HANDOUT

AACPD
Association of Anesthesiology Core Program Directors

NRMP

Mona M. Singer, M.P.H.

11/11/2016
8:00am – 8:25am

THE MATCH
NATIONAL RESIDENT MATCHING PROGRAM®

Association of Anesthesiology Core Program Directors

Mona M. Signer
President and CEO
November 11, 2016

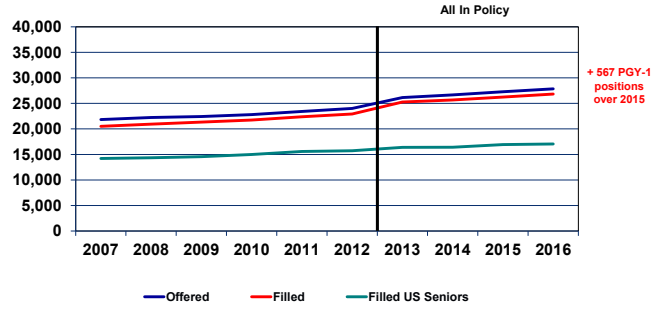
Today's Topics

- Main Residency Match Trends
- Policy Highlights
- NRMP National Conference

I have no conflicts to disclose….

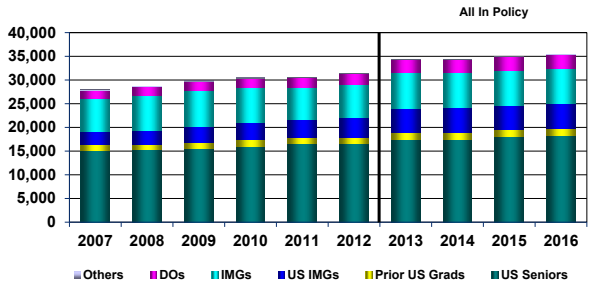
Main Residency Match
PGY-1 Positions Offered and Filled

6,015 More Positions Since 2007



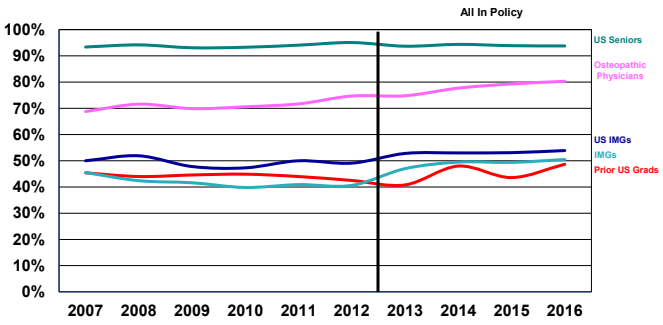
Active Applicants
162 More Seniors, 571 More Active Applicants

7,532 More Applicants Since 2007

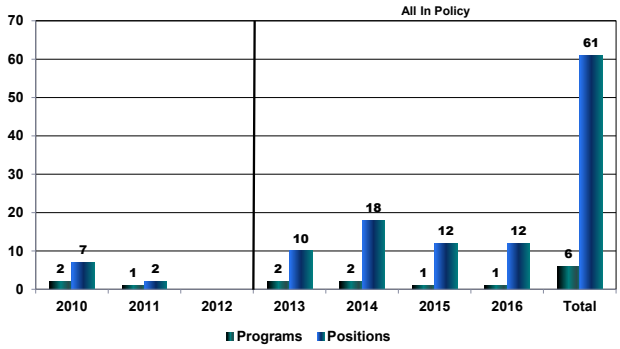


PGY-1 Match Rates by Applicant Type

Overall 2016 Match Rate: 75.6%

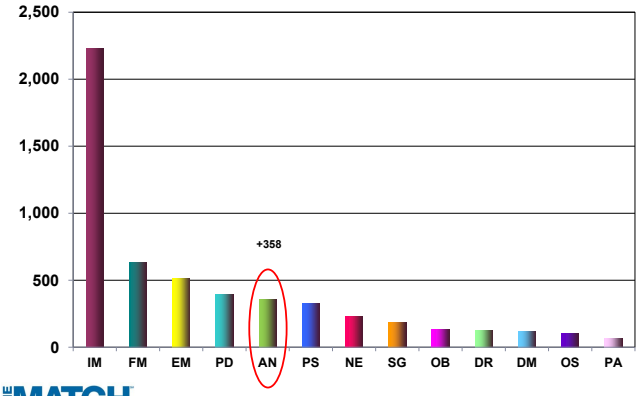


Effect of All In Policy
New Anesthesiology Programs/Positions
ACGME C, A, & R Programs Not in the Match Since 2002



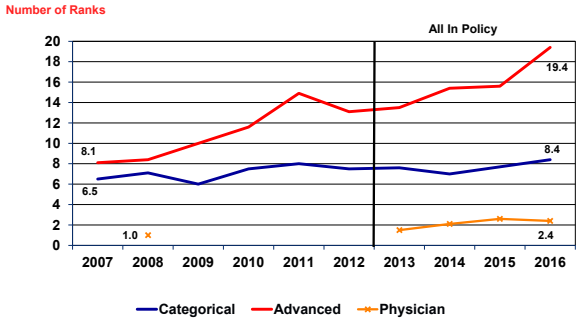
Position Increases by Specialty

At least +50 Categorical Positions, 2007 - 2016



Average Number Ranked Applicants*

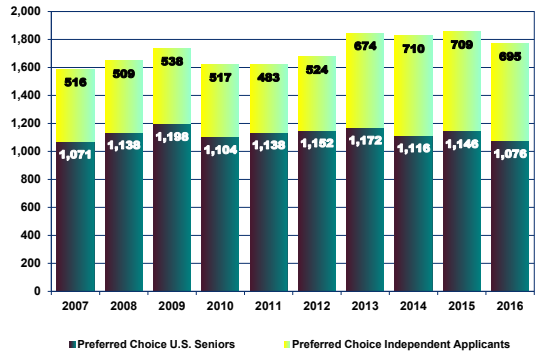
Needed to Fill All Positions



*Number of ranked applicants per position

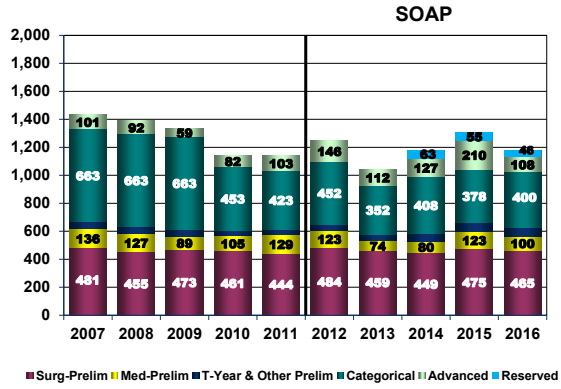
Applicants Preferring Anesthesiology

Includes C, A, and R Positions



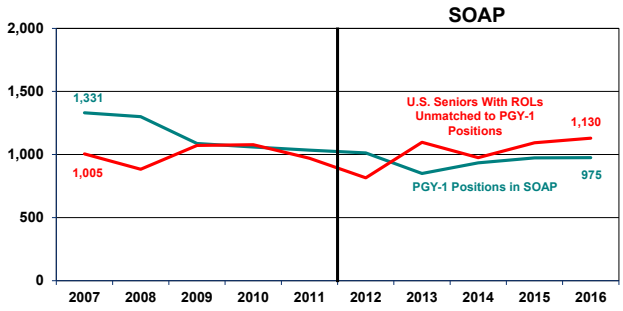
1,178 Unfilled Positions

128 Fewer Than 2015



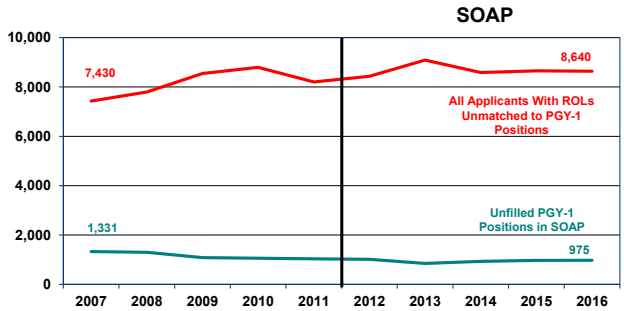
Unmatched Seniors, PGY-1 Positions in SOAP

