee on Physician Impairment. The Federation of State Medical Boards of the US, Inc. accepted this Report on Sexual Boundary Issues as policy in April 1996. Accessed 2/15/04.
http://www.fsmb.org/Policy%20Documents%20and%20White%20Papers/sexual_boundary.html

license and imprisonment.

In addition to relations with patients, personal or sexual relationships between supervisors and trainees are also unethical. Sexual relationships between residents and students or interns fall within the same category.

According to the AMA, the supervising party is responsible for maintaining boundaries because of the inherent inequality of status and power. Even if the parties in question consent willingly to such a relationship, it is considered unethical until the hierarchical relationship is terminated. In fact, some experts assert that the inherent inequality of status and power makes a consensual relationship impossible.

Hierarchical relations that govern the physician-patient relationship must also be dealt with before any more intimate association can be established. According to the AMA, at minimum, a physician's ethical duties include terminating the physician-patient relationship and transferring care to another qualified health care professional before being involved in a dating, romantic, or sexual relationship with a patient. Suggested guidelines for all specialties, psychiatry excepted, include a 2-year period after the last episode of patient care in which no social contact would be allowed before the initiation of the romantic relationship. However, sexual contact even with former patients may lead to medical board investigation and/or license action under some circumstances.

For psychiatrists, the American Psychiatric Association guidelines state that the doctor-patient relationship is essentially permanent and sexual contact between a therapist and a patient is never appropriate, even long after the termination of active therapy.

A physician who violates these standards risks the loss of his/her medical license, even if he/she was totally naïve or unaware of the standards.

DISCUSSION QUESTIONS

- How pervasive are issues of sex and power in your work place?
- Can sexual/romantic relationships ever be appropriate between physicians and patients, or faculty and residents, or residents and more junior learners?
- What are your program's or institution's written policies?
- How do you deal with complaints of sexual harassment by residents in your institutions?
- Have patients ever complained of physician boundary violations in your programs? If so, how do you handle the complaints?
- Have residents or students ever complained of boundary violations in your programs by faculty or more senior residents? If so, how have you addressed this situation?
- What is the impact of this situation on the entire program?
- How should physicians handle romantic/sexual invitations from patients?

Most of the time, boundary violations occur when well-meaning physicians try to go the "extra mile" for a patient. However, physicians may unwittingly cross boundaries if they are not attentive enough to the emotional state of the patient; boundary crossings may also occur if physicians invest more of themselves than they realize in their relationships with patients, perhaps to meet needs that are unsatisfied in other areas of the physicians' lives.

THE PREDATORY PHYSICIAN: A PROFILE

Although rare, there are physicians who engage in predatory behavior. Various explanations have been offered to account for their blatant behavior, including personal, psychological, and relationship problems. Psychiatric disorders can also play a role.

PROPOSED CAUSES OF BOUNDARY VIOLATIONS IN PHYSICIANS

Text for Button G

PERSONAL, PSYCHOLOGICAL, RELATIONSHIP PROBLEMS:

- History of childhood abuse
- Poor self-esteem or personal insecurity
- Need to control others
- Isolation
- Burnout
- Addiction (substance and sexual)
- Financial stresses
- Family problems

MAJOR PSYCHIATRIC DISORDERS ASSOCIATED WITH SEXUAL MISCONDUCT:

- Organic mental disorder
- Antisocial or narcissistic personality disorder
- Erotomanic delusional disorder
- Bipolar affective disorder
- Obsessive-compulsive disorder
- Atypical dissociative disorder
- Poor impulse control disorder
- Adjustment disorder (with disturbances of conduct)

Irons R. Sexually addicted healthcare professionals. Accessed 2/19/04.
http://www.prckansas.org/articles/sexually_addicted_healthcare_professionals.htm

The effects of boundary violations on patients can be severe. Patients come to physicians for help and healing. Their trust in the professional relationship is what allows them to engage in the very personal nature of the healthy doctor-patient relationship. When that relationship is distorted, when it becomes an inappropriate personal relationship, the patient may sustain real psychological damage. Depression, anxiety, and sexual dysfunction can all result. Those who are not able to cope with the unhealthy relationship or its loss may even turn to substance abuse. Consequently, patients may refuse to seek treatment for fear of being victimized once again.

CONSEQUENCES TO PATIENTS

Text for Button H

- Anxiety
- Dependency
- Depression
- Sexual and sleep disorders
- Cognitive dysfunction
- Substance abuse
- Relationship problems
- Distrust of the medical profession
- Lack of adherence to medical recommendations
- Reluctance to seek treatment
- Overuse of the medical system to get provider attention

Some of these same consequences afflict trainees if more senior physicians violate the boundaries an educator needs to maintain with a learner. Given these facts, it would be better for all physicians to avoid what Simon (1999) lists as the physician equivalent to the “slippery slope,” starting with a slow decline in physician neutrality and ending in a sexual relationship. It is essential to communicate and model appropriate behavior for residents, to monitor their behavior for potential boundary violations, and to have clear policies for these situations.

Usually we’re not dealing with predators, but with naïve and/or immature, well intentioned individuals who benefit from a proactive—policy, clear expectations and timely feedback. AT A MINIMUM, any supervisor/evaluator who engages in a romantic relation-

Often boundary violations begin with innocent behavior. One event in and of itself may be acceptable; however, this can start the physician down a slippery slope of more and more problematic behaviors.

Early indications of potential problems in a physician's behaviors include (not necessarily linearly):

- Neutrality slowly declines; physician spends more time with the patient or suggests appointments late in the day.
- Fraternalizing occurs outside the practice setting; physician arranges to see patients outside of regular office hours or outside the work environment (in non-hospital settings), makes frequent phone calls or emails that start by discussing laboratory results and continue to social conversation
- Treats patient as special in some way—with special treatment, extra time, extra appointments, charging less (or not at all) for visits
- Reveals confidential information concerning other patients or the work environment
- Engages in self-revelation, treating the patient as a friend
- Initiates physical contact, often beginning in a non-sexual manner
- Increasingly blurs the line between personal relationship and a professional/medical relationship
- Fails to keep or alters office records and documentation of the physician-patient encounters/connections
- Begins dating the patient
- Begins a sexual relationship with the patient

(Adapted from Simon, R.I. Therapist-patient sex. *Forensic Psychiatry* 22(1):31-47, 1999)

Factors that increase the likelihood of sliding the slippery slope with a patient:

- Not using chaperones during sensitive portions of the history and physical
- Accepting gifts that could have intimate meaning to the patient
- Accepting excessive gifts
- Keeping secrets about professional behaviors.
- Not completely documenting encounters and connections with the patient
- Treating some patients differently in a substantial way
- Revealing excessive amounts of personal information to patients
- Engaging in a behavior the physician would be embarrassed to have publicly revealed (in the local newspaper, or to his/her colleagues)
- Engaging in behavior(s) that makes other members of the health care team uncomfortable vis-a-vis the patient

As with all rules exceptions do and should exist.

- Revealing a little bit of personal information makes the physician more real, more trustworthy
- Graciously accepting baked goods or garden produce is courteous and gifts can often be shared with your office staff; appreciation for the gift can be expressed in the context of the entire team, e.g., "Thank you for the delicious coffee cake (or the flowers). I will put your gift in our break room so we all can enjoy your thoughtfulness."
- Going to the funeral of a patient may show respect and may be a display of support for other family members (who may also be the physician's patients) especially for a patient with whom the physician had a long and trusting relationship. On the other hand, the physician can't play favorites. Setting up an expectation that the physician will attend all significant family events (funerals, christenings, etc.) may be completely unrealistic. Attending these events for one family and not another may lead to patient dissatisfaction
- In small rural communities, physicians may be unable to avoid social contact with their patients
- One test of acceptability of behavior especially relevant in small communities is the publicity test. Imagine that whatever the physician is contemplating appears on the front page of the local newspaper. If this would be embarrassing or compromising to anyone in any way, the physician should refrain from doing it!
- The physician's behavior with trainees can also indicate boundary violations, which can occur between faculty and residents, and upper-year residents and junior residents or other learners

With trainees, warning signs include:

- Giving special consideration especially if not reviewed and agreed to by the program leadership or the entire faculty body
- Grading higher than the resident's performance merits
- Meeting, or requesting meetings, outside of the work setting or typical hours
- Establishing dating and/or sexual relations with anyone with whom one has supervisory/evaluative responsibilities

Residents should be encouraged to discuss such situations openly with faculty so that they can receive mentoring on the fine line between appropriate and inappropriate behavior.

ship with a trainee/learner should be removed from the teaching and/or evaluative role.

DISCUSSION QUESTIONS

- How realistic do you find the application of the “slippery slope” to the physician-patient relationship?
- Are these types of infractions (described in the stages of the slippery slope) common, in your experience? Do you find that they occur frequently or rarely in your institutions?
- What are strategies to prevent these situations?

Violations often begin with small steps, appearing innocent enough at first but ending in culpability. To avoid the slippery slope, here are some principles to adhere to: maintain physician neutrality and protect it. The presence of a chaperone is always appropriate, not just for some or all of the physical examination, but even during emotionally charged aspects of the taking of a history. Both men and women physicians should have chaperones present whenever rectal, pelvic, genital, or breast exams are being conducted. Chaperones are essential, regardless of the sex

GUIDELINES FOR AVOIDING MISUNDERSTANDINGS DURING PHYSICAL EXAMINATIONS (EXAMPLE OF A POLICY FROM THE NORTH CAROLINA MEDICAL BOARD)

It is the position of the North Carolina Medical Board that proper care and sensitivity are needed during physical examinations to avoid misunderstandings that could lead to charges of sexual misconduct against physicians. The Board offers the following guideline for preventing such misunderstandings.

1. Sensitivity to patient dignity should be considered by the physician when undertaking a physical examination. The patient should be assured of adequate auditory and visual privacy and should never be asked to disrobe in the presence of the physician. Examining rooms should be safe, clean, and well maintained, and should be equipped with appropriate furniture for examination and treatment. Gowns, sheets, and/or other appropriate apparel should be made available to protect patient dignity and decrease embarrassment to the patient while a thorough and professional examination is conducted.
2. Whatever the sex of the patient, a third party, a staff member, should be readily available at all times during a physical examination, and it is strongly advised that a third party be present when the physician performs an examination of the breast(s), genitalia, or rectum. It is the physician's responsibility to have a staff member available at any point during the examination.

GUIDELINES FOR AVOIDING MISUNDERSTANDINGS DURING PHYSICAL EXAMINATIONS (EXAMPLE OF A POLICY FROM THE NORTH CAROLINA MEDICAL BOARD) (CONT'D)

3. The physician should individualize the approach to physical examinations so that each patient's apprehension, fear, and embarrassment are diminished as much as possible. An explanation may be necessary of the necessity of a complete physical examination, the components of that examination, and the purpose of disrobing, in order to minimize the patient's possible misunderstanding.

4. The physician and staff should exercise the same degree of professionalism and care when performing diagnostic procedures (e.g., electro-cardiograms, electromyograms, endoscopic procedures, and radiological studies, etc.), as well as during surgical procedures and postsurgical follow-up examinations when the patient is in varying stages of consciousness.

5. The physician should be on the alert for suggestive or flirtatious behavior or mannerisms on the part of the patient and should not permit a compromising situation to develop.

(Adopted 5/91)

(Amended 5/93, 5/96, 1/01, 2/01, 10/02)

of the patient, even when a female physician examines a female patient.

It may also be useful to have meetings in which residents can learn about the policies, discuss examples of the inevitable feelings that come up as they care for patients, and develop strategies to address them constructively.

MAINTAINING PROFESSIONAL DISTANCE

Do not let any one patient take precedence over another. Do not assign more time than is usual to a patient or arrange to meet any patient outside of standard office hours. Do not discount a bill or provide treatment free of charge, outside of office policy.

Do not socialize with patients outside the practice. Do not accept gifts from a patient when you suspect there may be ulterior motives or misinterpretation or that could be viewed as excessive. Be exceedingly cautious about the amount and detail of personal information shared with patients; and any other behavior that you would keep secret from other professionals. Good judgment is critical.

