

## Identifying the “Problem Fellow”

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SAAA/AASPD Annual Meeting 2014

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## Objectives

1	Description of Fellow In Trouble (Logical/Analytical)
2	Emotional Responses
3	Practical Advice

ABA doesn't have a formal definition of the problem resident. ABIM does.

## ABIM “Problem Resident”:

Learner who demonstrates problem behavior significant enough to require intervention by program leadership.

## Other terms used:

Resident in difficulty
High-risk resident
Difficult resident
<b>Resident in trouble</b>

In this presentation, I will use the term “resident or fellow in trouble.”


There is little data on the fellow in trouble, so this presentation will focus on what I have learned about the resident in trouble.

Resident in trouble

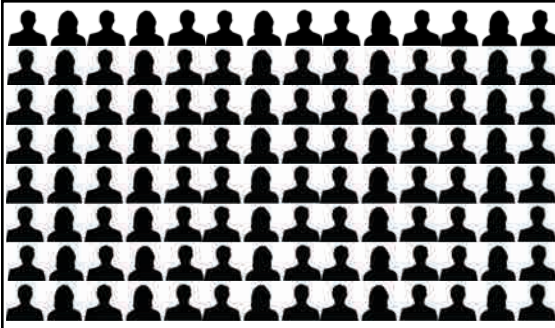


Fellow in trouble

These stories are based on a review of 12 years of a large residency program.




Residents in Trouble: 3 Stories



Review of RIT over 12 years


### RIT Study - Anesthesiology

<b>How RIT identified</b>	CCC referral
<b>Years</b>	2000-2012
<b>What was tracked</b>	ACGME competencies
<b>Interventions</b>	Mentoring, probation
<b>Reporting</b>	ABA Unsatisfactory Essential Attributes
<b>Outcomes</b>	Graduation, ABA certification



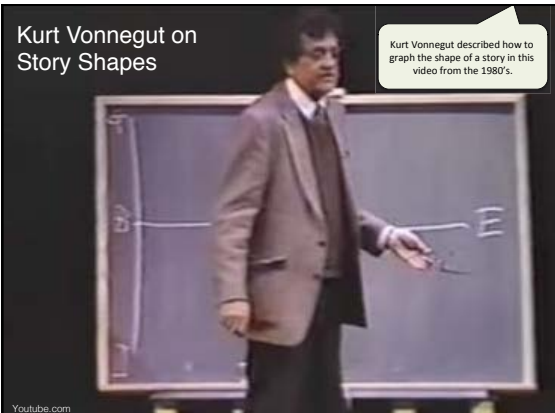
Residents in Trouble: 3 Stories

Red = poor performance  
Yellow = marginal performance  
Green = satisfactory performance