More Unmatched Seniors than PGY-1 Positions



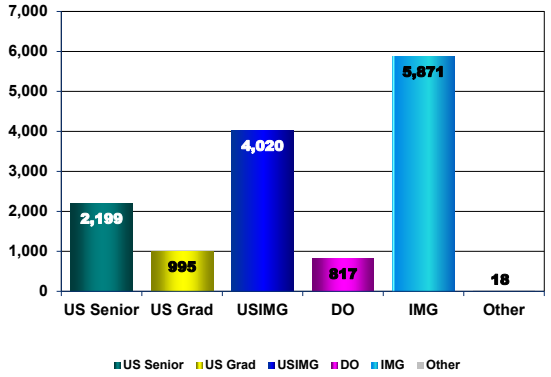
Unmatched Applicants, PGY-1 Positions in SOAP

9 Unmatched Applicants for Every Unfilled Position



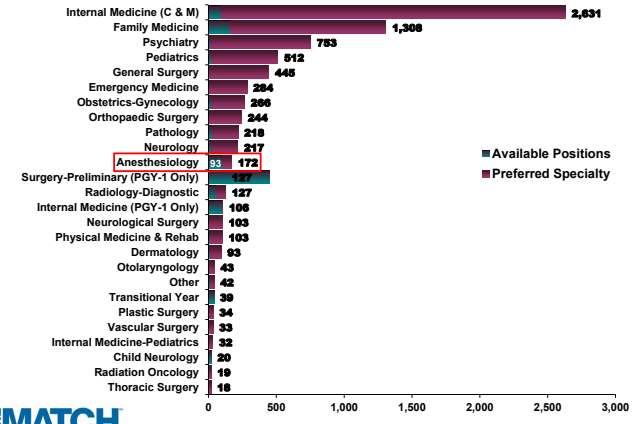
13,920 SOAP-Eligible Applicants

263 More Than 2015



Preferences of Unmatched Applicants

Available SOAP Positions



SOAP Positions

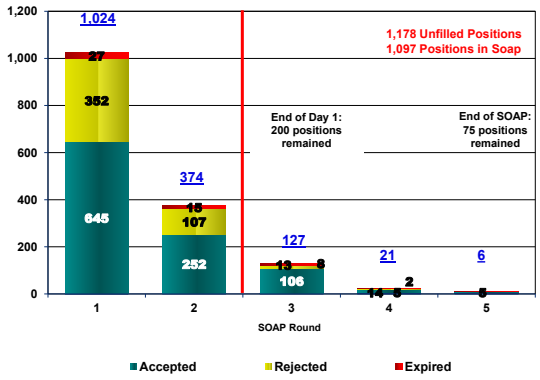
Anesthesiology Offered & Accepted by Applicant Type

More than Half Filled by U.S. Seniors

Applicant Type	Categorical			Advanced			Physician		
	2014	2015	2016	2014	2015	2016	2014	2015	2016
US Senior	16	13	35	19	18	22			
US Graduate	3	4	4	3	2	3	6	5	6
DO	4	5	5	2	2	2			1
US IMG	1	1	3	2	3	4		3	1
IMG			1	2	1	2			
TOTAL	24	23	48	28	26	33	6	8	8

2016 SOAP Positions

Offered & Accepted by Round

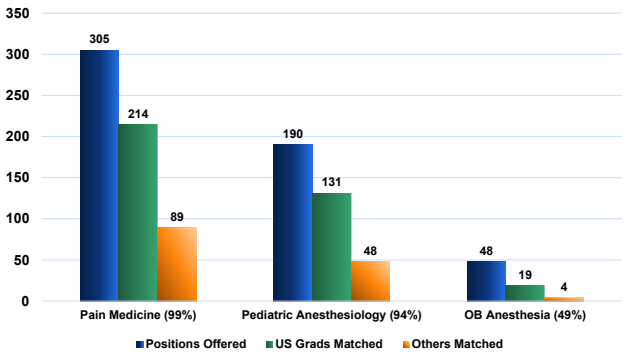


SOAP 2017

Monday	10:30 a.m.	School Unmatched Seniors Report
	11:00 a.m.	Applicant "Did I Match?"
		Program "Did I Fill?"
		List of Unfilled Programs: R3 system
	2:00 p.m.	ERAS opens for applicants
	3:00 p.m.	Programs begin receiving applications
Tuesday		Applicant/program communication
Wednesday	12:00 p.m.	SOAP Round 1: offers valid for 2 hours
	3:00 p.m.	SOAP Round 2
Thursday	8:00 a.m.	School match notification letters
		School match results
		Applicant choices by specialty
	9:00 a.m.	SOAP Round 3
	12:00 p.m.	Updated List of Unfilled Programs: R3 system
Friday	12:00 p.m.	***Match Day Ceremonies***
	1:00 p.m.	Applicant "Where Did I Match?"
	5:00 p.m.	Last offers expire
	12:00 p.m.	Match Results by Ranked Applicant
		Match Outcome for All Programs

Anesthesiology Fellowship Match

2016 Appointments



Today's Topics

- Main Residency Match Trends
- **Policy Highlights**
- NRMP National Conference

All In Policy

Any program participating in the Main Residency Match must register and attempt to fill all positions through the MRM or another national matching plan.

- *All PGY-1 and PGY-2 positions in specialties accredited to begin in PGY-1 and PGY-2*
- *PGY-2 Reserved positions (beginning in the year of the Match)*
- *PGY-3 positions in Child Neurology*

Exceptions considered for:

- ✓ *Programs dually-accredited by AOA and ACGME*
- ✓ *Off-cycle start dates: training begins before February 1*
- ✓ *Rural scholars/FMAT programs*
- ✓ *Innovative training programs*
- ✓ *Military appointees in civilian programs*
- ✓ *Post-SOAP positions for partially-matched applicants*

The Match Commitment

"The listing of an applicant by a program on its certified rank order list or of a program by an applicant on the applicant's certified rank order list establishes a binding commitment to offer or to accept an appointment if a match results and to begin training on the date specified in the contract."

The same binding commitment is established in SOAP.

"Failure to honor this commitment by either party participating in a match will be a breach of this Agreement and may result in penalties to the breaching program or applicant……."

"An applicant who gives notice of resignation, resigns, or vacates a position within 45 days of the start date specified in the appointment contract shall be presumed to have breached the Agreement."

The Match Commitment

Applicants who match to preliminary and advanced positions have two match commitments.

Both match commitments must be honored, and both are subject to the 45-day rule.

Example: An applicant matches to a Preliminary Medicine PGY-1 position to begin training on July 1, 2017 and to an Anesthesiology PGY-2 position to begin training on July 2, 2018. If the matches will not be honored the applicant and/or programs must seek waivers for both positions.

Match Waivers

Applicants:

- Hardship
- Change of specialty: must be requested by December 15
- Completion of residency postponed

Programs:

- Loss of funding
- Loss of accreditation
- Hardship

Waivers must be requested from, and can be granted only by, the NRMP. Applicants and programs cannot release each other.