FOUR-PRONGED APPROACH TO BOUNDARY VIOLATIONS

Monitoring resident behavior is always important. However, boundary violations will rarely be successfully prevented, identified, and managed without residency programs directly addressing these issues. A four-pronged approach is recommended:

- First, educate all faculty, residents, students, and staff about relationships with

- patients and junior learners, about treating patients equally, and about gift-giving
- Second, encourage and maintain open communications so that everyone has opportunity to discuss concerns with the PD
- Third, observe resident behavior in patient encounter settings
- Fourth, develop clear policies about boundary violations; the policies usually can be drawn from state medical board and individual institutional policies

**EXAMPLE OF A PROFESSIONAL EXPECTATION
FORM FOR RESIDENTS**

Text for Button J

You may wish to use this as a beginning to determine the expectations your own institution/program has for your resident physicians. Please review with your consultants (e.g., human resources, risk management, legal department, designated institutional official {DIO}) and modify for your own environment with their input.

PROFESSIONAL EXPECTATIONS

Purpose: Successful participation in graduate medical education depends on 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 committed to institutional policies and procedures, and to departmental, divisional, and program-specific expectations. This includes treating everyone (colleagues, faculty, students, patients, families, staff, and guests) with respect, demonstrating integrity and honesty.

This document, "Professional Expectations," is intended to provide written guidelines that outline expectations and potential disciplinary consequences for activities, practices, or behaviors of resident physicians that are consistent with professional behavior. The document also outlines potential disciplinary consequences for actions, practices, or behaviors that are not in line with these expectations.

Resources and techniques dedicated to developing a greater understanding of these expectations and supporting successful performance include but are not limited to:

- Incoming resident physician orientation
- The resident manual
- Graduate medical education web page

EXAMPLE OF A PROFESSIONAL EXPECTATION FORM FOR RESIDENTS (CONT'D)

Text for Button J

We expect resident physicians to:

- Treat everyone with respect (e.g., colleagues, faculty, students, patients, families, guests)
- Demonstrate integrity and honesty
- Ensure patient safety
- Regularly review performance evaluations with program director

Other resources

- The graduate medical education office
- The Office for Institutional Equity
- Personal assistance program/employee assistance program
- The disability office
- Faculty, attending, staff, student, and peer feedback

Standards of conduct and performance:

General standards of conduct and performance apply throughout the hospital and affiliated educational sites. Violations of and/or failure to adhere to these standards may result in warning (oral or written), corrective action and suspension, or even termination.

These standards are minimum guidelines for conduct and work performance of residents. These are not all-inclusive but rather representative of behavior and performance that are and are not acceptable. The standards may be supplemented by additional regulations when residents are subject to professional accreditation, state regulations, or licensure, and to the requirements of individual departments and programs.

All incoming residents must read and acknowledge by their signature that they have received a copy of the Professional Expectations.

**PROFESSIONAL EXPECTATIONS:
STANDARDS OF CONDUCT AND PERFORMANCE FOR RESIDENTS:**

STANDARD	Example of a VIOLATION	1 st event	2 nd event	3 rd event	4 th event
PERFORMANCE					
<p>Key: Recommended Disciplinary Action O: Oral Warning (written documentation filed in the training record) W: Written Warning CA/S: Automatic corrective action including suspension T: Termination</p>					
1.1 Perform assigned tasks safely and competently to maximize patient health and safety, in accordance with performance expectations	1.1a Fail to perform task(s) adequately as requested, either because of unwillingness to perform the task or carelessness in carrying out the assignment	O	W	CA/S	T
1.2 Demonstrate commitment to excellence and to continuous learning, improvement, and professional development	1.2a Being in an unfit condition to perform the duties of the job, including working under (or suspected of working under) the influence of drugs or alcohol	CA/S	T		
COMPLIANCE WITH POLICIES & PROCEDURES					
2.1 Understand and comply with all university, hospital, or affiliated premises, policies, and procedures, i.e., clinical, administrative, and safety policies	2.1a Fail to complete required safety training	W	CA/S	T	

PROFESSIONAL EXPECTATIONS:**STANDARDS OF CONDUCT AND PERFORMANCE FOR RESIDENTS: (CONT'D)**

	2.1b Fail to complete required HIPAA/ confidentiality training	W	CA/S	T	
	2.1c Fail to maintain current BLS or ACLS, as required by department/program	W	CA/S	T	
	2.1d Fail to maintain current NALS, PALS, ATLS (when required by department/ program)	W	CA/S	T	
	2.1e Fail to complete required ACGME competency modules	W	CA/S	T	
	2.1f Engage in unapproved "moonlighting" activities	CA/S	T		
	2.1g Fail to have an annual PPD with results recorded at EOHS	O	W	CA/S	T
2.2 Comply with all federal, state, and accreditation standards regulating the provision of professional services	2.2a Fail to maintain a valid medical license on file with the Office of GME	CA/S	T		
	2.2b Conduct any activity that violates federal or state standards regulating the provision of professional services, or violates regulations affecting continued licensure, commissioning, or certification in a profession	T			

**PROFESSIONAL EXPECTATIONS:
STANDARDS OF CONDUCT AND PERFORMANCE FOR RESIDENTS: (CONT'D)**

	2.2c Commit boundary violations and/or have sexual relationships with patients	T			
	2.2d Self-prescribe or prescribe for family members, in violation of policies of the state medical board	W	CA/S	T	
2.3 Maintain duty hours in compliance with institutional, ACGME, and RRC policies	2.3a Work in excess of 80 hours per week averaged over 4-week period; work in excess of call more frequently than 1 night in 3 averaged over a 4-week period; fail to take one 24-hour period in 7 days away from the hospital averaged over a 4-week period (unless program has received ICGME and ACGME exemption)	W	CA/S	T	
2.4 Protect confidentiality of sensitive information. Such information should not be repeated, discussed, or removed from the work area, except for legitimate and authorized work reasons	2.4a Use another's computer sign-on or computer access code or provide the use of an individual's sign-on code without proper authorization to gain unauthorized access to confidential or privileged information	W	CA/S	T	

PROFESSIONAL EXPECTATIONS:**STANDARDS OF CONDUCT AND PERFORMANCE FOR RESIDENTS: (CONT'D)**

	2.4b Behave in a way that compromises another's safety or privacy, or discloses confidential university information, including the access of medical records from curiosity rather than for participation in a patient's medical care, or a designated QI, or an educational function	CA/S vs. T depends on intent			
2.5 Demonstrate honesty and integrity	2.5a Falsify hospital or affiliated records, including the intentional failure to record time or medical records accurately	T			
	2.5b Fail to demonstrate commitment to ethical principles	CA/S	T		
	2.5c Fail to appropriately disclose relationship/gifts from industry, including pharmaceutical representatives, to avoid real or perceived undue influence	W	CA/S	T	
	2.6c Fail to comply with institutional policies on research, and fail to follow appropriate approval processes of the IRB and policies regarding animal welfare				

PROFESSIONAL EXPECTATIONS:**STANDARDS OF CONDUCT AND PERFORMANCE FOR RESIDENTS: (CONT'D)****AVAILABILITY FOR WORK**

3.1 Attend work as assigned; arrive on time fully prepared to begin work; remain throughout the work period and until work is completed (patients seen, notes written or dictated, messages completed); request authorization for time away from work according to established procedures, if there is a need to leave the workplace	3.1a Violate attendance policy involving unscheduled absence or tardiness for whatever reason, including the failure to report to work or to leave work before conclusion of the work period; absences may render a resident unable to complete a program within the training contract and may result in a trainee being ineligible to sit for boards, depending on specific rules of the relevant RRC	O	W	CA/S	T
3.2 Notify the supervisor well in advance of any unscheduled absence in accordance with departmental guidelines	3.2a Fail to inform supervisor when leaving duty or fail to report back	W	CA/S	T	
	3.2b Be absent without notice (provided in accordance with program procedures) for three consecutive workdays, constituting voluntary resignation	T			
3.3 Arrange coverage for patient follow-up when absent	3.3a Fail to arrange patient coverage when absent	O	W	CA/S	T

PROFESSIONAL EXPECTATIONS:**STANDARDS OF CONDUCT AND PERFORMANCE FOR RESIDENTS: (CONT'D)**

3.4 Answer pages and respond to emails in timely fashion	3.4a Fail to respond to pages or email promptly when on duty and on call (typically within 15 minutes for pages and within 24 hours for email)	O	W	CA/S	T
	3.4b Fail to use available systems to designate vacations, time away, etc.	O	W	CA/S	T

TEAMWORK & WORKPLACE BEHAVIOR

4.1 Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients, families, staff, and colleagues; work collaboratively with all co-workers, including those from other disciplines, to provide patient-focused care	4.1a Use inappropriate behavior and/or profane, abusive, or loud/boisterous language toward patients, families, staff, supervisor or co-workers	W	CA/S	T	
	4.1b Threaten or endanger any person's life or health, deliberately or through carelessness	CA/S	T		
4.2 Demonstrate respect and courtesy towards fellow staff members, faculty, students, patients, and visitors; demonstrate sensitivity and responsiveness to patients and co-workers' with	4.2a Fail to interact appropriately with anyone on hospital, or affiliated premises, including patients, their families, students, visitors, or other employees	CA/S	T		

**PROFESSIONAL EXPECTATIONS:
STANDARDS OF CONDUCT AND PERFORMANCE FOR RESIDENTS: (CONT'D)**

regard to culture, age, gender, and/or disabilities					
	4.2b Violate another's privacy or dignity, including sexual harassment or insensitivity to culture, age, gender and/or disabilities	CA/S	T		
	4.2c Have a sexual relationship with anyone with whom one has supervisory or educational evaluative responsibilities	CA/S	T		
4.3 Be productive and use all available time to accomplish expected work tasks; accomplish personal business outside of work times and/or in scheduled time-off	4.3a Fail to complete work assignments in a timely fashion; allow personal activities to interfere with professional responsibilities	O	W	CA/S	T
4.4 Use available resources to resolve work-related problems	4.4a Fail to seek assistance from hospital resources (e.g., human resources, physicians assistance programs) for work-related problems	O	W	CA/S	T
4.5 Facilitate learning of students and other health professionals	4.5a Fail to treat others with dignity and respect, or to maintain appropriate relationships that are conducive to equitable, balanced evaluations	O	W	CA/S	T

PROFESSIONAL EXPECTATIONS:**STANDARDS OF CONDUCT AND PERFORMANCE FOR RESIDENTS: (CONT'D)**

4.6 Dress for work according to the department's workplace attire guidelines, including the appropriate display of any required identification badge	4.6a Fail to conform to departmental uniform or dress-code policy, including the wearing of identification badges	O	W	CA/S	T
4.7 Give, accept, and ask for balanced feedback on a regular basis	4.7a Fail to acknowledge requests for feedback	O	W	CA/S	T
WORK REQUESTS & ASSIGNMENTS					
5.1 Complete all medical records in a timely fashion	5.1a Fail to complete medical records within hospital/department designated time frame	W	CA/S	T	
SAFETY & RESPECT					
	6.1a Send personal email on hospital computer; duplicate personal documents on university copy machines	CA/S	T		
	6.2a Transfer a hospital/institutional email account to another email address	W	CA/S	T	
	6.2b Conduct a personal business from a hospital/institutional email address	W	CA/S	T	

**PROFESSIONAL EXPECTATIONS:
STANDARDS OF CONDUCT AND PERFORMANCE FOR RESIDENTS: (CONT'D)**

6.3 Report immediately any accident on university, hospital, or affiliated premises involving an on-the-job injury or property damage	6.3a Fail to report the abuse of university or hospital equipment	W	CA/S	T	
6.4 Obey and abide by all civil, state, and federal laws and university regulations	6.4a Commit any crime on university, hospital, or affiliated premises such as theft or unauthorized removal of or willful damage to property	T			
	6.4b Have unauthorized possession of alcohol, weapons, explosives, or any possession of illegal drugs	T			
	6.4c Charge personal long-distance phone calls to the hospital, or affiliates	T			
	6.4d Gamble on hospital, or affiliated premises	T			
	6.4e Commit a work-related crime while off duty	T			

Finally, the importance of role-modeling by faculty cannot be over-emphasized. Faculty members need to model the appropriate workplace behaviors.