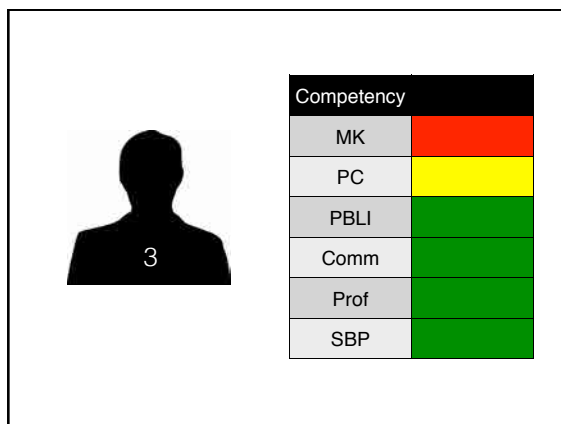
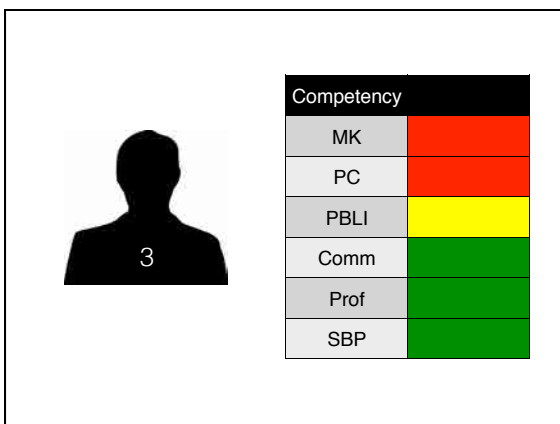
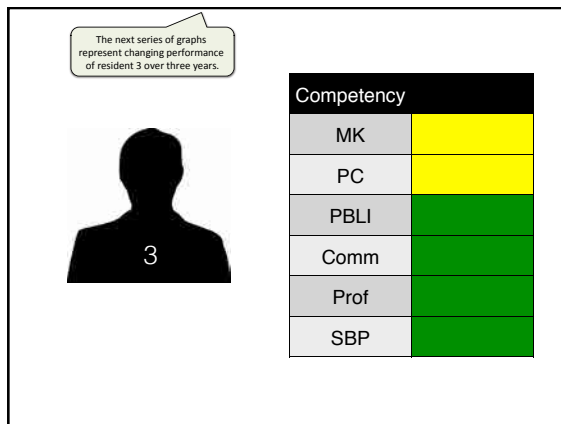
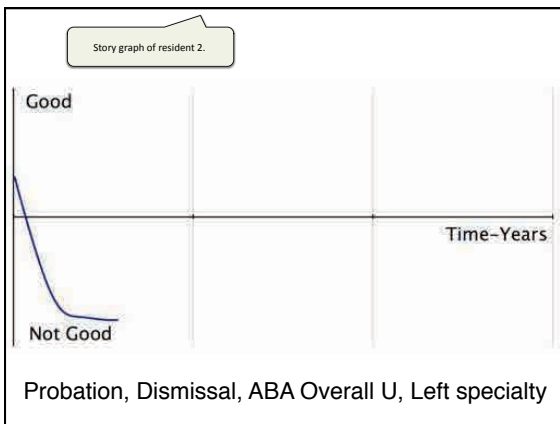
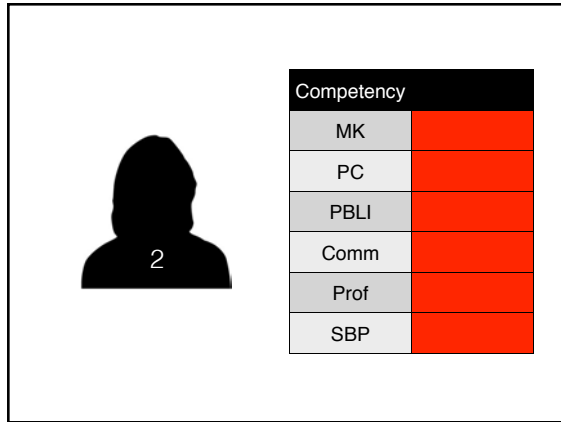
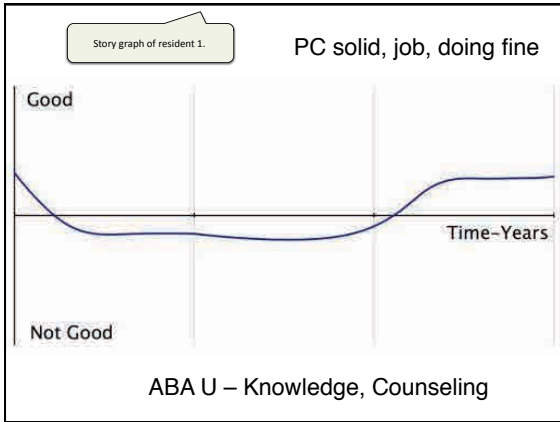
Competency	
MK	Red
PC	Green
PBLI	Green
Comm	Green
Prof	Green
SBP	Green