Match Communication

It is a violation for…

- *a program to request applicants to reveal the names, specialties, geographic locations, or other identifying information about programs to which they have or may apply*
- *an applicant or program to ask the other party to reveal ranking preferences*
- *an applicant to suggest or inform a program that placement on a rank order list or acceptance of an offer during SOAP is contingent upon submission of a verbal or written statement indicating the program's preference*
- *a program to suggest or inform an applicant that placement on a rank order list or a SOAP preference list is contingent upon submission of a verbal or written statement indicating the applicant's preference*
- *a program and an applicant in the Match to make any verbal or written contract for appointment to a concurrent year residency or fellowship position prior to the release of the List of Unfilled Programs*

Common Policy Pitfalls

Application and Interview

- Applicant fails to provide complete, timely, and accurate information to programs
- Program fails to provide complete, timely, and accurate information to applicants, including the contract and appointment policies
- Program asks applicants about other programs where they apply and/or their ranking intentions

Matching and SOAP

- Applicant fails to honor the match commitment
- Applicant accepts a concurrent year position in another program prior to receiving a waiver
- Program offers a position to an applicant matched to a concurrent year position in another program
- Program offers a position to an applicant prior to receiving a waiver
- Applicant contacts directors of unfilled programs outside the SOAP process

Violation Investigations

- Report potential violation to President/CEO
- Information gathered by NRMP
- Preliminary report reviewed by all parties
- Case reviewed by Violations Committee
- Review Panel Report to violator
- Violator can arbitrate; pending action in *R3* system
- Final Report distributed

Violation Investigations
Program Sanctions

- Final Report sent to NRMP IO, ACGME/RC, and program director organization
- Program identified as a violator in R3 system and/or barred from future Matches for 1 - 3 years or permanently
- Violation summary in Institution/Program Report

Violation Investigations
Applicant Sanctions

- Applicant barred from positions in Match-participating institutions for 1 year
- Applicant identified as a violator in *R3* system and barred from future Matches for 1 - 3 years or permanently
- Final Report sent to medical school, ABMS, ECFMG, FSMB, AOA
- Violation summary in Applicant Match History

Today's Topics

- Main Residency Match Trends
- SOAP
- NRMP National Conference

Transition to Residency: Conversations Across the Medical Education Continuum

May 4-6, 2017

- *Anna Quindlen: Health Care in an Information Age*
- *Dr. Daniel Goleman: Emotionally Intelligent Healthcare in Medical Education*
- *Dr. Kenneth Shine: Sustaining the Medical Education Enterprise*

Deadline for Breakout Session Proposals: November 30

Transition to Residency: Conversations Across the Medical Education Continuum

May 4-6, 2017

Broad Themes:

- ***Goodness of Fit**: exploring the role of medical schools and residency programs in addressing application overload*
- ***Matching Process**: using Match data to understand and inform workforce planning*
- ***Unmatched Applicants**: examining outcomes and considering alternatives to clinical medicine*
- ***Innovations in Medical Education**: evaluating the flexibility of the Match in supporting competency-based curricula*
- ***Single Accreditation System***

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HANDOUT

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Association of Anesthesiology Core Program Directors

SF Match

Tim R. Losch

11/11/2016
8:25am – 8:50am

sfmatch
Residency and Fellowship Matching Services

Tim Losch, Executive Director

NOVEMBER 11, 2016

Who is SF Match?

- Nearly 40 years of providing residency and fellowship matching services
- Average staff tenure of 14 years
- Located in San Francisco, CA
- Currently partner with over 20 specialties

sfmatch

SF Match Partners

- Adult Cardiothoracic Anesthesiology
- Critical Care Anesthesiology
- Ophthalmology
- Plastic Surgery
- Orthopaedic Sports Medicine
- Pediatric Neurosurgery
- + 18 Additional Specialties

sfmatch

Partnering With SF Match

- Specialty society is the sponsor
- Wide ranging size of participating specialties (25 programs to 100+ programs)
- Collaborate with the sponsor to set match dates
- Sponsor can customize the common application
- Work with the sponsor to respond to possible rule violations, implement society-specific rules and to adjudicate sanctions

sfmatch

SF Match System

- Easy to use
- Applications, rank Lists and match results in one place
- Easy access to program history
  - Previous cycles' rank lists
  - Match results
  - Applications
- Detailed customized data reports

sfmatch

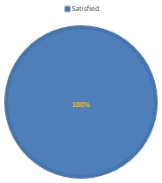
SF Match System Features

- Search and filter on specific criteria
- Customizable categories for sorting
- Customizable quick view preview options
- Consolidated applicant profiles
- Immediate email notifications

sfmatch

Proven Track Record

PROGRAMS



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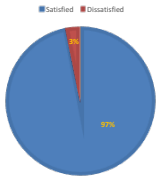
Proven Track Record

APPLICANTS



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Program Fees

- Registration 1st year
  - $325
- Annual registration thereafter
  - $150
- Ranking
  - $0

sfmatch

Applicant Registration Fees

- Non-centralized application match = $50
- Centralized application match
  - $100
- Ranking
  - $0

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Applicant Distribution Fees

# of CAS Distributions	Fee
1 - 10	$60 total
11 - 20	$10 per program
21 - 30	$15 per program
31 - 40	$20 per program
41+	$35 per program

sfmatch

SF Match Summary

- Flexible
- Customizable by the specialty partner
- Specialty representation during violations
- 100% partner satisfaction

sfmatch

tlosch@sfmatch.org 415.447.0244

Thank You

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Association of Anesthesiology Core Program Directors

Military Match

LCDR Derek L. Foerschler, D.O.

11/11/2016
8:50am – 9:15am

Military and the Match

SAAA 2016 Annual Meeting

Derek L Foerschler, DO
LCDR MC USN
Naval Medical Center Portsmouth

Disclaimer

- The views expressed in this presentation are those of the author and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense, or the United States Government.

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Objectives

- Describe the timeline for graduate medical education in the military system.
- Compare and contrast the current military and civilian graduate medical education application and selection processes.
- Understand the impact of current practices in the military on civilian GME selection.

GME in the Military

- Internship/PGY-1 application follows a similar timeline as the civilian Match, although results are known in December.
  - ERAS/NRMP vs. MODS
- However, in the military, 4th year medical students apply for *internship only.*
  - Most will complete internship at a military hospital.
  - A select few will be allowed to request a civilian deferment for internship +/- residency.
  - May apply to ERAS and military match without conflict.

Post-internship in the Military

- During internship, they apply for follow-on residency training and/or operational assignment as a General Medical Officer (GMO).
  - Most will complete an operational tour as a GMO, flight surgeon or diving medical officer.
    - Usually 2-4 years
  - A select few will be permitted to go straight through in residency training, depending on specialty and needs of the military.

Operational Medicine

Residency Training in the Military

- Application for residency follows a similar timeline as the civilian match, although results are known in December.
- Apply during last year of GMO tour.
  - Most will apply for military residency.
  - Some may be approved for deferment to civilian training, depending on the needs of the military.
  - May apply to ERAS and military match without conflict.

Fellowship Training in the Military

- Current military system and the (new) Fellowship Match system are out of sync.
- Fellowships have moved towards the Match which involves a year and a half process, starting with application in January.
- Military GME selection remains ~ 6 month process (July – Dec), and is too late to apply through the fellowship Match.

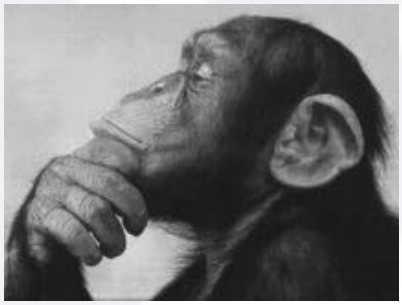
Fellowship Training in the Military

- The only current option is selection outside the Match, after the results of the Military GME selection board are released in December.
  - Benefit to civilian programs is that the position is fully funded by the military.

Fellowship Training in the Military

- The military is now moving towards a "Pre-Select" option for fellowship.
  - Will occur 2 years in advance and will allow timely participation in the fellowship Match.
  - Likely won't be in effect until 2018

Questions?