BOUNDARY VIOLATIONS REVIEW

- Discuss the imprecise nature of boundary violations
- Differentiate between transference and countertransference. Give examples of each as they might occur in your medical practice
- Define boundary violations. Give examples (i.e., from the more innocent types to the more extreme)
- Differentiate boundary violations from boundary crossings
- Discuss the nature of cultural differences that might play a role in medical practices. What others (besides those given as examples in the program) can you describe?
- Define and discuss the differences between sexual violations and sexual improprieties
- Discuss the AMA's position on physician-patient relationships. How does psychiatry differ from general medical practices?
- Describe the profile of the predatory physician
- Describe the consequences of boundary violations to the patient
- Describe the "slippery slope" as it applies to relationships between the physician and others

ADDITIONAL REFERENCES OF INTEREST

Danner C. Boundaries and the patient-physician relationship. Behavioral medicine briefs. University of Minnesota. Department of Family Practice and Community Health. 2002;24 (September) <http://www.med.umn.edu/fp/bmb/bmb24.pdf>

Glass L. The gray areas of boundary crossings and violations. *Am J Psychother* 2003;57:429–444.

Nadelson C, Notman MT. Boundaries in the doctor-patient relationship. *Theor Med* 2002;23:191–201.

Walker R, Clark JJ. Heading off boundary problems: clinical supervision as risk management. *Psychiatr Serv* 1999;50:1435–1439.

White GE. Medical students' learning needs about setting and maintaining social and sexual boundaries: a report. *Med Educ* 2003;37:1017–1019.



AIM

This module presents information about residents whose performance may suffer because of disabilities, medical conditions, or any maladaptive behavior that may emerge under conditions of stress (associated with residencies). It also presents information on the Americans with Disabilities Act (ADA) and explains how it applies to residency programs.

LEARNING OBJECTIVES

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

- Identify performance and behavior patterns that warrant an evaluation
- Recognize poor performance as a symptom with multiple possible etiologies that should be addressed
- Refer to an entity that can conduct an appropriate and confidential evaluation, and remain in your role as PD or evaluator of performance
- Determine when the program's best option is to terminate (or not renew the contract of the resident, with a recommendation that he/she consider a different specialty, a different program, or a different career
- Explain the principle of "reasonable accommodation," as set forth by the ADA
- List the "essential job functions" of your residency program
- Name effective interventions that can help a resident address deficiencies in performance or behavior
- Describe the process of evaluation by an employee health office and a state PHP
- Respond appropriately to candidates with disabilities who apply for residency positions

SCENARIO SUMMARY

Two attending physicians are shown questioning either the performance or the behavior of four different residents. The first resident is reprimanded for disorganized patient presentations; the second is suspected of drug abuse because of his pressured speech; the third is asked about her weight loss—which is attributed to carrying

fashion too far, and the fourth is questioned about her judgment because she is both a resident and pregnant.

Assumptions that underlie the initial scenario include the following:

- Sub-optimal performance and behavior issues rarely warrant investigation
- An admonition is all that's necessary to get the resident back on track
- Ignoring these behaviors is the best means of resolution
- The PD should medically evaluate residents with these behaviors and be aware of their diagnosis and necessary treatment

DISCUSSION QUESTIONS

What other assumptions might underlie this scenario?

- Does everyone agree the behaviors were inappropriate?
- If there is disagreement in your program, why?
- What do you do as a program when there is a lack of consensus about the appropriateness (or lack of appropriateness) of a given behavior?

SCENARIO RERUN

Two attending physicians are shown questioning either the performance or the behavior of four different residents. This time, however, instead of coming up with reasons for the sub-optimal performance of the residents, the attending physicians attempt to describe the problems and require that the resident take steps to remedy deficiencies. As it turns out, one resident has a learning disability that emerges when conditions become extremely stressful; a second has a bipolar disorder that has become uncontrolled because of medication discontinuation; the third has an eating disorder, and the fourth is in need of accommodation because of pregnancy.

The rerun attempts to teach the following principles:

- Sub-optimal performance needs to be evaluated
- Sub-optimal performance has ramifications for patient care
- Sub-optimal performance needs remediation.

PROGRAM TEACHING POINTS

SUB-OPTIMAL PERFORMANCE, BEHAVIOR, AND RESIDENT STRESS

All residency programs have at one time or another been faced with the need to manage residents who develop physical or psychological problems. Disabilities or

maladaptive behaviors may surface under demanding circumstances or in pressure situations in very bright, high achievers. In a stressful environment such as a residency program, even a normal condition like a pregnancy can impact performance. Any trainee who has previously performed well and who begins to manifest problems of one kind or another should be carefully monitored. Also, residency programs admit individuals who have disabling conditions but who are, as the language of the ADA puts it “otherwise qualified.” Fortunately much can be done to help individuals with medical conditions function well, even under less-than-optimal conditions.

PROBLEM RESIDENT: DEFINITION AND UNDERLYING CAUSE

A problem resident is defined by the Academy of Internal Medicine as “a trainee who demonstrates a significant enough problem requiring intervention by someone of authority, usually the PD or chief resident.” One national survey of internal medicine residency PDs reported that about 7% of residents manifested behaviors that indicated difficulties, ranging from insufficient medical knowledge to unacceptable moral or ethical behavior.

APPARENT DEFICIENCIES IDENTIFIED BY 298 INTERNAL MEDICINE PROGRAMS

- Insufficient medical knowledge
- Poor clinical judgment
- Inefficient use of time
- Inappropriate interaction with colleagues or staff
- Provision of poor or inadequate medical care to patients
- Unsatisfactory clinical skills
- Unsatisfactory humanistic behavior with patients
- Excessive and unexplained tardiness or absences
- Unacceptable moral or ethical behaviors

Yao DC, Wright SM. National survey of internal medicine residency program directors regarding problem residents. *JAMA*. 2000;284:1099-1104.

The underlying causes of the behaviors included conditions such as pregnancy; stress; depression; cognitive problems that include learning disabilities or attention deficit hyperactivity disorder; psychiatric illnesses that include bipolar or personality disorders; drug and alcohol abuse; medical problems such as diabetes, asthma, and chronic pain, and personal problems such as heavy domestic responsibilities or disturbances in primary relationships.

DISCUSSION QUESTIONS

- How common are “problem residents” in your institution?
- What kinds of issues, in your experience, arise most frequently in residents?
- What are the policies/procedures of your program to resolve the issues?

No PD should attempt to diagnose or evaluate etiologies of poor performance or inappropriate behaviors in residents. PDs, by definition, must function in critical educational roles and as such are evaluators. Any attempt to act as the resident's physician and thus to mix roles, dilutes the pedagogical relationship. Instead, PDs should concentrate on identifying any behavioral or performance problem manifested by a resident and, if necessary, arrange for an evaluation. The focus should always remain on describing as objectively as possible the specific performance and/or behavior in question.

Clearly defining the problem and/or behavior can be an extremely helpful first step. The problem should be stated objectively, concretely, and non-judgmentally. Other useful strategies include providing feedback to the resident to inform him/her of progress in achieving whatever goals need to be met; assigning a mentor who can help provide structured supervision (if acceptable, allow the resident to have input into selecting the mentor), and creating a learning contract for corrective action with a timeline for improvement. If the situation involves patient or resident safety, the timeline may span minutes to hours as compared with days to weeks.

Remediation or probation, which can be a good motivator, constitutes a more formal process of defining the performance or behavior that needs to change, and suggests a period or timeframe during which there will be close monitoring. If this alternative is selected, it is important to determine how the resident will be evaluated, and how frequently. All PDs should be familiar with their institution's policies. If no policies exist, they should be developed.

DISCUSSION QUESTIONS

- What resources exist in your institution to evaluate and manage problems with residents?
- Do you have written policies that guide the evaluation, treatment, and rehabilitation process from beginning to termination?

LETTER: NOTIFICATION OF REMEDIATION

Text for Button B

Programs should explore the policies/procedures in their institutions. These are frequently found in the sponsoring institution's bylaws and human resources policies. Some programs use the term "probation"; others prefer "remediation" or "corrective action" (or a term other than probation). Terms such as "corrective action" or "remediation" may be less pejorative than "probation." Some programs deem that residents are in an educational program and are not expected to be perfect or to know it all. Avoiding the use of the word probation may allow programs not to report to entities such as the National Practitioner Data Bank, and may allow trainees to respond truthfully to future inquiries: "No, I have never been placed on probation" (many licensing bodies and future hospital staffs frequently inquire about prior probationary episodes). It may not be best for trainees to have to admit to having been on probation, especially after having successfully completed corrective action.

Programs are advised to work closely with their own legal experts to make sure they are using appropriate language for their own setting

Provide sufficient notification for any termination or non renewal of contract. The ACGME states that (usually) a resident must be given 4 months notice before termination of his/her contract.

Finally, in some states, "probation" must be reported to the Medical Board or to the National Practitioner Data Bank.

After identifying suboptimal performance or behavior, programs should work with their resources (occupational health unit, legal department, human resources) to develop a plan, taking into account their own institutional/programmatic bylaws.

The following typify letters to a resident outlining poor performance and/or unacceptable behavior:

[Date]

S. Smith, MD*

Department X

University Hospital X

Dear Dr. Smith:

This letter is to inform you that, effective today, you are being placed on remediation until [date]. The reason for the remediation is that, based on its review of your performance (including an assessment of your evaluations) the Program Education

Committee has determined that you fail to meet the expectations of a first-year resident in our field:

1. Basic examination techniques—you have not mastered techniques such as [name several]; you have not completed the basic [field] skills examination sheet and signed it with Dr. Jones*; you continue to miss key findings on patient examinations.
2. Fund of knowledge (Note: Make certain your residency review committee program requirements allow you to use in-service training examination scores for promotion and program completion; some specifically disallow the use of such scores in this way)—your knowledge base is below that expected at your level of training; your in-service training examination score is [number]% (below the [number] percentile we require of our residents and which is stipulated in our resident manual of program policies and procedures.). You need to read more and demonstrate your knowledge in conferences and clinics. Work with your advisor to take one practice test per month [dates, e.g., February–April] and hand it in to your advisor to be graded. You must score higher than [number]% on these practice tests
3. Completion of assignments in a timely fashion—per your last two rotation evaluations, you have not followed through with specific instructions from attendings. These include failure to order detailed diagnostic and/or therapeutic plans they discussed explicitly with you.
4. Clinic flow—you have not been able to maintain a reasonable flow of patients in your clinic; per your 360 evaluations, patients are left waiting longer than our clinic average (several patients left the clinic without being seen; four patients wrote letters to complain of waiting times).
5. Presentations—your presentations lack sufficient preparation; for example, you could not summarize the patient's history during a particular conference on [date].
6. You failed _____ rotation.

Dr. Casey* has agreed to be your mentor. The Education Committee of the faculty will meet every 4 weeks to assess your progress and will review the documentation made available by you, Dr. Casey, your rotations, and your monthly multiple choice test. A 360 evaluation will be repeated in two months. The specifics of remediation are included in your remediation plan (attached).

LETTER: NOTIFICATION OF REMEDIATION (CONT'D)

Text for Button B

You will be given formal written feedback each time the Education Committee meets. If you have not made satisfactory progress in 4 months, the program will notify you that it will not renew your contract at the end of this academic year. If you have made satisfactory progress, the remediation period will end, and you will be expected to perform on par with your peer residents. If you make substantial progress, but have not completely remedied these issues, the remediation period will be extended and may be modified as needed to reflect your progress.

You will need to repeat the rotation that you failed and demonstrate minimum competency. The repeated rotation will be [dates]. Having to repeat this rotation will extend your training. by [number] weeks. Your new anticipated date of completion, assuming successful completion of all program components is [date]. The Board will be notified of your new anticipated completion date.

Sincerely,

J.Doe, MD*

Residency Program Director

I have received the above, and I have read and understand the expectations.

(Signed) S. Smith, MD

*None of the names in this document refer to actual people

It is recommended you add your institution-specific peer-review language to this document, e.g.: "This evaluation is confidential and is intended only for the program's use and that of the trainee. The information contained herein may be confidential under the attorney/client privilege and/or the quality-assurance and peer-review privilege."

Some programs might give resident the option to resign.

It is advisable to put in writing for the trainee what the final summary of the program will be, e.g.: "This confirms that Dr. [name] entered the [field, e.g., obstetrics] residency program [date] and [appropriate terminology, e.g., "resigned" or "his/her contract was not renewed"]. Dr. [name] successfully completed [number] months of training, specifically in [fields]."