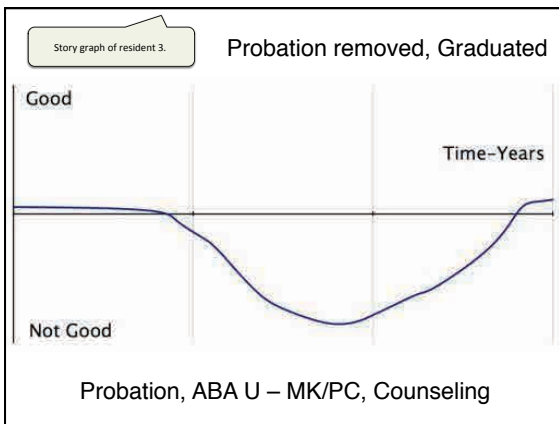
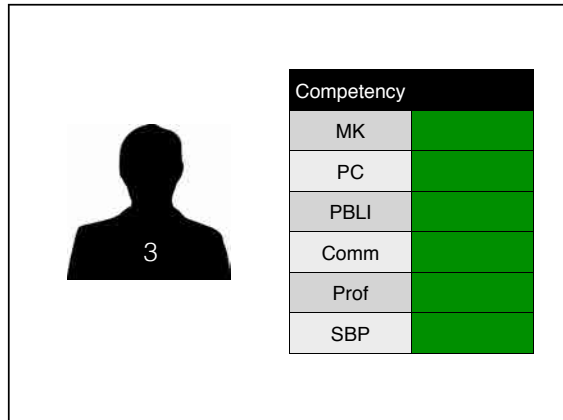
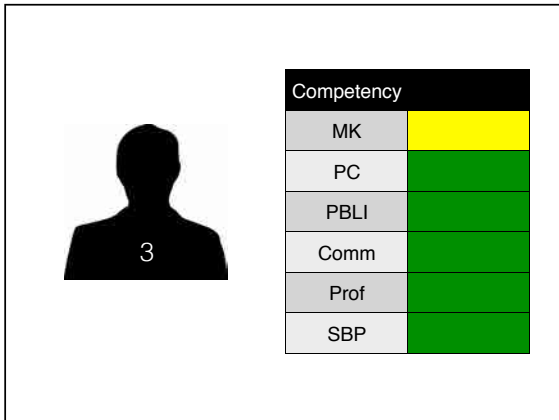
### Kurt Vonnegut on Story Shapes



Kurt Vonnegut described how to graph the shape of a story in this video from the 1980's.

Youtube.com





**APM**  
Association of Professors of Medicine

**APM Perspectives**

*The Association of Professors of Medicine (APM) is the national organization of departments of internal medicine at the US medical schools and numerous affiliated teaching hospitals as represented by chairs and appointed leaders. As the official sponsor of The American Journal of Medicine, the association invites authors to publish commentaries on issues concerning academic internal medicine.*

*For the latest information about departments of internal medicine, please visit APM's website at [www.im.org/APM](http://www.im.org/APM).*

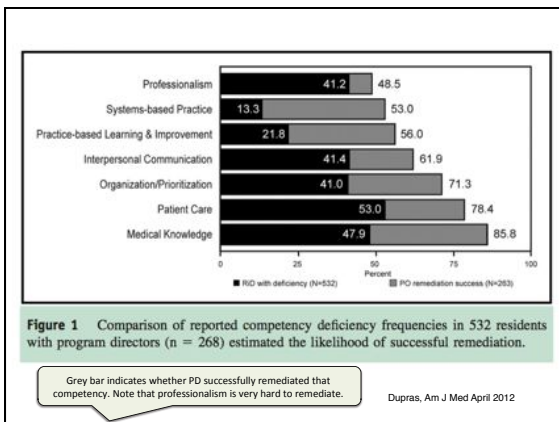
**"Problem Residents": Prevalence, Problems and Remediation in the Era of Core Competencies**

Denise M. Dupras, MD, PhD,<sup>a</sup> Randall S. Edson, MD,<sup>a</sup> Andrew J. Halvorsen, MS,<sup>a</sup> Robert H. Hopkins, Jr, MD,<sup>b</sup> Furman S. McDonald, MD, MPH<sup>a</sup>

<sup>a</sup>Mayo Clinic, Rochester, Minnesota; <sup>b</sup>University of Arkansas for Medical Sciences, Little Rock.