Contact Info

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  (757) 953-3270/3240 or
  derek.l.foerschler.mil@mail.mil

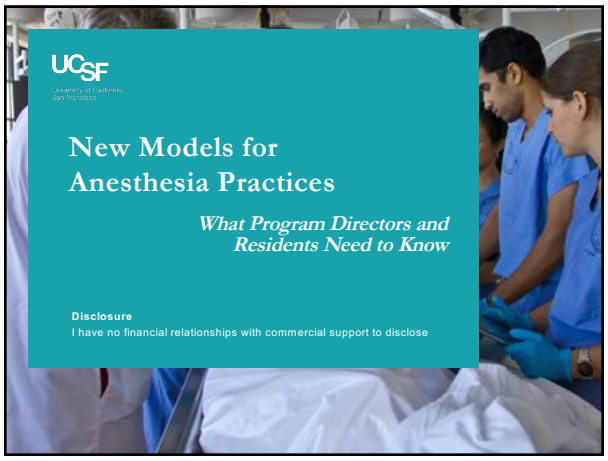
HANDOUT

AACPD
ASSOCIATION OF ANESTHESIOLOGY CORE PROGRAM DIRECTORS

New Models for Anesthesia Practices: What Program Directors and Residents Need to Know

Neal Cohen, M.D., M.P.H., M.S.

11/11/2016
9:30am – 10:00am



New Models of Anesthesia Practices *Implications for Resident Education*

Objectives

- Describe recent trends in health system and clinical practice consolidation
- Identify the potential impact of consolidation (and some associated changes) on resident and fellow educational needs, expectations, and professional goals
- Define implications of the consolidation of practices on the future of anesthesia training

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Clinical Practice Consolidation

- Hospital and Health System
- Anesthesia (and Other Single Specialty) Group Practices
- Multi-Specialty Group Practices

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Health System Consolidation

- **Consolidation of Health Systems Takes Many Forms**
  - Acquisitions
  - Affiliations
  - Accountable Care Organizations

  } May or may not include physician practices
- **Goal**
  - Create competitive advantage
  - Seamless transitions of care
  - Optimize patient access to tertiary care
  - Clinical and financial integration
    - Reduce redundancies, costs
    - Formation of a Health Plan, self-insurance

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Why Should We Care about Health System Consolidation?

- Academic and community system consolidation (and competition)
- "Distraction" from academic focus
- Distribution of clinical volume, service lines
  - Where will residents obtain breadth of clinical experience, training?
  - Who are the "faculty"?
  - How can we engage community providers?
  - How do we ensure consistent quality of education, commitment to ACGME requirements, etc?
  - How do we advance the multiple missions of academic departments?
- Redefining educational needs for our residents and fellows

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Why Should We Care?

Academic Health System Mergers, Acquisitions, Affiliations

- Large Health Systems will control patient flow, distribution of clinical services and impact the academic agenda
- Changing financial relationships between Academic Health Systems and Faculty Practices
  - Financial integration (Funds Flow)
  - Expanded Staff Physician Model
- Some recent examples
  - ***Banner Health***
    - Acquisition included UA Medical Centers, Faculty Practice, Health Plans
  - **Fairview Health**
    - Previously "rescued" the University of Minnesota Hospitals and Clinics and merged with UM Physicians
  - ***Canopy Health*** (UCSF Health, John Muir Health System)

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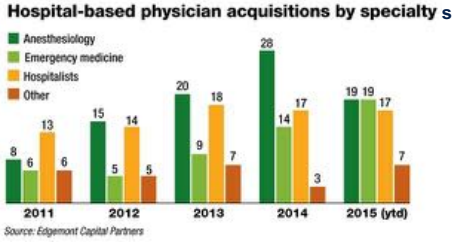
Consolidation of Anesthesia Practices

- Accelerating acquisition of community practices into large groups
- Integration of community practices and academic departments
- Expansion of multispecialty physician groups

Acquisition and Consolidation



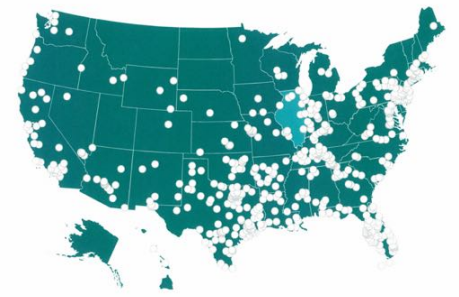
Anesthesia Practice Consolidation

- Scale Creates Opportunity
  - Access to human, technical and information management resources
  - Enhanced financial performance and stability
  - Better able to fulfill healthcare reform requirements
  - Essential for implementation of new clinical and payment models
  - Improves ability to focus on improving patient care
- Diversification Expands Options
  - More diverse workforce, greater flexibility in staffing options
  - Better able to manage continuum of care
  - Improved ability to partner with health systems

"Anesthesia" Practice Consolidation

- SheridanHealthcare – AmSurg – (Envision Health)
  - Anesthesiology, Emergency Medicine, Neonatology, Radiology
  - Ambulatory Surgery Centers
- Mednax
  - Anesthesiology, Neonatology, Maternal-Fetal Medicine, Pediatric Specialty Services
  - Acquired 9 physician practices in 2016 – so far
- TEAMHealth
  - Anesthesiology, Emergency Medicine, Hospital Medicine
- USAP (US Anesthesia Partners)
  - Anesthesiology, Pain Management
- North American Partners in Anesthesia
  - Anesthesiology, Pain Management (NAPPM), Gastroenterology
- CEP America
  - Emergency Medicine, Urgent Care, Telehealth, Hospital Medicine, Anesthesiology, Critical Care Medicine

Diversification – Clinical and Geographic



What Does This Consolidation Mean for Academic Programs?

"If I were a CEO looking for anesthesia today I would definitely select ___ anesthesia services, because they always do what they say they're gonna do."

- Perception that LGPs make "better partners"
  - Both small anesthesia practices and academic departments
- *At the same time*, creates opportunity to expand training programs to community sites (differentiate health system)
- Multi-specialty groups provide broader scope of services
  - Aligned incentives
  - Less internal competition

Gartner Hype Cycle

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What does this mean for resident education?

- Practice opportunities and professional expectations have changed
- Training programs need to understand and respond to these changes
  - Redefining clinical skills, experiences, workforce needs
  - Ensuring that educational program and professional opportunities align

but…

- Do we follow or do we lead?
- What will be our measure(s) of success?

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Current Realities…

- Anesthesia Practice Opportunities
  - Academic and community practices have similar (clinical) expectations
  - Scope of involvement in clinical care may vary
    - Generalist/specialist opportunities
    - Perioperative care; extended models of care
- Professional Expectations
  - Employed model is not only acceptable, but preferable
  - Lifestyle, Work-Life Balance are significant determinant
  - Clinical roles and responsibilities are evolving
    - Traditional role(s) for anesthesiologists
    - Subspecialty opportunities
    - New models of care

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Educational Concerns of Large Group Practices

- "Anesthesia residents are *not ready* for practice"
  - Clinical skills acknowledged
  - "Speed", efficiency under-emphasized
  - Limited understanding of the changing scope of practice or the "business" of anesthesia
- *but* what do they really mean?

…Anesthesia residents are not ready for "our" practice

Practice models (care team, others)
Differentiated roles and responsibilities

Proprietary quality metrics
Business relationships that impact clinical practice

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Educational Implications of these Trends

The challenge for our residents and training programs is to adopt a new paradigm for anesthesiology

- Good intraoperative care is not enough – but remains our primary obligation!
- Improve coordination and communication through transitions of care
- Define opportunities to participate in the entire continuum of care
- Understand the changing role(s) graduating residents will have within large groups and incorporate some of the basic skill needs into the residency program
- Identify basic clinical, supervisory, management and administrative roles
  - Understand implications of the shift to value-based purchasing on anesthesia care
  - Define and operationalize the "quadruple" aim – quality, safety, cost, patient satisfaction
  - Define the foundational practice management skills (models of care, economics, negotiations, etc.) and develop educational approaches to providing them
- Clarify *patient* needs and define ways to fulfill them
- Identify professional goals for each resident and tailor the program appropriately.