LETTER: NOTIFICATION OF REMEDIATION (CONT'D)

Text for Button B

"An assessment of his/her competencies indicates [key items in assessment].The [field] Board was notified of this [date]."

[Date]

S. Smith, MD*

Department X

University Hospital X

Dear Dr. Smith:

This letter details our previous discussion on [date]. As you were informed, and effective immediately, you have been placed on remediation. The reasons for the corrective action and the plan for remediation are outlined below. You can appeal this decision by writing to [name] within 14 days of receipt of this letter. I have enclosed the pertinent pages from [name of document] that fully describe the appeals process [or direct the resident to XXX Manual or Web site for a description of the appeals process].

The reason[s] for the corrective action are as follows:

(The following are examples, i.e., episodes describing deficient or unprofessional behavior that can occur either with patients, peers, or staff; document in the resident's file any specific deficiency or behavior).

- Lack of sufficient didactic knowledge and organizational skills required to manage patients with illnesses typical of our specialty, as judged by [provide name of evaluating method, e.g., faculty evaluations; in-service training examination; other testing such as Objective Structured Clinical Examination]. Specific examples of these deficits have been documented and placed in your file
- (Note: Make certain your residency review committee program requirements allow you to use inservice training examination scores for promotion and program completion; some specifically disallow the use of such scores in this way) Your scores on the national in-service training examination fall short of the [number] percentile, required for [event—e.g., promotion, graduation continuation in our program].Your scores have not improved (or have declined) despite a specific educational plan put in place after last year's examination results. In fact, they are so low this year that it is unlikely you will be able to pass the written certifying examination in another year
- Compromise of patient safety (or dereliction of duty to patients), specifically the following episode(s): [examples]

LETTER: NOTIFICATION OF REMEDIATION (CONT'D)

Text for Button B

- Failure to achieve the minimum level of competency for professionalism expected by our program as detailed in [specify—e.g. residency manual]. We note specifically [example/s], which occurred in spite of the following earlier remediation plan [details of plan]
- Failure to achieve the minimum level of competency for interpersonal communication as demonstrated by failure to adequately communicate in a timely fashion with supervisors, through dictations, etc.

The specific expectations for and monitoring of your improvement are as follows:

- Your behavior with patients and staff will be professional at all times. Your advisor, Dr. [name] will:
 - Elicit monthly the opinions of all supervisors and staff with whom you have been in contact, and monitor the survey opinions that come in from patients under your care during these rotations
 - Meet with you monthly to discuss this information and give you feedback on your progress
 - Provide you with a written summary of this feedback; a copy will be retained for your file
- Your didactic and organizational skills must improve substantially
 - This will be judged by either a weekly meeting with the ward attending to go over all your histories and physicals and your management plans, or a random audit of one-fourth of them for that week
 - You will be expected to be able to justify—on the basis of evidence from the medical literature—the management plans you selected
 - We expect you to achieve a minimum level of [number] percentile national score for your training year at the time of the in-service examination on [date], as expected of all of our trainees and as outlined in [source—e.g., residency manual, promotion criteria outline, etc.]

Additionally, you will:

- Complete the suggested reading list during the next 4 months
- Meet with the faculty member noted for each section to discuss the topics covered by the reading list
- Complete weekly practice tests, taken from prior in-service training examinations
- You will be expected to demonstrate professional responsibilities that enhance patient safety:
 - Carry out all assigned duties, including night, weekend, and holiday call assignments

LETTER: NOTIFICATION OF REMEDIATION (CONT'D)

Text for Button B

- Answer all pages within a reasonable period of time unless engaged in urgent care of a patient
- Report to your advisor, Dr. [name], who will meet with you monthly to discuss your progress and the timeliness of your attention to assigned duties, as monitored and reported on by the chief residents and the ward attending

The duration of probation/remediation/corrective action will be [number] months, or until approximately [date]. At that time, the decision will be made either for your return to active status, or for further continuation of the probation/remediation/corrective action for an additional period of time, or for non-renewal (termination) of your contract for the next training year.

The events of the last [time frame] have obviously been very stressful for you. I strongly encourage you to consider counseling. Please recall that you can obtain confidential counseling through [institutional/hospital/community resources]. A list of other resources external to the program/institution is also available should you prefer.

If you wish to review your file please let me know and I will ask [name] to retrieve it for you.

I speak for our entire faculty in expressing hopes that you will be able to correct your deficiencies and achieve success in our program.

Sincerely,

J.Doe, MD*

Residency PD

cc: GME office

[resident/fellow's name] file

I have read the above statement and understand the terms of my remediation.

(Signed) S. Smith, MD

* None of the names in this document refer to actual people.

Make certain any evaluation such as this is consistent with your institution's policies and procedures. In some cases, it may be possible to appeal a routine remediation plan; in other cases appeal might be only at the prerogative of the PD and faculty.

LETTER: NOTIFICATION OF REMEDIATION (CONT'D)

Text for Button B

Consider a program evaluation council so that any issue of suboptimal performance behavior is considered by a group of faculty and not just the individual PD. This may help the PD function to some extent as an advocate, communicating the decision of the faculty group, rather than setting up a one-on-one adversarial relationship between the PD and the trainee.

It is recommended you add your institution-specific peer-review language to this document, e.g.: "This evaluation is confidential and is intended only for the Program's use and that of the trainee. The information contained herein may be confidential under the attorney/client privilege and/or the quality-assurance and peer-review privilege."

Some programs might give resident the option to resign.

It is advisable to put in writing for the trainee what the final summary of the program will be, e.g.: "This confirms that Dr. [name] entered the [field, e.g., obstetrics] residency program [date] and [appropriate terminology, e.g., "resigned" or "his/her contract was not renewed"]. Dr. [name] successfully completed [number] months of training, specifically in [fields]. The last date in the program was [date].

"An assessment of his/her competencies indicates [key items in assessment]. The [field] Board was notified of this [date]."

Strict behavioral/performance guidelines should be provided. The resident needs to know what he/she must do to succeed. A realistic timeline during which there will be closer scrutiny and regularly scheduled feedback should be developed. The consequences of a continued poor performance within the timeframe should be determined. The consequences may include coming off probation/remediation/corrective action, extending probation/remediation/corrective action, or even termination or non-renewal of contract. All progress or lack of progress should be carefully documented. Resist the tendency to diagnose the reason. Instead, refer to the employee and occupational health clinic, or a state PHP. Know the appropriate resource in your institution that may be used. For the program direction, it is most important to know when the resident can return to work, and what accommodations, if any need to be made—but not the details of the specific diagnosis and medical management.

**LETTER: PLAN OF REMEDIATION DURING PERIOD OF
CORRECTIVE ACTION**

Text for Button C

[Date]

S. Smith, MD*

Department X

University Hospital X

Dear Dr. Smith:

Your plan of remediation consists of:

1. You will work with Drs. Jones*, Casey*, and Dervavich* as designated on your rotation schedule. In addition, your Tuesday clinic with Dr. Sheehan* will be changed to clinic with Dr. DeSanto* beginning [date]. You should seek the assistance of these attendings in clinic to help you with any part of the examination with which you are not comfortable. They will assess your examination skills during supervised clinics and will provide feedback to you on your progress. At the end of each clinic session they will complete a written evaluation and forward it to my office for your file. You are free to come by my office and see these at any time. You should complete each written note and have it signed by Dr. Sheehan by [date].
2. You should complete all reading assignments given to you by the faculty. In addition, you should read the following assignments: [specify material] by [date], and you will be tested on this material. You should read about specific patients' problems that you encounter in clinic and be prepared to discuss these patients with attendings.
3. You will be assigned no more than five patients per half day in your Friday afternoon clinic.
4. You should practice your patient presentations with Dr. Jones* before giving them to the department, so that she can provide recommendations for improvement. You should know all the pertinent details regarding any case that you are going to present.
5. You should call the graduate medical education (GME) office at [phone number] to make an appointment to meet with Dr. Scurlock* within the next 2 weeks.
6. We will meet (weekly, every other week, monthly) to review your progress. Please see me if you have any questions regarding specifics of your remediation.

**LETTER: PLAN OF REMEDIATION DURING PERIOD OF
CORRECTIVE ACTION (CONT'D)**

Text for Button C

Sincerely,

J.Doe, MD*

Residency Program Director

I have read the above statement and understand the terms of my remediation.

(Signed) S. Smith, MD*

*None of the names in this document refer to actual people

It is recommended you add your institution-specific peer-review language to this document, e.g.: "This evaluation is confidential and is intended only for the program's use and that of the trainee. The information contained herein may be confidential under the attorney/client privilege and/or the quality-assurance and peer-review privilege."

Some programs might give resident the option to resign.

It is advisable to put in writing for the trainee what the final summary of the program will be, e.g.: "This confirms that Dr. [name] entered the [field, e.g., obstetrics] residency program [date] and [appropriate terminology, e.g., "resigned" or "his/her contract was not renewed"]. Dr. [name] successfully completed [number] months of training, specifically in [fields]."

LETTER: FEEDBACK DURING PERIOD OF CORRECTIVE ACTION

Text for Button D

[Date]

S. Smith, MD*

Department X

University Hospital X

Dear Dr. Smith:

The Program Education Committee of the faculty met on [date] and discussed

LETTER: FEEDBACK DURING PERIOD OF CORRECTIVE ACTION (CONT'D)

Text for Button D

your progress in the residency program. This letter is to provide you with formal feedback from that discussion.

Previously identified areas of deficiency were:

1. Basic examination techniques—you have made progress; however, you continue to miss key findings on patient examinations.
2. Fund of knowledge—your knowledge has improved; your application of that knowledge to patient care is lacking.

Additional areas of deficiency:

3. Completeness of history and physical—you often fail to take a complete history or to perform the examination necessary to make the correct diagnosis.
4. Clinical judgment—you frequently fail to take into account the important historical facts and examination findings that would enable you to develop a logical problem list, differential diagnosis, overall assessment, and management plan.
5. Practice examinations—you have returned each of the practice examinations on schedule, with a current average of 89% on the examinations.
6. Clinic flow—you seem able to see the five patients assigned to you in a timely fashion, so they do not have a long wait time. However, your notes are not always as comprehensive as those of your peers.
7. Participation at conferences—it is difficult to judge your participation at conferences. You are quiet, and when you do speak, the faculty report that you are barely audible.

The Program Education Committee believes your performance has improved, although you are still not performing on a par with your peers. Because there has been some improvement, and you have been working hard, the committee is extending your corrective action for an additional 2 months. During this time, you are expected to:

1. Take an oral examination given by me on [date and time] on the contents of your assigned reading.

LETTER: FEEDBACK DURING PERIOD OF CORRECTIVE ACTION (CONT'D)

Text for Button D

2. Complete all the book assignments before that examination.
3. Study all the attachments; use these as a guide for all patient encounters. One chart will be selected at random after each clinic session for an audit to determine if your notes follow this guide.
4. Work closely under the supervision of Drs. Jones*, Casey*, Dernavich*, and Sheehan* beginning [date]. Present all patients in your comprehensive clinic to the supervising attending physicians.
5. Speak loudly and clearly at conferences and grand rounds so that all participants can hear you.

The Program Education Committee of the faculty will meet in 4 weeks and in 8 weeks to assess your progress. You will be given formal written feedback each time the faculty meets.

The faculty expects that by [date] you will have made sufficient progress to be able to function as a second year resident beginning [date]. You must demonstrate the knowledge, judgment, and ability to care for patients at a level expected of a second-year resident and to supervise incoming first-year residents. If satisfactory progress has not been achieved, your contract will not be renewed. You will be notified before any dismissal action and will be given a copy of the hospital's appeals mechanism.

Sincerely,

J.Doe, MD*

Residency Program Director

I have read the above statement and understand the terms of my remediation.

(Signed) S. Smith, MD*

*None of the names in this document refer to actual people.

It is recommended you add your institution-specific peer-review language to this document, e.g.: "This evaluation is confidential and is intended only for the program's use and that of the trainee. The information contained herein may be

LETTER: FEEDBACK DURING PERIOD OF CORRECTIVE ACTION (CONT'D)

Text for Button D

confidential under the attorney/client privilege and/or the quality-assurance and peer-review privilege.”

Some programs might give resident the option to resign.