~ 270 PDs, 15K residents, 3.5% prevalence

Am J Med April 2012



**Observations by IM colleagues**

- 6% of residents self-identified their problems
- One-third reported that better screening would prevent (USMLE, interview, MSPE, LOR, resident input)

Dupras, Am J Med April 2012

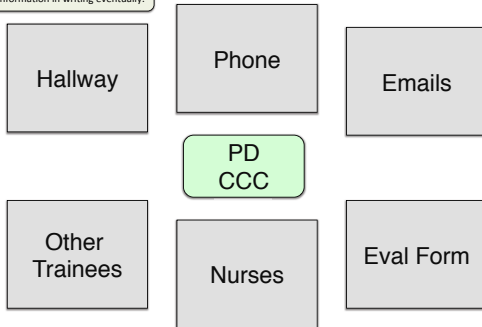
## Programs with fewer RIT

Higher ABIM pass rates
University-based training
<b>Higher PD salaries</b>
<b>Longer tenured PD</b>

Dupras, Am J Med April 2012

## Information Sources to ID RIT

Biggest challenge is to get information in writing eventually.



## Lessons Learned Dealing with RIT

Good

4 Things to Consider

Depression

Not Good

Good

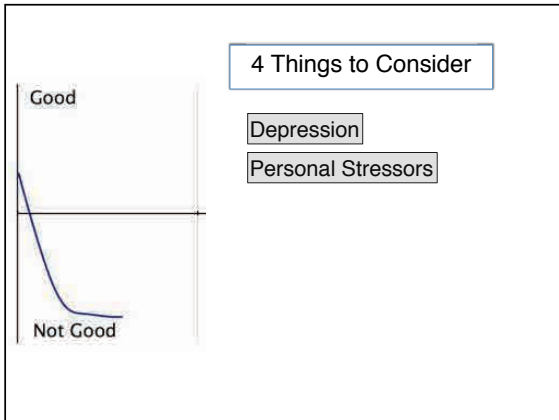
4 Things to Consider

Depression

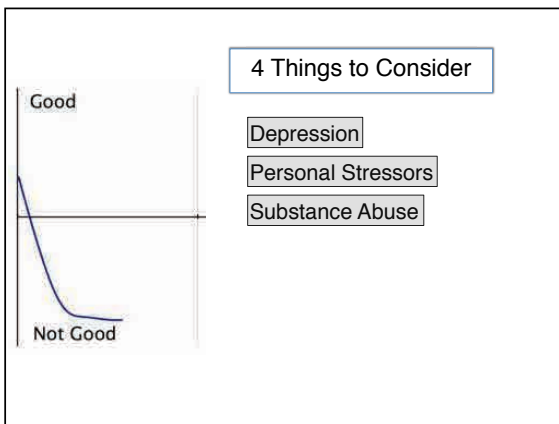
Not Good



Remember that you are not a psychiatrist - do not diagnose this yourself!