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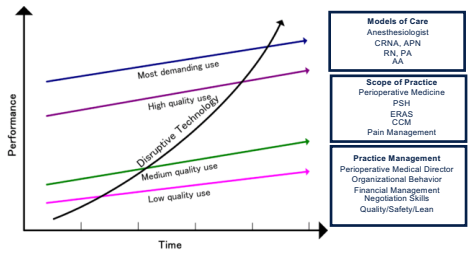
Redefining the Anesthesia Care



Clayton Christensen, The Innovator's Perscription; McGraw Hill, 2009

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Implications of Anesthesia Practice Acquisitions - How Do We Prepare Residents for This Accelerating Trend?

- What are we doing right?
  - Our residents have good clinical capabilities in "traditional" *anesthesia care*
  - ACGME requirement for participation on *quality initiatives*
  - Health system *incentives* (financial and other)
  - *Scholarship* opportunities
- What challenges need to be addressed?
  - What should be included in core residency training?
  - What is better provided during fellowship training?
  - How can (or should) we define our role in the continuum of care?
  - How can we prepare residents for "their" personal expectations and address individual career goals – many of which are not defined until later?
  - Is there a role for the training programs to help practicing anesthesiologists develop new skills after core residency training?

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Other Educational Implications of Practice Consolidation/Integration

- Define ways for academic and community practices/large groups to work collaboratively to meet resident educational/clinical needs
  - Clinical experiences, scope of role and responsibilities
  - Teaching opportunities for community providers, including educational programs, clarifying expectations, ensuring compliance with duty hours and other requirements
  - Management opportunities
  - Exposure to group quality metrics, approach to managing bundled payments, value based purchasing

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What is the Role for RRC, ACGME, ABA, ABMS?

- Accrediting and credentialing organizations have refined the educational program needs
  - ACGME and RRC have some ability to refine program requirements and "mandate" clinical and other educational goals
    - Duty Hours
    - Clinical Learning Environment (CLER)
    - Quality of Care Projects
  - ABA has refined the credentialing process to include clinical skills, crisis management, team coordination, etc.
  - ABMS and ABA continue to refine "maintenance of certification" process
- For the most part, these organizations are more reactive than proactive, *by design*
- At the same time, ACGME and ABA can serve as monitors of the impact of consolidation on resident education and faculty development

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Educational Opportunities

- Programs have the ability to be proactive and propose and evaluate "blue sky" initiatives to address the changing landscape
  - Pilot educational programs
  - Perioperative medicine experiences (whatever those might be)
  - Management training, negotiation skills, data analytical skills
- Program Directors and Faculty can reevaluate the continuum of "anesthesia training"?
  - How can we think differently about the core residency and fellowship scope of training and practice?
  - Where do training related to perioperative medicine, perioperative management or non-hospital-based clinical strategies fit into the *continuum of anesthesia education*?
- While doing so, we must also ensure that the *faculty* have the expertise, commitment and ability to participate in the changes, serve as role models and teachers, particularly with respect to expanded scopes of practice?

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What Will Be Our Measures of Success?

- Clinical Competence?
- Continued ACGME Accreditation?
- Exam Pass Rates, Board Scores?
- Acknowledgement from Large Group Practices, Health Systems, Other Clinicians?
- Advancing Safety and Quality of Care
- Providing Value (but to whom?)

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New Models for Anesthesia Practices
Summary

- The practice of medicine in general and anesthesia in particular is undergoing dramatic change
  - Consolidation
  - Competition
  - Changing scope of practice, roles and responsibilities
- Residency programs are responding to these changes by refining the educational experiences, though the dynamic environment makes it challenging to define “best practices”
- All residency programs need to monitor the impact of consolidation and health care reform initiatives on practice needs and refine the educational program (requirements) to ensure that each resident has the foundation upon which to build a successful career

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HANDOUT

AACPD
Association of Anesthesiology Core Program Directors

Managing Difficult Trainees

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

11/11/2016
10:30am – 12:00pm

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."[1] 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.[2] This falls within, though at the higher end, of the spectrum of reported incidences of problem or difficult trainees across medical specialties.[3-5] 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.[1,3] 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.[6]

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.[2] 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%.[2]

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

HANDOUT

AACPD
Association of Anesthesiology Core Program Directors

Mock RRC Meeting

Keith H. Baker, M.D., Ph.D.
Robert R. Gaiser, M.D., M.S.Ed.
Anne Gravel Sullivan, Ph.D.
Andrew J. Patterson, M.D., Ph.D.
James Ramsay, M.D.
Santhanam Suresh, M.D., F.A.A.P.
Cynthia A. Wong, M.D.

11/11/2016
1:30pm – 3:00pm

HANDOUT

AACPD
Association of Anesthesiology Core Program Directors

Everything You Always Wanted to Know About Other Programs…

Paul W. Kranner, M.D.
Amy Murray, M.D.

11/11/2016
3:30pm – 5:00pm

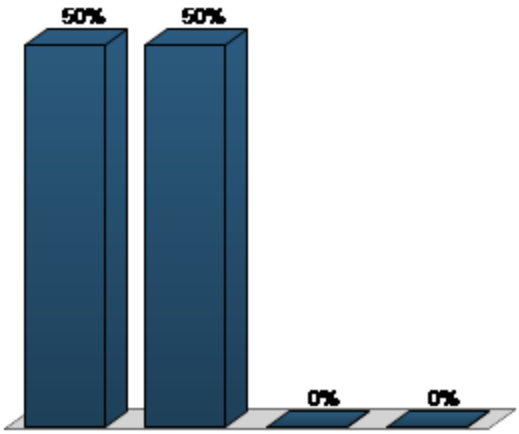
Session Name: Everything YAWTK 2016 report

Date Created:	11/11/2016 3:22:25 PM	**Active Participants:**	85 of 85
Average Score:	0.00%	**Questions:**	32

Results by Question

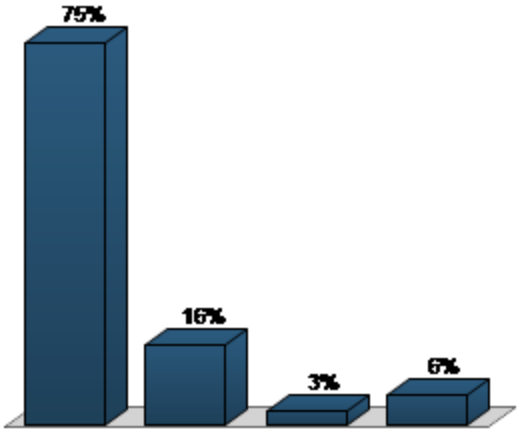
1. Results from the previous "Everything You Always Wanted to Know" audience response sessions have been: (Multiple Choice)

	Responses	
	Percent	**Count**
Useful and I have shared some of those results with my own program	50%	1
Not very useful for sharing, but still interesting	50%	1
Not useful or interesting (but it seems to be keeping me awake)	0%	0
ZZZZZzzzzzzz	0%	0
Totals	**100%**	**2**



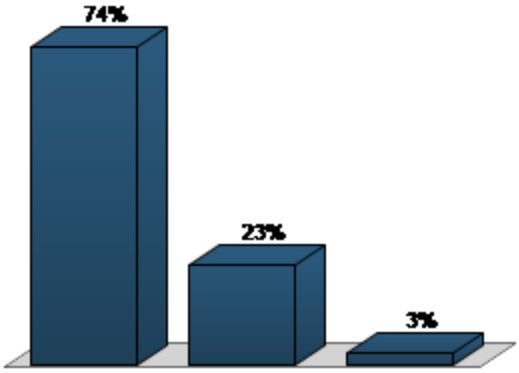
2. Results from the previous "Everything You Always Wanted to Know" audience response sessions have been: (Multiple Choice)