It is advisable to put in writing for the trainee what the final summary of the program will be, e.g.: “This confirms that Dr. [name] entered the [field, e.g., obstetrics] residency program [date] and [appropriate terminology, e.g., “resigned” or “his/her contract was not renewed”]. Dr. [name] successfully completed [number] months of training, specifically in [fields].

“An assessment of his/her competencies indicates [key items in assessment]. The [field] Board was notified of this [date].”

LETTER: EXPECTATIONS AND RECOMMENDATIONS TO PURSUE DISABILITY CONSULT

Text for Button E

[Date]

S. Smith, MD*

Department X

University Hospital X

Dear Dr. Smith:

This letter, which is in follow-up to our meeting, confirms in writing your current standing and the program’s expectations in order for you to continue in this residency. This letter will be your last and final warning, and will serve as a remediation/probation/corrective action plan for the time period [inclusive dates]. Successful completion of these specific expectations and of those delineated in the residency manual will result in promotion to your third year of residency at the conclusion of this academic year. Any deviation from these expectations will result in termination of your residency position within this department.

You are currently repeating the second year of residency training. This action was the result of not meeting the requirements for successful completion of your second year and your failure to successfully remediate the issues outlined in your corrective action [date]. The issues include:

- Failing two major rotations, constituting 6 months of Year 2
- Recurrent absenteeism, with lack of communication about your absences in spite of the prior corrective action

LETTER: EXPECTATIONS AND RECOMMENDATIONS TO PURSUE DISABILITY CONSULT (CONT'D)

Text for Button E

- Consistent faculty comments indicating that you have not sufficiently mastered the skills and knowledge of a second-year resident
- Some concerns regarding judgment and professionalism: not coming in on two occasions to care for your assigned patients and not calling anyone to indicate you would be unavailable. The lapses potentially jeopardized patient safety
- Absenteeism at the annual required residency research forum
- Sub-optimal performance on the in-service training examination (you were at the [number] percentile, compared with the [number] percentile required by our program for advancement)

Because of your absenteeism and poor performance, we do not believe you are ready to advance to the third year of our residency. Our third year requires more independence, greater skill, and the ability to teach and supervise others. This, in turn, requires a demonstrated strong fund of knowledge and mastery of first and second-year core material, as well as a track record of responsible judgment.

Our Program wishes the best for you and your career, but for you to continue, you must fulfill all of the clinical duties expected of you as outlined in the residency manual. Expectations include, but are not limited to, the following, wherein you must:

- Be reliable and on time (within 5 minutes of the start of clinic or other day's session)
- Be present for the full duration of your clinical activities
- Participate in all patient care activities and complete the clinical content of all assigned rotations in a competent manner
- Complete a research project this year, submit an abstract, and participate in the activities of the research day
- Inform your respective attending and me, your PD, of each and every time you will be absent, BEFORE the beginning of the half-day in which the absence will occur (informing a member of the nursing staff is not sufficient)
- Bring a note from your doctor, within 72 hours of any medical absence
- Perform at or above the [number] percentile on the annual in-service training examination
- Pass all of your clinical rotations during this academic year; if you fail any of your rotations during this academic year, you will not be allowed to repeat them

If you are unable to comply with any of these requirements, your contract will be terminated.

LETTER: EXPECTATIONS AND RECOMMENDATIONS TO PURSUE DISABILITY CONSULT (CONT'D)

Text for Button E

I would like to bring to your attention one of the resources available to all members of our community. Attached to this letter is information highlighting the hospital's procedure for exploring coverage and reasonable accommodations for the purposes of the Americans with Disabilities Act (ADA). There is a description of the reasonable accommodation process, reasonable accommodation request form, and documentation criteria for several common conditions (e.g., ADHD, learning disability, mobility-related impairments, psychological impairments, and low vision impairments). I strongly urge you to review this information and contact the [title, e.g., accommodations director] of the local ADA [contact information] office by [date] to discuss options or any questions you may have about the process. If you feel you have a disability and wish to receive accommodations you must activate this process.

I recommend we meet every other week to review your performance and attendance, together with a faculty member of your choice who will serve as an advisor for you. I will put in writing any feedback I receive regarding your performance and attendance at those meetings.

Sincerely,

J.Doe, MD*
Residency Program Director

I have read the above statement and understand the terms of my remediation.

(Signed) S. Smith, MD

*None of the names in this document refer to actual people.

It is recommended you add your institution-specific peer-review language to this document, e.g.: "This evaluation is confidential and is intended only for the program's use and that of the trainee. The information contained herein may be confidential under the attorney/client privilege and/or the quality-assurance and peer-review privilege."

Some programs might give resident the option to resign.

It is advisable to put in writing for the trainee what the final summary of the program will be, e.g.: "This confirms that Dr. [name] entered the [field, e.g.,

LETTER: EXPECTATIONS AND RECOMMENDATIONS TO PURSUE DISABILITY CONSULT (CONT'D)

Text for Button E

obstetrics] residency program [date] and [appropriate terminology, e.g., “resigned” or “his/her contract was not renewed”]. Dr. [name] successfully completed [number] months of training, specifically in [fields].

“An assessment of his/her competencies indicates [key items in assessment]. The [field] Board was notified of this [date].”

To refer appropriately, the PD should be knowledgeable about available resources, what they can handle, what services they offer, and how to access them.

Resources might include skill improvement, sources of study skills, time management, and communication workshops often available through human resources, “the employee health service (including employee assistance programs) other local services, and, finally, the state physicians health plan. Thorough familiarity with these resources will enable the PD to direct residents to services and thereby facilitate the process of remediation.

DISCUSSION QUESTIONS

- What resources does your institution have?
- What kinds of problems in performance or behavior are they equipped to handle?
- What services are offered?
- Do you know how to access them?

LETTER: NON RENEWAL OF CONTRACT

Text for Button F

[Date]

S. Smith, MD*

Department X

University Hospital X

Dear Dr. Smith:

I am very sorry to inform you that you will not be offered renewal of your contract for the next academic year. The Program Education Committee of the faculty met and discussed your progress in the residency program. The faculty decided unanimously that this action be taken.

The reason for your dismissal is that you have been unable to make sufficient progress in the previously identified areas of deficiency that led to your two periods of corrective action. These areas are:

1. Basic examination techniques—you continue to miss key findings on patient physical examinations.
2. Completeness of history—you frequently fail to take a complete history and/or use the patient's medical record to obtain important information.
3. Clinical judgment—you frequently fail to take into account the important facts and examination findings to develop a logical problem list, differential diagnosis, overall assessment, and management plan. Although your knowledge has increased, your clinical application is deficient.
4. Presentations—your patient presentations in clinic are frequently marred by the lack of a methodic approach in relating the patient's history, physical examination findings, assessment, and treatment approach.

You have the right to appeal this decision; a copy of the appeal procedure is included with this letter.

Sincerely,

J.Doe, MD*
Residency Program Director

I have read the above.

(Signed) S. Smith, MD

*None of the names in this document refer to actual people.

It is recommended you add your institution-specific peer-review language to this document, e.g.: "This evaluation is confidential and is intended only for the program's use and that of the trainee. The information contained herein may be confidential under the attorney/client privilege and/or the quality-assurance and peer-review privilege."

Some programs might give resident the option to resign.

It is advisable to put in writing for the trainee what the final summary of the program will be, e.g.: "This confirms that Dr. [name] entered the [field, e.g., obstetrics] residency program [date] and [appropriate terminology, e.g., "resigned" or "his/her contract was not renewed"]. Dr. [name] successfully completed [number] months of training, specifically in [fields]. "An assessment of his/her competencies indicates: The [field] Board was notified of this [date]."

REFERRING THE RESIDENT: WHAT DOES THE PD NEED TO DO?

When the PD does refer a resident, he/she should provide careful documentation of the issue at hand and should request of the resource/consultant a careful, comprehensive evaluation. To achieve this, referral resources need to understand their role. Ideally the consultant will have experience treating physicians, because it is well known that these individuals are notoriously challenging to care for as patients. The referral resource should also be able to treat as well as manage and monitor any condition that is diagnosed.

Once the performance or behavioral problems have been addressed, the resident is then deemed "fit for work," and is then ready to return to duty. The PD can then resume monitoring performance and professional behaviors.

LEARNING DISABILITIES AND THE ADA (ADA)

Learning impairments frequently remain undiagnosed until adulthood; consequently, it is not unusual to find some residents with learning disabilities (LDs). In most cases, the condition will not be severe enough to affect medical training, or the resident will have found ways to compensate. Most residents will not qualify for coverage under the ADA, as they have demonstrated ability for learning well above the average individual. Consider, for example, that such individuals have been quite successful in completing college as well as gaining admission to and completing medical school. When an LD does emerge, it undoubtedly constitutes a response to the pressures and time constraints of residency.

If an LD materializes or is suspected, the resident should be directed to specialized services by the mentor, the PD, the employee assistance program, or others. This situation should be managed as are all others.

Let us use as an example inadequate knowledge as demonstrated on standardized testing.

- First, define the problem
- Intervene with constructive counseling
- Provide direction for accessing appropriate resources
- Draw up a timeline for improvement

Note that your expectations for demonstrating competence in the testing situation will not change, but some modifications, such as extending the testing time, may be an option. Some boards have a specific process that must be used for accommodations, such as extended time to be granted to the trainee. Others leave this up to the discretion of the PD. Some boards have a process to consider accommodations, such as extended time for the actual Board examination. In some cases, one of the elements of required documentation is whether the trainee received similar accommodations on the in-service training exam.

All residents, as with all employees, must be offered the opportunity to explore coverage under the ADA. However, even if the resident is not deemed a covered individual, a program may elect to make accommodations, such as allowing the resident more study time to take an examination, a certain number of retakes, or oral (versus written) examinations. Such a step should be taken with great care, after insuring such permission is within the ability of the program to grant (and doesn't require a formal process from the distributors of the in-service examination). In addition, such a step may set a precedent that will alter a program's residency standards.

Programs should also develop technical standards regarding what their residents are specifically required to do (e.g., what lifting and repetitive motion, what auditory acuity and communication skills are required for education and patient safety). The following are just a few examples of technical standards that might be adopted, and by no means cover the range of physical and mental skills and abilities needed for successful completion of a medical school curriculum:

1. Observation

- Observe materials in the learning process (e.g., written documents, microscopic examination of microorganisms, audiovisual presentations, diagnostic images, etc.)
- Observe patients (requires vision, hearing, sensation)

2. Communication
 - Speak, write, hear, read, clearly in a way that is understandable by others
 - Use a keyboard, computer
3. Motor
 - Use palpation, auscultation, and percussion to elicit information from patients
 - Be able to move as well and swiftly as required to give general medical care and emergency treatment, e.g., coordination of gross and fine motor movements, equilibrium, and sensation
 - Have sufficient motor and sensory skills as to be able to perform the necessary procedures required
4. Work long hours (up to 80 hours per week) with on-duty periods of up to 30 hours at a time, with no control over scheduling breaks
5. Be able to multi-task—to set priorities quickly among many competing demands in high-risk situations, many of which are largely outside of the individual's control
6. Respond to honest feedback regarding areas for improvement
7. Develop progressively more independence in learning, identifying one's own weakness, and knowing the necessary learning plans to address

A list similar to the above should be individualized to your specialty, encompassing the full range of abilities required (e.g., intellectual, attitudinal, psychomotor, social, and emotional) to complete residency.

APPLICANTS AND THE ADA

We need now to examine how to handle the admissions process for applicants with disabilities that transcend any particular context. It is to these kinds of disabilities that the ADA most applies.

Perhaps the most important feature of the ADA is its requirement that residency programs develop accurate job descriptions that clearly outline the essential features or functions that all residents, including disabled ones, must be able to perform.

ADA

Requirements of the ADA

- Develop accurate job descriptions
- Outline the essential performance features or functions

Losh DP, Church L. Provisions of the ADA and the development of essential job functions for family practice residents. *Fam Med* 1999;31:617–621.

Disabled individuals are defined by the ADA in three ways: as a person who has a physical or mental impairment that substantially limits one or more of the major life activities of the individual; as a person with a record of such an impairment, or as a person regarded as having such an impairment. State law may differ on conditions that meet the criteria for disability status. Many medical schools have graduated individuals who are wheelchair bound, hearing impaired, and blind, who would qualify under this act.

DEFINITION OF DISABLED

A person who

- Has a physical or mental impairment that substantially limits one or more of the major life activities of the individual
- Has a record of such an impairment
- Is regarded as having such an impairment

Facts About the ADA. Accessed May 9, 2004.