- ### Stressful Life Events Scale
1. Death - spouse
  2. Divorce
  3. Marital separation
  4. Jail
  5. Death – close family
  6. Personal illness/injury
  7. Marriage
  8. Fired at work
  12. Pregnancy
- Holmes and Rahe, 1967



Research

**Original Investigation**  
**Substance Use Disorder Among Anesthesiology Residents, 1975-2009**

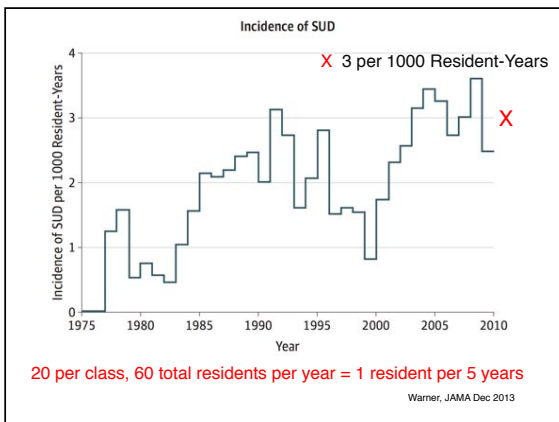
David Q. Warner, MD, Keith Berge, MD, Huaping Sun, PhD, Ann Harman, PhD, Andrew Hanson, BS, Darrell R. Schroeder, MS

**IMPORTANCE** Substance use disorder (SUD) among anesthesiologists and other physicians poses serious risks to both physicians and patients. Formulation of policy and individual treatment plans is hampered by lack of data regarding the epidemiology and outcomes of physician SUD.

Supplemental content at [jama.com](http://jama.com)

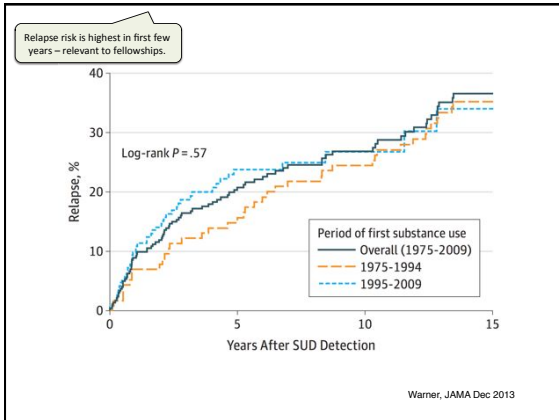
N = ~46,000

Warner, JAMA Dec 2013



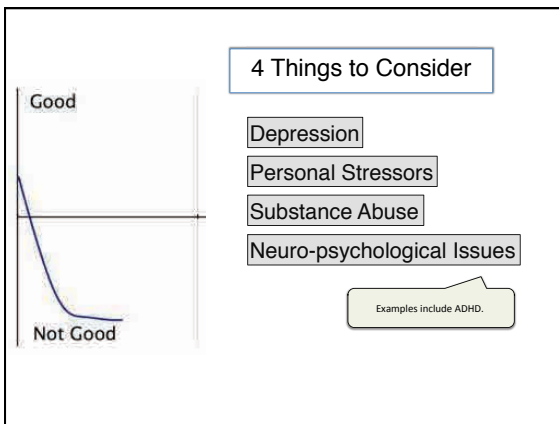
Drug	% of Total (242)
Opioid - All	62%
Opioid - IV	57%
Opioid - Oral	11%
Alcohol	35%
Anesthetics	19%
Marijuana/Cocaine	21%

Warner, JAMA Dec 2013

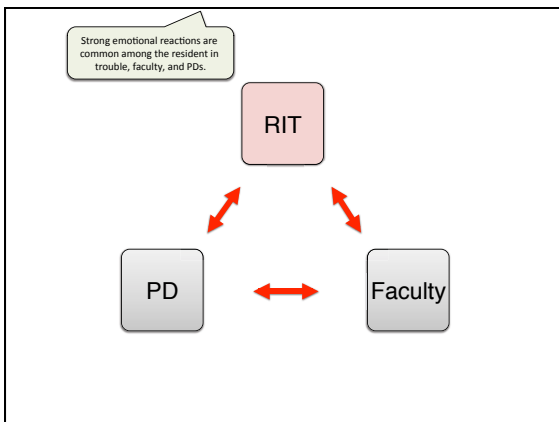


This does not imply a subspecialty-specific difference in SUD, only that access differences exist.