	Responses	
	Percent	**Count**
Useful and I have shared some of those results with my own program	75.36%	52
Not very useful for sharing, but still interesting	15.94%	11
Not useful or interesting (but it seems to be keeping me awake)	2.9%	2
ZZZZZzzzzzzz	5.8%	4
Totals	**100%**	**69**



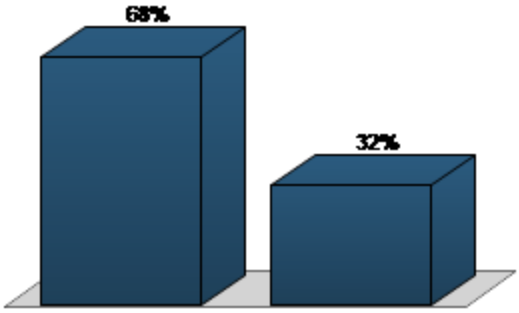
3. Regarding the ABA exams, in general: (Multiple Choice)

	Responses	
	Percent	**Count**
Our learners want to be "taught to the test" but they are still getting a solid foundation	73.97%	54
Our learners want to be "taught to the test" and they are NOT getting a solid foundation	23.29%	17
Our learners don't focus on being "taught to the test" (please share your secret)	2.74%	2
Totals	**100%**	**73**



4. Do you provide an online question bank resource for your residents? (Multiple Choice)

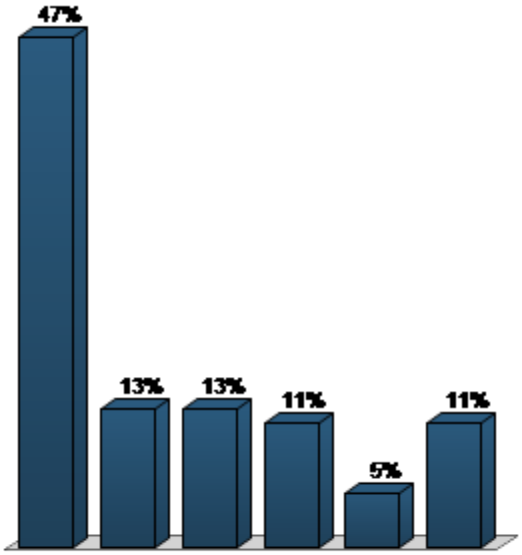
	Responses	
	Percent	**Count**
Yes	67.5%	54
No	32.5%	26
Totals	**100%**	**80**



5. Whether you provide it or not, which question bank resource are your residents primarily using? (Multiple Choice)

	Responses	
	Percent	**Count**
True Learn	46.84%	37
Learnly	12.66%	10
M5	12.66%	10

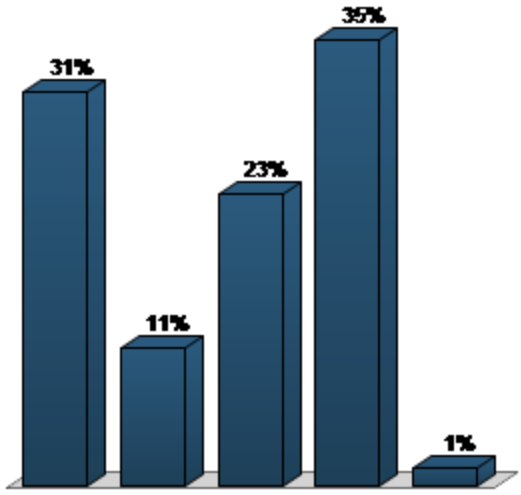
ACE questions	11.39%	9
Hall questions	5.06%	4
I have no idea	11.39%	9
Totals	**100%**	**79**



6. From ACGME Program Requirements: Effective July 2016, Residents must have at least two weeks of experience managing the anesthetic care of patients undergoing diagnostic or therapeutic procedures outside of the surgical suite. Our program will: (Multiple Choice)

	Responses	
	Percent	**Count**
Create a 2-week rotation from scratch	30.67%	23
Adapt a current 2-week rotation	10.67%	8
Allow the experience to happen over the course of residency, less	22.67%	17

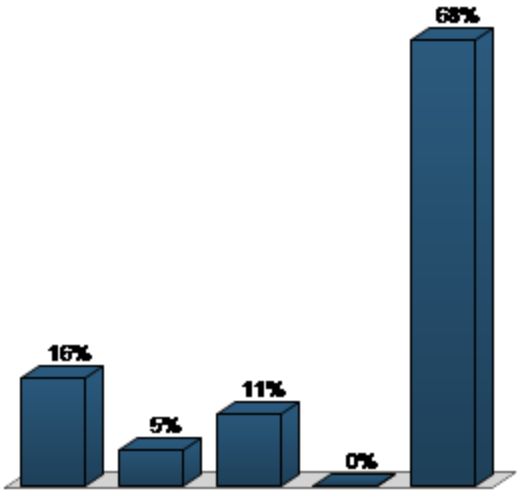
identifiable as a formal rotation, but adequate		
Not be doing anything differently as we already have an "outside" the O.R. rotation	34.67%	26
Not be doing anything differently and we don't have a rotation	1.33%	1
Totals	**100%**	**75**



7. For this "outside the O.R." experience, our residents will primarily be training in the following environment: (Multiple Choice)

	Responses	
	Percent	**Count**
GI lab	16.22%	12
Electrophysiology/Cardiac	5.41%	4

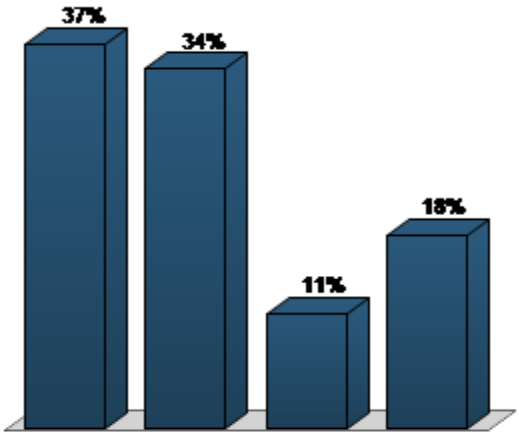
Cath lab		
Radiology/MRI	10.81%	8
Sedation team	0%	0
Other	67.57%	50
Totals	**100%**	**74**



8. Regarding Critical Care experience during residency, ACGME requires that resident education must include a minimum of 4 months (and no more than two of those should be before CA-1 year). Our residents: (Multiple Choice)

	Responses	
	Percent	**Count**
Do exactly 4 required months of critical care during residency	36.59%	30
Do 4-5 required months which seems acceptable	34.15%	28
Do more than 5 required months of critical care	10.98%	9

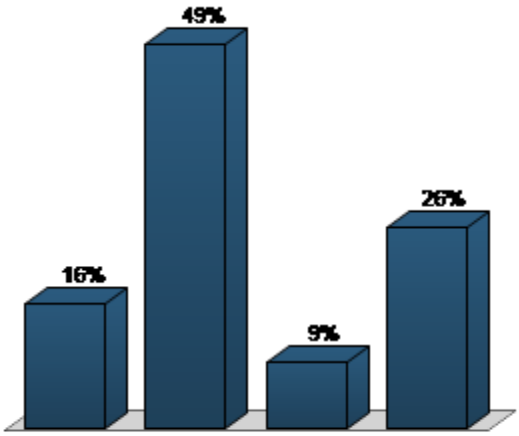
during residency because there is no maximum number		
Some do more than 5 months, but they are ELECTIVE months, not required	18.29%	15
Totals	**100%**	**82**



9. The ACGME Resident Survey is useful vs. NOT useful for program improvements. Our residents provide accurate vs. inaccurate data: (Multiple Choice)