<http://www.eeoc.gov/facts/fs-ada.html>

CASES THAT HAVE SHAPED DISABILITY SERVICES

Text for Button H

SOUTHEASTERN COMMUNITY COLLEGE V.DAVIS, 442 U.S. 397 (U.S. SUPREME COURT, 1979)

Summary: The nursing school rejected the application of a student who had a hearing impairment. The school believed that the student would be unable to satisfy the clinical requirements of program. The school was unwilling to allow the student to waive out of the clinical components of the program or to assign an

aide to help her communicate in a clinical setting. The Supreme Court determined that Section 504 did not require the College of Nursing to admit the student. The Court's rationale was that 504 did not prohibit institutions from establishing physical qualifications for admission to the clinical program and that the accommodations requested by the student amounted to "affirmative action" that was not required under 504. The Court defined "otherwise qualified" as a person who can meet all of the program requirements in spite of "handicap."

Key Points: Technical standards are permissible; the ruling begins to define "otherwise qualified"; it sets forth an analysis to determine what accommodations are reasonable (required) and what accommodations would impact the essential elements of a program (not required).

PUSHKIN V. REGENTS OF THE UNIVERSITY OF COLORADO (10TH CIR. 1981)

Summary: Pushkin was a physician with multiple sclerosis applying for a medical residency at the University of Colorado Psychiatry unit. He was denied admission. Those in the interview committee justified their decision to deny him admission, stating that (a) they were concerned with how patients would react to Dr. Pushkin; (b) they felt Dr. Pushkin had not come to terms with his disability, and that this would affect his ability to treat patients; (c) Dr. Pushkin would not be able to handle the stress on the job because of his condition; and (d) that Dr. Pushkin would require too much medical care to be able to satisfy the requirements of the job. The members of the admissions committee gleaned all this from a 45-minute interview. Dr. Pushkin's therapist offered testimony stating his belief that Dr. Pushkin would be able to handle the stress of the job. Dr. Pushkin offered information on how he would handle his need for on-going medical treatment. The 10th Circuit found that the residency program had discriminated against Dr. Pushkin.

Key Points: *Pushkin* makes clear that there must be an individualized inquiry into the circumstances of each individual and that broad stereotypes of the limitations of individuals with various disabilities are not properly the basis of a decision that someone is not otherwise qualified. Typical applications in higher education involve students in clinical placements or teacher education programs. *Pushkin* teaches that we may not stereotype students with disabilities when deciding whether they are otherwise qualified for such programs, but rather consider how each individual student can or cannot meet program requirements.

WYNNE V. TUFTS UNIVERSITY SCHOOL OF MEDICINE, 976 F.2D 791, 932 F.2D 19 (1ST CIR. 1992 AND 1991 (EN BANC))

Summary: Wynne was a medical school student with an LD appealing his academic dismissal on the basis that Tufts had not properly accommodated his disability. Most critically, Wynne had wanted Tufts to refrain from using multiple-choice examinations when testing him. Tufts refused this accommodation request. Initially the First Circuit was unwilling to accept Tufts' explanation as to why it would only use multiple choice tests. The Court indicated that, while some deference was owed to an institution making academic judgments, such institutions nevertheless have a duty to seek out reasonable means of accommodating students with disabilities. The Court further indicated that to conscientiously carry out this duty, institutions should show that relevant officials considered reasonable means of accommodating a student, considered their feasibility and effect on the program, and came to a justifiable conclusion that providing such accommodations would result in lowering academic standards or substantially modifying the program in question. When the matter came back to the Court a second time, the Court accepted Tufts' explanation that critical thinking skills were taught by use of multiple-choice examinations and therefore allowed the dismissal of Wynne to stand.

Key Points: *Wynne* tells us what thought process an institution should go through before refusing to provide an accommodation on the basis that doing so would lower academic standards and /or substantially modify a program of study. In essence, an institution should show that (a) officials with relevant duties and experiences considered the accommodation request; (b) they meaningfully considered the impact on the program and the availability of alternatives; and (c) they reached a rational conclusion that accommodations could not be offered. *Wynne* Clarifies "otherwise qualified" to mean "can complete program requirements with or without reasonable accommodation."

OHIO CIVIL RIGHTS COMMISSION V. CASE WESTERN RESERVE UNIVERSITY (CWRU), 666 N.E.2D 1376 (OHIO SUP CT. 1996)

Summary: A blind applicant to the CWRU Medical School was denied admission and filed suit under state disability law that used the same statutory language as the Section 504 regulations. In finding for the university on the basis that the student was not otherwise qualified, the Court majority relied heavily on an Association of American Medical College technical standard that medical school candidates must have an ability to "observe." The majority opinion identified

various tasks that the student would be unable to do, such as insert an IV or directly observe an x-ray and make independent judgments. The majority ignored experiences of a blind medical school graduate (Hartman) who had attended the Temple University Medical School as not “probative.” Dissenting opinion seemed to believe that reasonable accommodation existed given the experiences of Hartman at Temple.

Key Points: The fundamental question is how far one has to go to accommodate someone before the accommodation becomes “unreasonable.” Both majority and dissenting opinions handle this issue poorly in our view. Hartman’s experience at Temple was important, but not for reasons cited by the dissenters. Temple found it necessary to provide constant one-on-one assistance to Hartman, to exempt him from certain requirements, and to do so at cost of help to other students. This amounts to a substantial change in the way in which the program is taught and the provision of personal aides that go above and beyond what relevant law requires. In that respect, if Temple’s handling of Hartman is the only way that a student can complete the requirements, it is not reasonable to require this of an institution. The facts show what an example of “undue burden” might be. The decision also stands for the proposition that a school can require that its graduates be able to perform a full range of functions (i.e., to be generalists) and need not make an accommodation that exempts a student from certain pieces of a program that he/she cannot complete. For example, an arts school can require all graduates to complete “dance” even though they will not all necessarily have to dance to pursue their desired careers and even though students with mobility impairments may not be able to complete the requirement.

GUCKENBERGER V. BOSTON UNIVERSITY (BU), 974 F. SUPP. 106 (D.MASS. 1997)

Summary: A class action suit by students with learning disabilities was brought against BU, alleging discrimination principally because BU would no longer approve course substitutions for a foreign language requirement for students with learning disabilities. Using analysis in *Wynne*, the court ultimately determined that, if BU could establish by such a “deliberative process” that allowing a substitute for a foreign language requirement would either lower academic standards or substantially alter the program of study, it could refuse to permit course substitutions for students with LDs.

Key Points: The existence or merits of an LD as a diagnosis were never called into question by BU or the court. Course substitutions are not per se required as an

CASES THAT HAVE SHAPED DISABILITY SERVICES (CONT'D) Text for Button H

accommodation if the university can justify unwillingness to offer substitution through deliberative process, as outlined in *Wynne*.

Brian Rose, JD, Rutgers, The State University of New Jersey. Accessed May 9, 2004.
http://gwired.gwu.edu/dss/index.gw/Site_ID/32/Page_ID/12096/

DISCUSSION QUESTIONS

- What do you learn from these legal cases?
- What are the technical standards required in your residency?

According to Losh and Church (1999), the law states that no disabled person who is “otherwise qualified” can be rejected for employment because of a disability. The law also requires that when possible, reasonable accommodation should be made to help the disabled person perform the essential functions of the position.

EXAMPLES OF INCLUDED/EXCLUDED CONDITIONS DECIDED BY THE ADA AND SUBSEQUENT COURT CASES*

Conditions included as a disability**

Tuberculosis
AIDS
Alcoholism
Learning disabilities
Epilepsy
Hypersensitivity to smoke
Drug addiction
Obesity

Conditions excluded as a disability**

Intermittent depression or stress
Posttraumatic stress disorder
Chronic tardiness
Gender identity disorders
Sexual behavior disorders
Compulsive behavior disorders
(e.g., kleptomania and gambling)
Current illegal use of drugs
Temporary non-chronic condition
(e.g., broken leg)

* Helms LB, Helms CM. Medical education and disability discrimination: the law and future implications. *Acad Med* 1994;69(7):535–543.

** Individual state laws may significantly alter certain items listed in the above examples from federal law and subsequent cases. For example, in Washington state, gender identity disorders and temporary conditions may qualify for disability status.

From Losh DP, Church L. Provisions of the Americans with Disabilities Act and the development of essential job functions for family practice residents. *Fam Med* 1999;31:617–621.

Examples of *reasonable accommodation* include modification of equipment or barriers that impede access, job restructuring, providing part-time or modified work schedules, adapting training materials and policies, and providing equipment to assist the person in communicating.

ACCEPTABLE AND UNACCEPTABLE QUESTIONS FOR APPLICANTS OR ESTABLISHED RESIDENTS

Text for Button J

Programs may *not* ask:

- Questions about medical history or disability status on application materials
- If applicants have previously requested or received reasonable accommodation
- About an enrolled resident's medical condition, unless the need to do so is triggered by evidence of educational performance problems

Programs *may* ask:

- If the applicant can perform, with or without reasonable accommodation, the essential requirements and/or functions of being a resident. These functions include fundamental skills, attitudes, knowledge, and behaviors (all applicants should be asked the same questions)
- If the applicant has any condition that would prevent him/her from completing the curriculum/program
- An applicant, with a known disability that may interfere with essential functions, to document or demonstrate how he/she will be able to perform the essential functions with or without accommodation

Equal Employment Opportunity Commission. Regulations to implement the equal employment provisions of the Americans With Disabilities Act, 29 CFR Part 1630, Sect 1630. Bethesda, Md: US Government Printing Office, 1998.

From Losh DP, Church L. Provisions of the Americans with Disabilities Act and the development of essential job functions for family practice residents. *Fam Med* 1999;31:617-621.

There are two key concepts here that require further consideration: "reasonable," and "accommodation." The first, the concept of what constitutes "reasonable," may be relative in its application. What is reasonable for one hospital may not be for another. Larger programs and facilities will be expected to accommodate to a greater degree than smaller ones. A program that accepted someone with a known "challenge" will be expected to accommodate to a greater degree than a program that was unaware. The concept of "accommodation" is more nuanced than the concept of "reasonable."

The ADA may appear complex. To simplify, consider a resident in a program. For the sake of argument, assume that the program has accepted a resident with a seizure disorder—let us assume that the program knew nothing of the condition when he/she was recruited. The seizures have been under excellent control. But now the seizures resume, possibly due to the sleep deprivation from night call. Does the ADA require the PD to make “an accommodation” for the resident and remove him/her from the call schedule?

DISCUSSION QUESTIONS

- Discuss the implications of the concepts “reasonable,” and “accommodation,” as they might apply to your institution
- What are the limits of “accommodation” as it occurs in your institution?

Just because the resident did not declare a disability when he/she was hired does not exclude the need for evaluation and/or coverage in the future. For modifications in the call schedule, it must be demonstrated that he/she is covered under the ADA, that a schedule with less potential for sleep deprivation is an appropriate limitation, and that the accommodation for “no call” is “reasonable” for the program to implement as an employer.

In this example, it is unlikely that an employer could reject the resident’s need for adequate sleep as a reasonable accommodation unless something in the “on call” experience was considered intrinsic to residency training. Even then, it might be determined that night call be taken, e.g., to work with a particular type of patient condition that occurs more often at night; in such a case, the resident would be allowed to return home to sleep during the day.

ESSENTIAL FUNCTIONS OF A RESIDENCY

When defining the essential functions of a residency, the following may be helpful. Essential functions are the fundamental tasks required by the position. These functions take up a substantial portion of the resident’s time and, if eliminated, would fundamentally change the nature of the resident’s job or educational experience. If essential functions are not performed or mastered, the consequences would be significant. These functions require expertise and can be performed only by a limited number of persons.

All PDs should be thoroughly familiar with the essential functions of their residency programs and should know whether residents who are covered under the ADA (e.g., wheelchair bound, hearing impaired, or blind) can function successfully in their programs. For those programs that do not as yet have a formal document, the human resources department or employee occupational health unit may be good resources to make use of when writing a comprehensive job description.