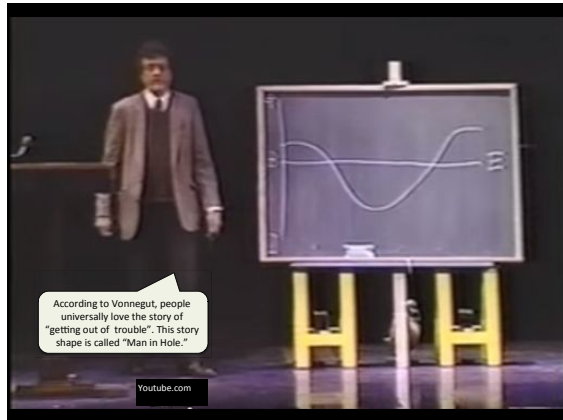
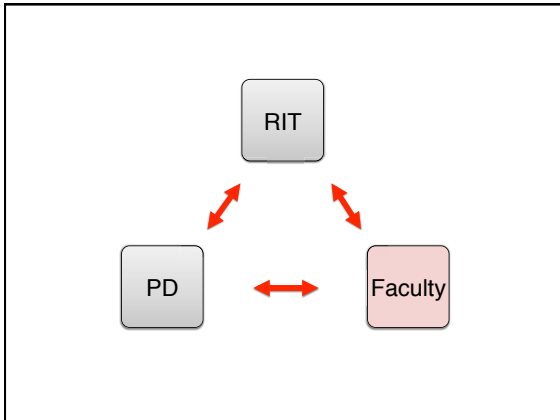
Fellowship	Anesthetic/IV Opiate Access
Cardiothoracic	++++
Crit Care	+
OB	+
Pain	+
Pediatrics	++



## Emotional Aspects of Dealing with RIT

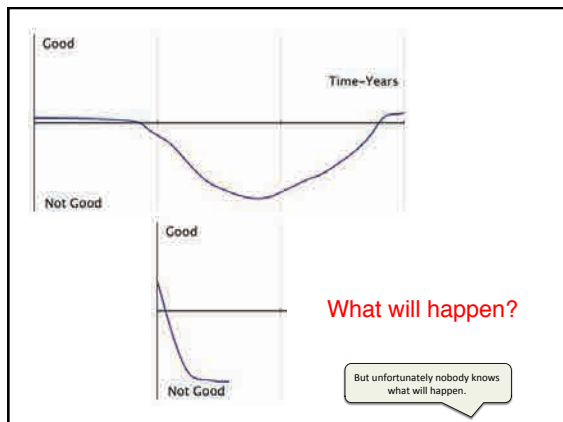


- ## Resident: Stages of Grief
1. Denial
  2. Anger
  3. Bargaining
  4. Depression
  5. Acceptance
- Emotions 1-3 are very common, especially since very few RIT believe initially that they were in trouble.



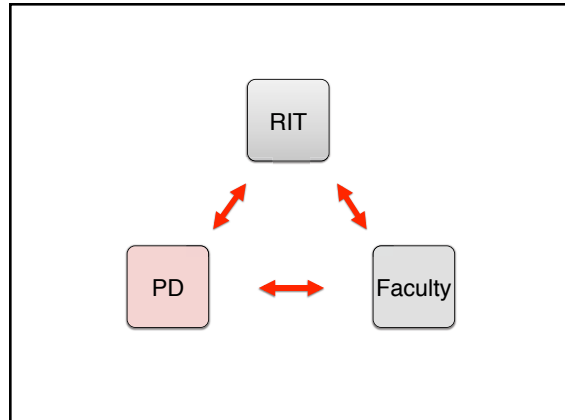
Most faculty want the happy ending to the story.

## Faculty who want happy ending



## Coaching versus Judging





What's best for the trainee?

What's best for the program?

What's best for the PD?