	Responses	
	Percent	**Count**
useful , accurate	16.05%	13
useful , inaccurate	49.38%	40
NOT useful, accurate	8.64%	7
NOT useful, inaccurate	25.93%	21

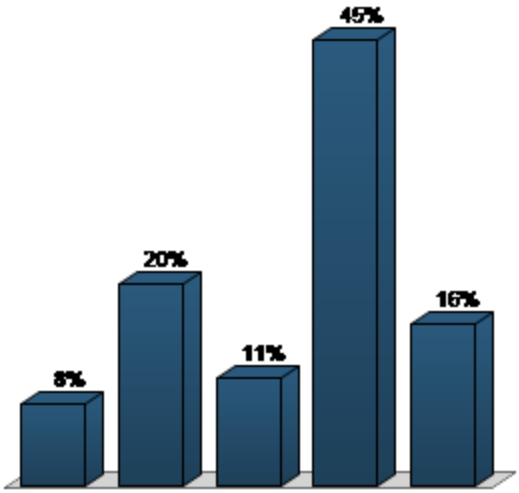
Totals	**100%**	**81**



10. Regarding the CLER… When it comes to institutional Quality and Safety projects, we: (Multiple Choice)

	Responses	
	Percent	**Count**
Have a useful up-to-date web-based repository or on-line tool that lists current projects/investigators and effectively communicate across departments	8.11%	6
Have that tool described above, but it is not very useful or effective	20.27%	15
Do NOT have that website described above, but plan on having one soon	10.81%	8
Don’t have the website, can’t	44.59%	33

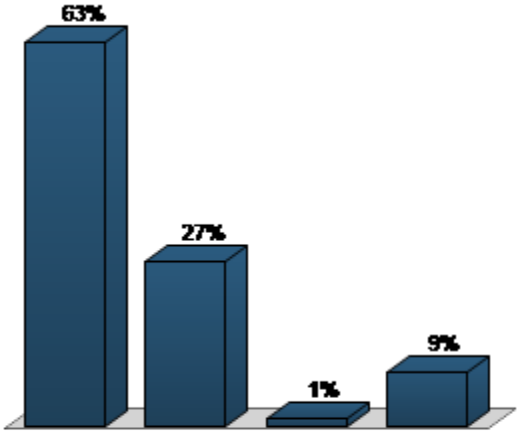
imagine that happening anytime soon		
Are still trying to figure out what the CLER is all about	16.22%	12
Totals	**100%**	**74**



11. Last year, 83% of programs responded that they had a year of "fundamental clinical skills education" (CBY Internship). How would you best describe that internship?: (Multiple Choice)

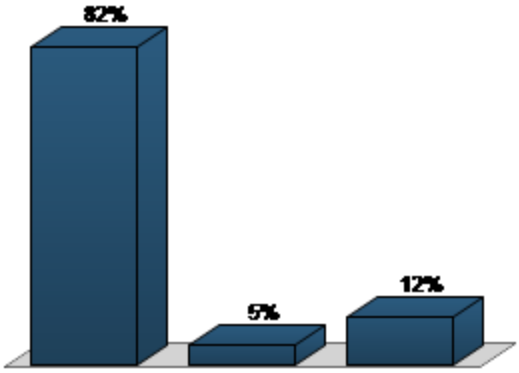
	Responses	
	Percent	**Count**
Primarily scheduled and controlled by Department of Anesthesiology	62.82%	49
Primarily run by Internal Medicine	26.92%	21
Primarily run by General Surgery	1.28%	1

We do not have one	8.97%	7
Totals	**100%**	**78**



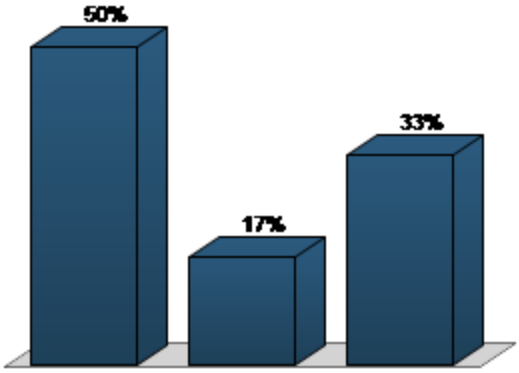
12. Do any of your residents take 24 hour in-house call? (Multiple Choice)

	Responses	
	Percent	**Count**
Yes, is there anything wrong with that?	82.5%	66
Yes, but we may be making some changes in the future	5%	4
No	12.5%	10
Totals	**100%**	**80**



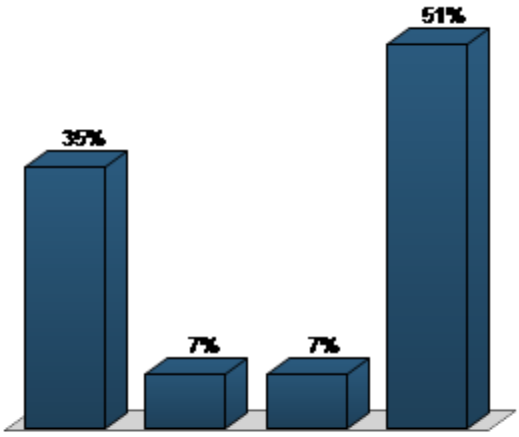
13. Last year, only 15% of programs offered "internal moonlighting" $ to residents (after typical workday or on weekends). Regarding "moonlighting": (Multiple Choice)

	Responses	
	Percent	**Count**
Our program offers moonlighting and pays for it out of departmental funds	50%	41
Our program offers moonlighting and GME/hospital pays for it	17.07%	14
Our program does not offer internal moonlighting	32.93%	27
Totals	**100%**	**82**



14. If you do offer internal moonlighting, which services are covered: (Multiple Choice)

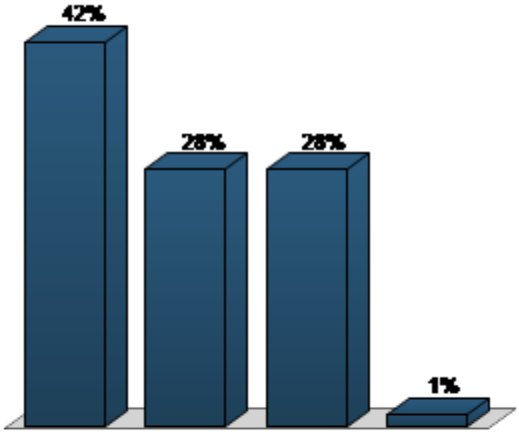
	Responses	
	Percent	**Count**
O.R.	34.55%	19
ICU	7.27%	4
OB	7.27%	4
More than one of the above	50.91%	28
Totals	**100%**	**55**



15. Regarding "point of care" ultrasound training: (Multiple Choice)

	Responses

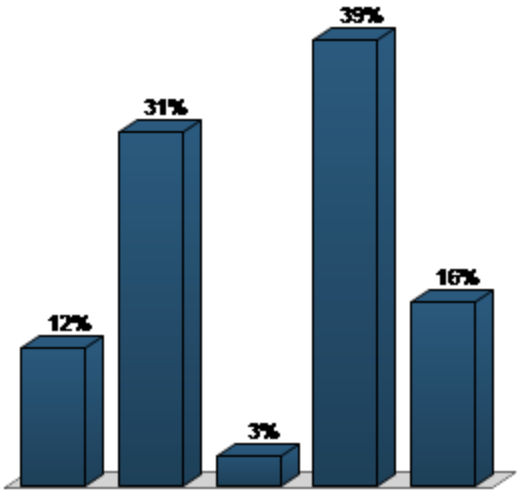
	Percent	Count
We have FORMALLY incorporated it into our curriculum	42.25%	30
We have INFORMALLY incorporated it into our curriculum	28.17%	20
We hope to incorporate it in the future	28.17%	20
We will not be incorporating it	1.41%	1
Totals	**100%**	**71**



