

## **Managing Difficult Trainees Session**

**Moderators:** John D. Mitchell, M.D., Timothy R. Long, M.D.

**Panelists:** John O'Brien, M.D., Joshua L. Goldstein, M.D., Scott L. Warner, J.D.

### **Scope of the Problem**

Difficult or problem trainees are an issue across all training programs in all specialties. In Internal medicine, the problem resident is defined as “a trainee who demonstrates a significant enough problem that requires intervention by someone of authority, usually the program director or chief resident.”<sup>1</sup> The frequency of trainees coming to the attention of the clinical competency committee within anesthesiology training programs was reported at 25% in a recent retrospective study.<sup>2</sup> This falls within, though at the higher end, of the spectrum of reported incidences of problem or difficult trainees across medical specialties.<sup>3-5</sup> For example, a 2000 JAMA survey of Internal Medicine Residency programs suggested a 7% prevalence at that time with 94% of all programs acknowledging active experience with problem trainees.<sup>1,3</sup> The higher reported rate in Anesthesiology programs may be due to recently increased focus on performance issues, differences in definitions amongst authors and programs, and the longstanding presence of clinical competency committees in Anesthesiology as opposed to other specialties that could result in better documentation of trainee issues.

In Pediatric training programs, issues in medical knowledge are the most prevalent. When remediation was required, trainees exhibited more than one competency issue in 26% of cases; 42% of residents dismissed from programs had competency issues across more than one core competency. Issues related to competencies other than medical knowledge were higher in the group of residency dismissed and carried a lower likelihood of remediation. These less common deficiencies were often found in those with more than one core competency involved, supporting the idea that those with more complex problems are less likely to be successfully remediated.<sup>6</sup>

In a July 2016 paper in Anesthesiology, a group from four US Anesthesiology training programs (several of them SAAA members!) reviewed 865 residents training from 2000-2009 and followed them through 2016 for actions by clinical competency committee committees and board certification rates.<sup>2</sup> Like Pediatric programs, competency issues spanned all areas. Medical knowledge was the most common issue, with patient care, professionalism, and communication issues representing the majority of remaining problems, (in about equal numbers). 44% of residents identified as problematic had issues in more than one competency area. The researchers also discovered that if residents had no issues or solitary problems, they had high graduation rates (99% no issues, 97% 1 issue) and board passage (99% no issues, 95% 1 issue). If, however, residents experienced issues across multiple competences or in an ABA Essential Attribute (largely professionalism traits, substance issues, or disabilities), rates dropped significantly. For example, residents reported as “unsatisfactory” to the ABA were only 89% likely to be board certified, and if they were also cited for lack of an essential attribute, that number dropped to 45%.<sup>2</sup>

In this session, we will attempt to address the complex issues that arise with the difficult or problem trainee. The session will focus on the themes that emerge in the literature review above. The areas of professionalism, communication, disability, and multifactorial problems, will be addressed via a series of de-identified cases supplied by SAAA

members. Our panel of experts includes a Designated Institutional Officials (DIO), Departmental and Training program leaders, and an attorney expert in graduate medical education and hospital related issues who will address these issues from multiple perspectives. Audience participation will be solicited, so please bring questions and opinions, as there are many ways to approach these complex issues.

## **Cases**

### *Professionalism issues*

1. DUI early in training- reprimand by board of medicine. Progressed in program, difficult with peers but no specific issues. Later caught watching video in OR and reprimanded again. Ultimately dismissed when caught diverting narcotics and refusing treatment. Later discovered to have threatened chief residents with violence and been involved in a serious physical altercation outside of work.

How many chances should you give someone?

Should he have been dismissed after DUI?

2. Research misconduct: Resident submitted same posters to multiple meetings without significant mentor involvement used inappropriate methods and preliminary results represented as final conclusions. This is linked to issue 1 in communication (same resident).

What actions should be taken?

Is this remediable behavior?

### *Communication Issues:*

1. Poor verbal communicator— A resident has difficulty with verbal cues and direct communication. Avoids talking to people, sends abrupt emails. Workup results in dx of Asperger's, outpatient counseling recommended. No indication from residency program when taken in to fellowship.

How to manage?

Can you graduate him with this personality?

He requires remediation on several occasions but ultimately graduates from the training program.

What is your duty to warn the next program or job, assuming he can graduate?

What should you include in a letter?

What can you say by phone?

2. Poor listening skills- A resident is overall performing well, but several complaints from faculty about communication/closed loop workflow surface. Workup evolves and the resident reports being deaf in 1 ear.

Must accommodations be made?

Can this resident practice safely in the operating room environment?

### *Disability:*

1. Regarding the first case above, can the Asperger's resident above be considered disabled? If so, what accommodations must be made?