Sometimes what is best for PD (e.g., will take less time of PD) is not what's best for the trainee or program.

Dealing with the "hateful resident"

This concept is based on an article called "the hateful patient".

SPECIAL ARTICLE

TAKING CARE OF THE HATEFUL PATIENT

JAMES E. GROVES, M.D.

**Abstract** "Hateful patients" are not those with whom the physician has an occasional personality clash. As defined here they are those whom most physicians dread. The insatiable dependency of "hateful patients" leads to behaviors that group them into four stereotypes: dependent *clingers*, entitled *demanders*, manipulative *help-rejectors* and self-destructive *deniers*.

care requires limits on expectations for an intense doctor-patient relationship. *Demanders* evoke a wish to counterattack; such patients need to have their feelings of total entitlement rechanneled into a partnership that acknowledges their entitlement — not to unrealistic demands but to good medical care. *Help-rejectors* evoke depression; "sharing" their pessimism diminishes their notion that losing the symptom

Clingers  
Demanders  
Help-rejectors

Article written by psychiatrist, since some patients evoke negative emotions from their physicians, potentially impacting their care.

Groves, NEJM 1978

PERSPECTIVES

The "Hateful Resident"

MATTHEW ALEXANDER, PhD  
VANESSA McPHERSON, MD  
MARY NOLAN HALL, MD

In a 1978 article entitled "Taking Care of the Hateful Patient" James Groves identified 4 types of patients who induce "hateful" feelings in medical providers. The 4 types overlap considerably with personality disorders (1,2,3,4). Groves' seminal article identified a common, yet hidden fact of patient care—that certain patients evoke strongly negative feelings in their providers. This insight runs counter to the ideal that providers should "love" all of their patients. Having hateful feelings toward difficult patients is normal and can provide useful diagnostic

categories of hateful residents early on in their training, make appropriate assessments, and implement useful strategies for remediation. Educators hoping to manage stress levels generated from the difficult issues posed by these residents will do well to consult with, and gain emotional support from, other colleagues or by presenting such cases in Balint groups or other personal and professional development groups. With difficult residents, as with difficult patients, one does not want to "fly solo."

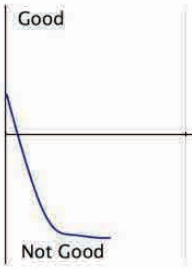
Alexander, JGME 2013


Dependent Clinger	
Characteristics	Bottomless need Repetitive after-hours pages
Emotional cues	Overwhelmed Avoidance
Suggestions for PD	Early recognition Boundary setting
Suggestions for trainee	Social support Counseling

Entitled Demander	
Characteristics	Special treatment Threaten
Emotional cues	Anger, Disbelief Desire to counterattack
Suggestions for PD	Don't wait too long, Document Boundaries, Consistency
Suggestions for trainee	? (Esp. If Narcissistic) Consider job impact





Manipulative Help-Rejecter	
Characteristics	Repeated complaints Reject advice
Emotional cues	Guilt, Inadequacy Avoidance
Suggestions for PD	Don't offer advice Elicit suggestions
Suggestions for trainee	Join a committee

**Practical Advice  
to  
Fellowship Directors**





1. Act quickly if you suspect Fellow in Trouble

Need mix of junior/senior, coaches and judges.

2. Choose your CCC faculty wisely

3. Be prepared for the emotional responses

4. Review selection file, consider changes

ITE scores, interview, MSPE, **LOR**

Would more standardized PD Letters help with fellow selection?