EXAMPLE OF AN ESSENTIAL JOB FUNCTION LIST FOR FAMILY PRACTICE RESIDENTS ESSENTIAL JOB FUNCTIONS—THE [NAME] RESIDENCY

The following list includes tasks that are representative of those required of a resident at [name of practice]. The list is not all-inclusive nor does it constitute all academic performance measures or graduation standards. It does not preclude the residency from temporarily restructuring resident duties as it deems appropriate for residents with acute illness, injury, or other circumstances of a temporary nature. The resident, without the use of an intermediary, must be able to:

- Take a history and perform a physical examination
- Administer injections and obtain blood samples
- Use sterile technique and universal precautions
- Perform cardiopulmonary resuscitation
- Move throughout the clinical site and hospitals to address routine and emergent patient care needs
- Deliver a baby and learn to repair an episiotomy
- Assist at operations
- Communicate with patients and staff—verbally and otherwise—in a manner that exhibits good professional judgment and good listening skills, and that is appropriate for the professional setting
- Demonstrate timely, consistent, and reliable follow-up on patient care issues, such as laboratory results, patient phone calls, or other requests
- Input and retrieve computer data through a keyboard and read a computer screen
- Read charts and monitors
- Perform documentation procedures, e.g., chart dictation and other paperwork, in a timely fashion
- Manage multiple patient care duties at the same time and prioritize them
- Make judgments and decisions regarding complicated, undifferentiated disease presentations in a timely fashion in emergency, ambulatory, and hospital settings
- Demonstrate organizational skills required to eventually care for ten or more outpatient cases per half day

EXAMPLE OF AN ESSENTIAL JOB FUNCTION LIST FOR FAMILY PRACTICE RESIDENTS ESSENTIAL JOB FUNCTIONS—THE [NAME] RESIDENCY (CONT'D)

- Take call for the practice or service, which requires inpatient admissions and work stretches of up to 36 hours at a time
- Present well-organized case presentations to other physicians or supervisors
- Participate in and satisfactorily complete all required rotations in the curriculum

Losh DP, Church L. Provisions of the Americans with Disabilities Act and the development of essential job functions for family practice residents. *Fam Med* 1999;31:617–621.

A clear description of a resident's job function, careful documentation about the person's goals, and about achievement of those goals, help both the institution and the individual share a special relationship and advance all of us in our understanding of one another, in our weaknesses as well as in our strengths.

IMPAIRMENT REVIEW

- Describe the conditions under which disabilities or maladaptive behavior in residents might emerge. Give examples from your institution
- Define “problem resident”
- Name some of the common issues (such as those described in a national survey of internal medicine residency PDs as reported in JAMA)
- Discuss why PDs should not intervene in the diagnosis and evaluation of residents with impairments. Do you agree with the reasons given by this program?
- Describe some of the policy letters outlined in the program that deal with resident remediation
- When the PD refers a resident for evaluation, what kinds of materials should he/she provide to the resource/consultant?
- Describe the requirements of the ADA
- How does the ADA define a disabled individual?
- Discuss the cases that have shaped disability services. What about them do you find informative?
- Name some of the conditions that are included/excluded as impediments by the ADA as they apply to hiring
- How are “essential functions” of a residency defined?

ADDITIONAL REFERENCES OF INTEREST

Boon K,Turner J. Ethical and professional conduct of medical students: review of current assessment measures and controversies. *J Med Ethics* 2004;2:221–226.

Centrella M. Physician addiction and impairment—current thinking: a review. *J Addict Dis* 1994;13:91–105.

Epstein RM, Hundert EM. Defining and assessing professional competence. *JAMA* 2002;287:226–235.

Kennedy M. Patient Safety. *WMJ* 2001;100:16–19.

Petersen-Crair P, Marangell L, Flack J, Harper R, Soety E, Gabbard GO. *Am J Psychiatry* 2003;160:850–854.

Yee P. Brain cramp: the emergency physician's worst nightmare. *Ann Emerg Med* 2002;39:329–330.

VISIT OUR WEBSITE FOR UP-TO-DATE REFERENCES



AIM

This module offers advice on how to provide instructive feedback to residents, something that is difficult for most of us to do.

LEARNING OBJECTIVES

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

- Identify barriers to honest, productive communication
- Describe the common traps of the evaluation process and enumerate ways to avoid them
- Name the five stages of a learner's reaction to critical or instructive feedback
- List strategies to deal with these reactions
- Explain the paradoxical statement: if the interaction with the learner went smoothly, then it did NOT go well

SCENARIO SUMMARY

This program, which is structured somewhat differently than the others, uses scenarios from the other LIFE modules to demonstrate behavior that will ultimately prove troublesome for the resident featured in the segment. The scenarios indicate that sooner or later, someone in a position of authority must confront the offending resident and insist on remediation of one type or another if that individual is to continue the residency.

PROGRAM TEACHING POINTS

HANDLING RESIDENTS AND "PROBLEMS IN LIVING"

Problems in living, no matter how they manifest, are all part and parcel of the human condition. Like anyone else, medical professionals—residents and fellows—are fully capable of acting out some of the more troublesome problems. Many of these problems are associated with extremely negative consequences.

The clips from the LIFE program illustrate several types of problems that either faculty or PDs see on a fairly routine basis and should be prepared to address promptly. For example, as one segment makes clear, disruptive and aggressive behavior, once tolerated, is now acknowledged as something that can adversely affect an institution, patient care, and staff morale, and that is no longer acceptable. Substance abuse is a problem that affects the general population and physicians, as well; if residents

develop a problem, it must be identified and treated immediately. Also, residents, for reasons such as severe stress—burnout or even major depression—can have difficulty in just keeping up, managing daily tasks, and meeting the demands of their professional lives. The deficiencies of residents should be recognized quickly so that a remediation plan can be developed.

PROVIDING INSTRUCTIVE FEEDBACK

In addition, the different scenarios show various situations that a PD might be familiar with and demonstrate how these situations might best be handled. However, giving instructive feedback or providing necessary criticism to residents or learners is not as easy as it looks on film. All too often educators ignore, minimize, or excuse inappropriate behavior or mistakes. Undoubtedly, confronting people whose performance is substandard can be uncomfortable. Also, the human tendency for the most part is to avoid conflict if at all possible. Avoidance, however, compounds the problem because it postpones what is really called for—either remediation or, if it becomes necessary, dismissal.

DISCUSSION QUESTIONS

- How difficult do you find it to provide residents with instructive feedback?
- Have you ever let problems of residents slide?

Fortunately, there are techniques that are helpful when a PD is required to handle the emotional aspects of situations that require confrontation, and confrontation is or can be quite stressful.

TEN REASONS WHY NOBODY WANTS TO PROVIDE INSTRUCTIVE FEEDBACK

Providing residents with criticism or instructive feedback—conveying the bad news—is a formidable and challenging undertaking. All too often, supervisors don't do it, even though it is an important part of their teaching duties. Here are ten excuses superiors continually use to justify their reluctance to make honest evaluations.

DISCUSSION QUESTIONS

- Discuss the ten reasons given as explanations for not wanting to provide instructive feedback. How accurate do you feel they are?
- Can you think of others to add to this list?

1. I don't want to be the bad person—(You're not alone; no one does)

How will the person feel about opinions voiced behind his/her back? The negative comments are a teaching opportunity. You are concerned about his/her performance, and about helping the resident succeed.

2. I don't want to upset him/ her—(You probably will—be prepared)

He/she will be even more upset to learn that you let him/her go on thinking everything was fine when you knew it wasn't.

3. I don't want to make a big deal of it—(Medicine IS a big deal. Patient safety is at issue, as is your accountability to the future patients with whom this resident interacts)

Stay focused on the immediate problem and what the resident can do specifically to correct it. Sometimes the person's response to your discussion will reveal an underlying difficulty. For instance, it is a far different discussion if the resident owns the difficulty and takes responsibility for identifying some solutions, and then acts on them!

4. I don't want ruin his/her career—(You're not that powerful)

You are not responsible for the person's mistake. He/she can either correct the mistake or accept the consequences. Remember, sometimes people fail despite their best efforts and our efforts to help them. Perhaps the resident's strengths lie in a different career entirely. You may not be ruining a career so much as helping a resident identify where he/she may be successful.

5. I don't want to end up in court—(A legitimate concern, but a fairly remote possibility)

You are more likely to end up in a deposition for a malpractice suit. Just as in clinical practice, follow established procedures and policies that are educationally sound and legally defensible. Be proactive. Have your human resources, risk management, DIO, and legal experts review existing policies and help you craft notifications if needed.

6. I'm not sure how he/she will react—(You probably are)

You just don't know to what degree. If you have serious concerns about his/her welfare—or your safety—you need to address them as well. Frequently programs may benefit from an "educational council" composed of faculty who make the performance, evaluation, and promotion decisions. The PD is then the agent for communicating these to the resident, not viewed as the sole individual responsible for the decision. It may be advisable to have another individual, perhaps the resident's faculty advisor, join you for this discussion.

7. I (or others) may have contributed to the problem—(That is a possibility)

If true, acknowledge it. Don't compound the situation by using that as an excuse for not talking with the person. Ironically, past failures to address the mistake or problem often contribute to the current problem.

8. He/she realizes it was wrong and will not do it again—(Unlikely)

Wishing, hoping, or thinking the problem will go away does not work—problems rarely resolve themselves spontaneously. Talking and providing clear expectations are more likely to succeed.

9. *It's too late in the program or in the year—(Not really)*

Address the mistake or problem when it occurs. A determination of whether action should be taken does not depend on when the problem occurs. It's never too late to help another person improve.

10. *I don't like confrontation—(Few of us do)*

Confront the problem, not the person. View the interaction as a teaching opportunity—a time to help. Approach him/her as you approach a patient with bad news—in a caring, concerned, and compassionate manner.

Providing Instructive feedback: Planning the Meeting

Once a PD has overcome his/her reluctance to confront a person, it is important that he/she plan the meeting carefully if the outcome is to be successful. Have a full description of the complaint that has been registered along with supporting documentation at hand. Be prepared to document the encounter as meticulously as is humanly possible. Take careful notes. This signals the seriousness of the event to the person and will help you with your recall when you revise in more detail. Focus completely on the goal of the endeavor. That goal is to deliver a reprimand or correct a mistake as clearly and unambiguously as possible. However, there are traps in the evaluation process that need to be taken into account.

SIX TRAPS IN THE EVALUATION PROCESS

1. *Reviewing another person's performance from an autobiographical perspective*

This occurs when we compare an individual's performance with how we performed in the same situation, instead of using established standards. We then tend to accept unsatisfactory performance or make excuses for inappropriate behavior.

ACCEPT THE POSITION—ACCEPT THE RESPONSIBILITY

DISCUSSION QUESTIONS

- Can you give examples of reviewing another person's performance from an autobiographical perspective?

2. *Being the target of "responsibility ricochet"*

This occurs when an individual turns the tables and shifts the responsibility for his/her actions onto others (e.g., "Why are YOU picking on me?" or "Why are YOU giving me this grade/score?")

USE INSTRUCTIVE FEEDBACK TO CORRECT MISTAKES

3. *Basing judgment on extraneous factors*

This occurs when we fail to follow the established criteria and use other factors such as effort or likeability (e.g., “She is trying hard.” or “He is a nice fellow”). We can get side-tracked by issues related to student loan debt, personal matters, health problems, date of occurrence, etc.

DISCUSSION QUESTIONS

- Have you ever fallen for the “extraneous factor” trap?

STICK TO ESTABLISHED CRITERIA—AVOID ARBITRARY DECISIONS

4. *Using only one assessment instrument and/or a single evaluator*

This occurs when we rely on one evaluation tool or one incident to assess complex skills or a behavioral problem.

COMPLEX SKILLS REQUIRE MULTIPLE MEASURES FROM MULTIPLE SOURCES

DISCUSSION QUESTIONS

- How many tools do you use in your assessment processes?
- How well do they correlate with the desired outcomes of your training program
- Have you used the ACGME “Competencies” and tool box to enhance assessments?

5. *Introducing bias—the “halo effect”*

This occurs when we over-generalize an individual’s performance and tend to see everything they do as positive (can do nothing wrong) or negative (can do nothing right).

FOCUS ON THE PERFORMANCE, NOT THE PERSON

DISCUSSION QUESTIONS

- Give examples of the “halo” effect as it might operate in your program

6. *Creating artificial barriers or obstacles*

This occurs when we give special treatment to a group or an individual, thereby arbitrarily changing the standards or process. Examples of such contrived obstacles include: “Senior-itis,” “Job-itis,” and NOMRS (Not Our/My Resident/Student).