2. See hearing Loss above (communication case 2)- resident wants to do pain management on graduation, which will require less listening to monitors and be easier to see lips and faces while talking- is he safe to graduate with this disability? Do you have any duty to accommodate under ADA?

3. Following dismissal early in spring of PGY-1 year for lesions in professionalism, patient care, and medical knowledge, trainee appeals dismissal. During hearing, cited ADHD diagnosed in 3rd year of med school. Resident had not disclosed this during application, interview, or post acceptance medical and psychological occupational health credentialing paperwork. Despite this, grievance panel voted that immediate dismissal had not been warranted. Negotiations about accommodations occurred. After dismissal, resident had applied for and been accepted into another specialty training program and started this program after he was notified he would be accepted back into the anesthesia training program. After 2 weeks of discussions about accommodations, the resident elected not to pursue anesthesiology training. The resident subsequently filed suit for wrongful termination in federal district court.

Should you be concerned or is this a "nuisance" lawsuit?

Is there any way this could have been avoided?

This submission cites a number of interesting case law precedents (provided by submitting faculty):

Precedent review: Discrimination laws do not require "an educational institution to lower or to effect substantial modifications of standards to accommodate a handicapped person." *Southeastern Community College v. Davis*, 442 U.S. 397, 413 (1979). "When the accommodation involves an academic decision, '[courts] should show great respect for the faculty's professional judgment.'" *Amir v. St. Louis Univ.*, 184 F.3d 1017, 1028 (8th Cir. 1999) (quoting *Regents of Univ. of Mich. v. Ewing*, 474 U.S. 214, 225 (1985)). "'University faculties must have the widest range of discretion in making judgments as to the academic performance of students and their entitlement to promotion or graduation.'" *Ewing* at 225 n.11, (quoting *Bd. of Curators, Univ. of Mo. v. Horowitz*, 435 U.S. 78, 96 n.6, (1978) (Powell, J., concurring)). Courts must also give deference to professional academic judgments when evaluating the reasonable accommodation requirement. See *McGregor v. Louisiana State Univ. Bd. of Supervisors*, 3 F.3d 850, 859 (5th Cir.1993); |

#### *Procedural Issues:*

1. Disclosure - A Resident came to PD early in CA1 year and was concerned that anesthesia wasn't a good fit for him. He had significant anxiety issues in the OR - to the point of sweating profusely, shaking, etc. He took an LOA to explore his options. He was seen in employee health and they recommended time away. At this point, the program was asked to wait (as his condition wasn't revealed). Eventually he returned to the OR only to decompensate again and take another LOA. It turns out he had a significant psychiatric problem (which he eventually revealed). He eventually decided to pursue different residency training, ended up at another program in another specialty, had the same problem, ended up with a couple months of inpatient psychiatric care, withdrew from that program, asked about return to anesthesia, applied to another program in the second specialty, which he is in now. Interestingly, this resident also had a 2 month LOA for "personal reasons" during medical school, which was not clarified.

What should have been disclosed to the training program by the trainee?

By the medical school?

What should the training program disclose when asked for letters and performance evaluations of this trainee?

2. Is it appropriate to give a resident who you plan on terminating the option to resign? Does a resident resigning make you more or less vulnerable to legal action?
3. If your state has a physician monitoring or health organization, should you always involve them in the assessment process of a struggling trainee, or only if substance abuse is suspected? If you involve them, are you bound by the results of their findings?

## References

1. Yao DC, Wright SM: The challenge of problem residents. *J Gen Intern Med* 2001; 16:486-92
2. Turner JA, Fitzsimons MG, Pardo MC, Hawkins JL, Huang YM, Rudolph MDD, Keyes MA, Howard-Quijano KJ, Naim NZ, Buckley JC, Grogan TR, Steadman RH: Effect of Performance Deficiencies on Graduation and Board Certification Rates: A 10-yr Multicenter Study of Anesthesiology Residents. *Anesthesiology* 2016; 125:221-9
3. Yao DC, Wright SM: National survey of internal medicine residency program directors regarding problem residents. *JAMA* 2000; 284:1099-104
4. Resnick AS, Mullen JL, Kaiser LR, Morris JB: Patterns and predictions of resident misbehavior--a 10-year retrospective look. *Curr Surg* 2006; 63:418-25
5. Reamy BV, Harman JH: Residents in trouble: an in-depth assessment of the 25-year experience of a single family medicine residency. *Fam Med* 2006; 38:252-7
6. Riebschleger MP, Haftel HM: Remediation in the context of the competencies: a survey of pediatrics residency program directors. *J Grad Med Educ* 2013; 5:60-3