Anesthesiology Standardized Letter of Recommendation (SLOR) - AACPD

1. Applicant's Name

Jane Doe

2. Applicant's AAMC #

1234567

3. Reference provided by:

Name: Manuel Pardo, Jr. MD  
Institution/Department: UCSF  
Position/Title: Residency Program Director

10. Compared with other residency candidates you have recommended, how would you rank this applicant?

- Above peer level (top 1/3)
- At peer level
- Below peer level but still likely to succeed as resident
- Substandard performance

11. Last year, what percentage of applicants that you evaluated were rated in the following categories? [Columns must add up to 100%]

Above peer level (top 1/3)	35
At peer level	50
Below peer level but still likely to succeed as resident	15
Substandard performance	0

12. What is your prediction of success for this applicant in an anesthesiology residency?

- Outstanding
- Excellent
- Good
- Poor

During her residency, Dr. [redacted] has exceeded the educational goals and objective Department of Anesthesiology Residency Program. Her performances in the subspecialty of anesthesiology (including critical care medicine, cardiac, obstetric and regional anesthesia) were excellent. The following comments from various faculty members may serve as a summation of her performance:

- Hard working, inquisitive student who is eager to learn. Asks intelligent questions and does a great job in the OR. she is progressing very well and will only continue to improve.
- Very good resident-- eager to learn
- [redacted] did an excellent ICU transfer of an intubated patient for the first time and a pleasure to work with.
- [redacted] is solid, dependable, and developing her technical skills well. A pleasure to work with.

Standardized PD Letter Example 1

Medical knowledge-	<b>Superior</b>
Patient care-	<b>Superior</b>
Interpersonal and communication skills-	<b>Superior</b>
Professionalism-	<b>Superior</b>
Practice-based-learning-	<b>Superior</b>
Systems-based practice-	<b>Superior</b>

Standardized PD Letter Example 1

Scholarly Activity To Date	
<b>Regional and National Presentations:</b>	
MCC: "Parturient with Congenital Prolonged QT Syndrome Requiring Lifevest" with Dr. Vallejo	
<b>Department presentations:</b>	
PUH M&M: "Intraoperative Pulmonary Embolism"	
<b>Other:</b>	
Case Report: "Case of Pericardial Tamponade: The Importance of TTE for the	

Standardized PD Letter Example 1

CATEGORY	# OF CASES	CATEGORY	# OF CASES
Cardiac	36	Peripheral Nerve Block	118
Cesarean Section	78	Special Situation Complex	15
Epidural	123	Spinal	69
Intracerebral	10	Vaginal Delivery	115
Intracerebral Open	10	Vascular, Major Vessels	10
Intrathoracic non-cardiac	10	Patients less than 12 yrs. old	93
Pain Evaluation – New Patient	45		

Standardized PD Letter Example 1

**Academic Progress**

Dr. XXXX successfully completed rotations during the CA-1 year and CA-2 year. She has NOT been subject to probation or other disciplinary action. ABA/ASA In-training examination score during the CA-1 year was 83rd percentile, and was 62nd percentile during CA-2 year.

Standardized PD Letter Example 2

**Competency-Based Assessment**

Faculty submit global competency-based evaluations of our residents. Scores include 1-3 = unsatisfactory, 4-6 = satisfactory, 7-9 = superior.

- Patient Care 7.51
- Medical Knowledge 7.45
- Interpersonal and Communication 7.74
- Professionalism 7.72
- Practice-Based Learning 7.47
- Systems-Based Practice 7.39

Standardized PD Letter Example 2

**Comments from Selected Rotations**

I will provide faculty comments from some of our most challenging rotations:

OR Rotations: "Highly motivated, resourceful and engaged skills and has the great ability to ask the right questions very professionally and her social skills are outstanding, she demonstrates that she is thinking about what she is doing. She's also comfortable asking me for the basis of decisions. She has progressed nicely in her skills, thought process as doing a case in my room and know that she will call when always look forward to working with her."

ICU Rotations: "Outstanding resident. Dedicated to patient care."

Standardized PD Letter Example 2

### Summary: The Fellow in Trouble

<b>Description of RIT</b>	Patterns, Competencies Information sources
<b>Emotional Responses</b>	RIT, faculty, PD
<b>Practical Advice</b>	4 things to consider CCC faculty; Speed ? Change selection ? Standard PD letters