BE FAIR, BE FIRM, BE POSITIVE

DISCUSSION QUESTIONS

- How often do you see programs falling into the trap of creating artificial barriers?

KUBLER-ROSS STAGES APPLIED TO RESIDENT EVALUATIONS

Any negative evaluation is certain to cause some degree of discomfort and embarrassment, which, in turn, will elicit highly emotional responses. In fact, one way to understand the nature of the event is to conceptualize it in terms of the Kubler-Ross stages (or modifications of them) that patients pass through when they are given medical “bad news.” Challenges should be anticipated and may be a way of ascertaining that the feedback has been heard. This explains the statement, “If the interaction goes smoothly, then it did not go well.”

Once the instructive feedback is delivered, the first response that may be expected is denial. Denial is a normal response to pain or discomfort. For example, expect that a resident who is reprimanded for an interaction with one of the nurses will deny the episode. (*“Hang on. Who said so? When? I can probably explain the whole thing. Are you sure they meant me? Other residents do that. No. I didn’t do that. I’m sure it’s not me.”*)

After denial, expect anger. (*“Ok. So tell me. What am I supposed to do when I see something that needs to get done...and nobody seems to be doing it!! What about these nurses who aren’t doing their jobs? Why do I get blamed?”*)

The strategy for handling denial is to be extremely precise. Describe the problem in specific, concrete behavioral terms. Avoid judgments of intent. For instance, state: “You were late to rounds” not “you are lazy or are uncommitted.”

Then describe what specifically must be done to correct the problem. Include the consequences the resident can expect both if the problem is corrected, and the consequences he/she should expect if the problem remains uncorrected.

Maintain composure even if you feel flustered. Monitor your levels of frustration and take a break if necessary. Having another individual as a third party in the conversation may be beneficial. The meeting can even be postponed.

1. DENIAL (Expect it—it’s a normal response to pain)

Criticism stings. The person will try to protect him/herself emotionally.

STRATEGY:

1. Describe the mistake or problem in clear, succinct, and specific behavioral terms.
2. Describe what needs to be done to correct the mistake.

3. Describe what will happen if the mistake is corrected and what will happen if the mistake is not corrected.

Monitor your own frustration level. You can expect it to rise as the person continues to deny the mistake or problem. If you don't seem to be getting through, repeat Steps 1–3. If you fail to break through the denial, call a time-out for a brief period, or stop and schedule another meeting.

2. ANGER/ UPSET (Acknowledge the feeling, not the comments)

When the denial wall (i.e., excuses) comes tumbling down, the person will very likely become angry or upset. Remember, these feelings are inner-focused but outer-directed.

STRATEGY:

1. Stay focused on the mistake or problem and do not get distracted by any lashing out, tone, or other comments—don't bite the bait.
2. State that it is okay to be angry or upset. But remember that the goal is to help him/her recognize and correct the mistake or problem.
3. Resist the tendency to feel that you have to justify your position or your actions—repeat Steps 1–3 in Stage 1.
4. Watch the person's reactions and call a time-out if the person becomes too upset to continue, or appears threatening. Give the person time to regain composure or cool off.
5. If the person becomes unable to continue the conversation, make a date for a follow-up meeting or seek consultation from a behavioral specialist. The person may need to be evaluated.
6. Consider including in the instructive feedback session a faculty member the resident perceives as a mentor or advocate

NOTE: With some individuals, you might not progress through Stage 1 or Stage 2!

3. UNDERSTANDING (if possible the resident should be able to articulate the issue in his/her own language)

The key to correcting the mistake or resolving the problem is getting the person to "own up" and take responsibility.

STRATEGY:

1. Watch for verbal and nonverbal signs that the person understands the nature of the mistake/ problem and the necessary corrective steps.
2. Ask the person to tell you in his/her own words what the problem is, what must be done to correct it, and what the consequences will be if it is (or is not) corrected.

3. Take notes as the person tells you the problem, the corrective steps, and consequences— this will serve as a record of the interaction. Writing notes is an especially useful technique if the interaction gets heated or if there is a major problem. Be careful—sometimes the person will revert back to Stage 1 and start to deny the problem or its seriousness, upon realizing he/she is in a difficult situation. If the person begins to deny the problem, repeat Steps 1–3 from Stage 1 and reiterate that your goal is to HELP resolve the problem.

4. BARGAINING (Know what is within your authority or control) The goal is to correct the mistake or solve the problem, not minimize it.

STRATEGY:

1. Remind the person (and yourself) that your goal is to help him/her correct the mistake or solve the problem.
2. Repeat the corrective actions described during Stage 1. Some individuals will try to negotiate different corrective steps or consequences.
3. Decide whether there is room for negotiation and what YOU are willing (or unwilling) to negotiate. Remember—only negotiate changes that are within your authority or control.
4. Don't be afraid to say, "Sorry, this is NOT NEGOTIABLE."

NOTE: If you are unsure whether something is within your authority, be candid and say, "Let me check with...and I will get back to you."

5. ACCEPTANCE/AGREEMENT (Written or oral)

At this point, the goal is to reaffirm the person's responsibility to correct the mistake or problem and your willingness to help.

STRATEGY:

1. Conclude the interaction by recognizing the effort involved in reaching this final stage. Acknowledge the person's professionalism.
2. State the corrective steps to be taken and the consequences for achieving (or failing to achieve) them.

NOTE: General guideline: as the "seriousness" of the problem increases, so does the need for a written record—a formal remediation plan—signed by both parties.

DISCUSSION QUESTIONS

- In your experience, how accurately do these stages describe resident reactions to instructive feedback?
- Does seeing resident reactions through the paradigm of these stages help you to de-personalize and deal with situations where you must confront a resident?

DISMISSAL

Sometimes, despite all efforts to help a resident improve or correct deficiencies, progress cannot be made and the appropriate standards are not met. When that happens, the resident must be dismissed from the program. This can be very difficult to do. At moments like this, though, all supervisors should remember that they are not obligated to graduate every resident who passes through their programs. But they are obligated to graduate competent residents. That is their job and their responsibility, to themselves, to aspiring physicians, and to the general public. Almost all RRCs mandate that PDs must write a final “ verification” statement, that residents who complete the program are capable of practicing within that specialty competently and independently. If you can’t truthfully write that, the resident shouldn’t be finishing!

INSTRUCTIVE FEEDBACK REVIEW

- Name and discuss the ten reasons most frequently given to justify not giving instructive feedback
- What are the most important steps a PD should take to ensure a successful meeting with a resident to provide instructive feedback?
- Name and describe the ten pitfalls common to the evaluation process that should be avoided
- Apply the Kubler-Ross stages to resident evaluations. Describe each stage and give examples
- Explain the statement, “If the interaction goes smoothly, then it did not go well”

ADDITIONAL REFERENCES OF INTEREST

Brinko KT. The practice of giving feedback to improve teaching: what is effective? *J Higher Educ* 1993;64:574–593.

Ende J. Feedback in clinical medical education. *JAMA* 1983;250:777–781.

Kaprielian VS, Gradison M. Effective use of feedback. *Fam Med* 1998;30:406–407.

Kübler-Ross E. *On death and dying*. New York: Touchstone, 1997.

McKegney CP. Medical education: a neglectful and abusive family system. *Fam Med* 1989;21:452–457.

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PDs, faculty, and residents are teachers and physicians. Among their many duties is the need to deal effectively with residents or junior learners who have sub-optimal performance. Although there are many causes of impaired performance, most instances will be handled according to a similar algorithm, involving experienced people who are part of your institution's professional resources, and with whom you have cultivated a working relationship. Three principles should guide your approach to any resident you see as having problems that require assistance.

THREE PRINCIPLES TO GUIDE YOUR APPROACH TO RESIDENTS WITH PROBLEMS

First, be alert in your observations and quick in your interventions. Time here is very much of the essence. Do not ignore a problem, do not wait for it to solve itself—it won't—and do not talk to someone else. In short, don't put off until tomorrow what you can do today. The earlier the intervention, the better the chances of recovery become.

Second, as a physician, your first impulse will probably be to try to care for your resident yourself. This is noble but ultimately ineffective and self-defeating. Ignore this urge! Do not mix relationships. Your relationship as a PD with a resident is that of a teacher with a student, not a doctor with a patient. You are an evaluator of performance, not a diagnostician, and not the treating clinician. It is important that you allow your professional resources such as the employee assistance program or your state PHP, to take charge of the evaluation and management of any doctor with impairment. The departments of risk management and occupational medicine, the DIO, or in some cases, human resources, may also be well-equipped to handle issues of impaired performance.

Another critical constant is the designated institutional officer or the GME leadership. These professionals have experience dealing with impairment and are able to function neutrally and, therefore, effectively. They can also share with you the experience of other PDs and trainees at your own institution, reminding you of resources of which you may be unaware. Once an impaired resident has been identified and the appropriate resources have been marshaled, certain procedures should be followed.

After confronting the resident, describing the problem as it has been reported, and producing supportive documentation, follow a protocol like the “5-step protocol.” This should ultimately lead to either a correction of the problem, to non-renewal of contract, or in some cases to termination. The purpose of this protocol is to articulate your plan in written form and to set up an appropriate timeline.

CORRECTIVE ACTION AND HEARING PROCEDURES: THE 5-STEP PROTOCOL

(Adapted from the five-step policy of Dr. John Weinerth, DIO, Duke University Hospital)

Report to the office of GME all corrective actions, adverse actions, summary suspensions, automatic corrective actions, or decisions for non-renewal of contracts. For consistency and affirmation of understanding between PDs and graduate medical trainees, deal with each instance in a five-step fashion.

1. Describe the issue/complaint in behaviorally specific terms and include sources of documentation.
2. Describe remediation, including a timeline to completion. Specify date the plan starts and ends.
3. Describe measurable goals, including points of assessment and timeline.
4. Describe consequences of success or failure in meeting defined goals.
5. Have document signed and dated by both PD and graduate medical trainee.

Send a copy confidentially to director of GME and to the DIO.

At the completion of the corrective action/remediation, send a confidential completion report to the DIO and the office of GME. Specify the resident’s status:

- Return to usual status within the program
- Continuation of remediation (state for how long and repeat steps 1-5)
- Nonrenewal of contract at the end of the training year
- Termination

First, a full description of the complaint along with supporting documentation is compiled.

Second, we outline the process of remediation and include a timeline for that process to be completed. Remediation may include drug testing, inpatient treatment,

therapeutic sessions, and the like. Remember you're not coming up with these remediation plans. You are using your resources such as the PHP to determine what is necessary.

DISCUSSION QUESTIONS

- Does your institution use a process similar to the Five Step Protocol? If so, describe it.

Third, we provide a description of measurable goals, milestones in the treatment course. For example, if the resident has a problem, with attention—resulting from attention deficit disorder—we outline the tools we will use to measure mastery of skills taught to help accommodate the disorder's effect. If the problem is substance abuse, we draw up a plan for inpatient and/or outpatient treatment. We set dates for return, for future testing, and dates for the specific assessments along the timeline.

Fourth, we very carefully describe the consequences of the resident's success or failure in meeting the defined goals. This can include a continued period of rigorous observation, full return to work, or nonrenewal of contract and, in some cases, dismissal.

And, finally, all of this is put into writing and forms the basis of a learning contract. It is then dated and signed by the PD and the resident, and then forwarded to the director of medical education.

THE LEARNING CONTRACT

The ACGME Competencies are essential components of the learning contract and can specifically identify key areas in patient care, medical knowledge, practiced-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. A learning contract is not a legal contract per se, but rather an agreement drawn up between the trainee and the program to clarify and document expectations.

The learning contract is important for several reasons: it formalizes a serious situation; it provides a clear and permanent record of steps required to correct a situation, and it forms the basis of a bond between the residency program and the resident. The contract clearly identifies a specific performance and/or behavior that the resident must achieve to demonstrate their competency. It clarifies specifically what the resident must do, how that will be measured, and how feedback will be provided. It says in so many words, "We are here to help. And this is how we can."

CONCLUSION REVIEW

- What three principles should guide your approach to any resident you see as having problems that require assistance?
- What is the purpose of the five-step protocol?
- Outline the five-step protocol
- Why is the learning contract important?