16. Incorporation of technology (web-based games, desk top computer simulations, etc…) into our training program is: (Multiple Choice)

	Responses	
	Percent	**Count**

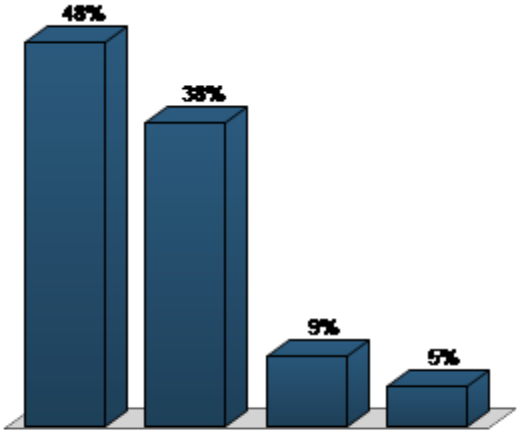
One of our strengths that faces no significant limitations	12%	9
Limited by the interest/motivation of the faculty	30.67%	23
Limited by the interest of the residents	2.67%	2
Limited by the lack of competent IT support	38.67%	29
Doesn't matter, because this is all just a fad	16%	12
Totals	**100%**	**75**



17. Our residency program is rigorous vs. NOT as rigorous clinically,and strong vs. NOT as strong academically: (Multiple Choice)

	Responses

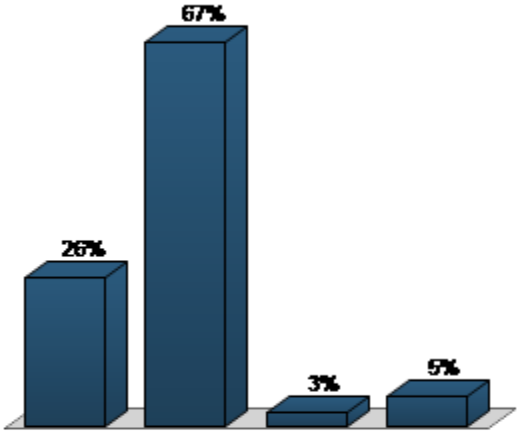
	Percent	Count
rigorous, strong	48.1%	38
rigorous, NOT as strong	37.97%	30
NOT as rigorous, strong	8.86%	7
NOT rigorous, NOT strong	5.06%	4
Totals	**100%**	**79**



18. We would be stronger academically if it weren't for (choose the one best answer): (Multiple Choice)

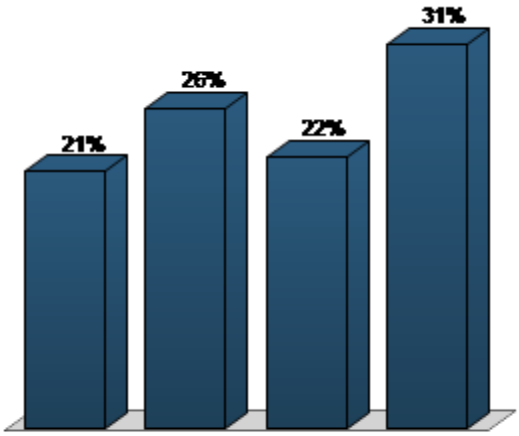
	Responses	
	Percent	**Count**
Disengaged faculty	25.64%	20
Too many clinical duties, service over education	66.67%	52
Lack of resources for research	2.56%	2

Unmotivated residents	5.13%	4
Totals	**100%**	**78**



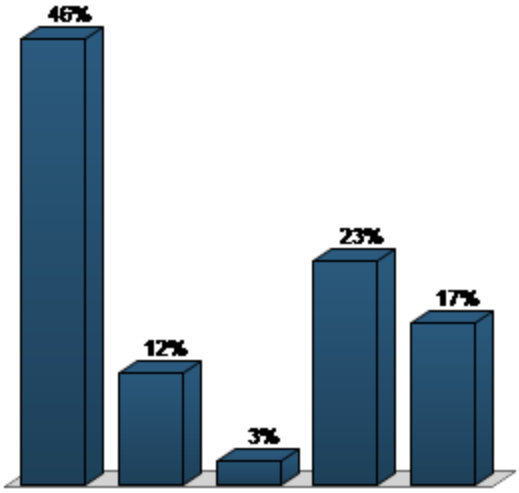
19. Regarding faculty evaluations of residents: Our evaluations are confidential vs. signed and we get useful vs. not very useful data from them. (Multiple Choice)

	Responses	
	Percent	**Count**
Confidential/useful	20.78%	16
Confidential/not very useful	25.97%	20
Signed/useful	22.08%	17
Signed/not very useful	31.17%	24
Totals	**100%**	**77**



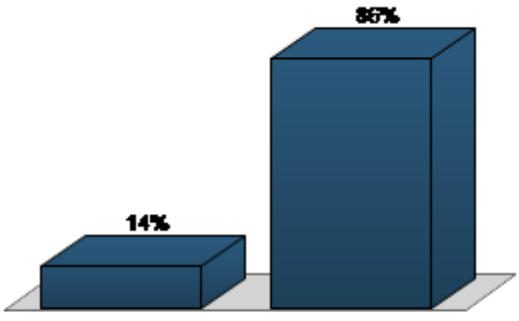
20. In general, our faculty engagement is: (Multiple Choice)

	Responses	
	Percent	**Count**
Getting better because the newer faculty bring some energy	46.15%	36
Getting better because of more incentives from our Chair (please share ideas)	11.54%	9
Getting better, no explanation though	2.56%	2
No better, no worse than previous years	23.08%	18
Getting worse	16.67%	13
Totals	**100%**	**78**



21. In 2014, 47% of PDs responded that they will not use the SLOR. In 2015, 67% responded that they will not use the SLOR. This year: (Multiple Choice)

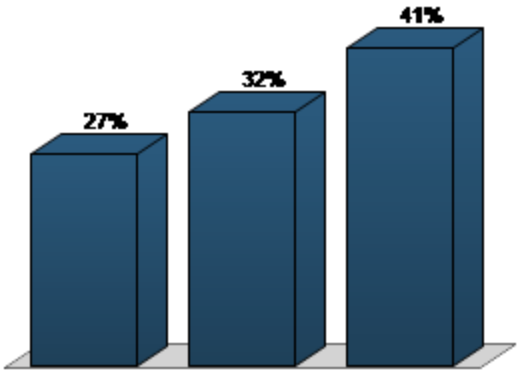
	Responses	
	Percent	**Count**
I will use/am using the SLOR	14.47%	11
I will not use/am not using the SLOR	85.53%	65
Totals	**100%**	**76**



22. When I come across a SLOR, I find it to be: (Multiple Choice)

	Responses

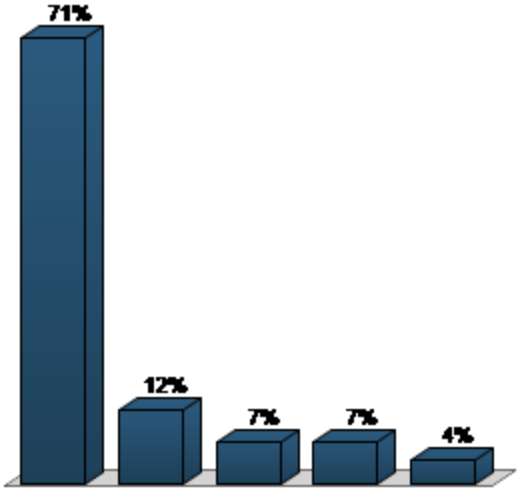
	Percent	Count
More useful than a traditional letter	27.03%	20
Less useful than a traditional letter	32.43%	24
Equivalent to a traditional letter, as I primarily value the brief narrative at the end	40.54%	30
Totals	**100%**	**74**



23. The administrative support that my program coordinator provides to me is: (Multiple Choice)

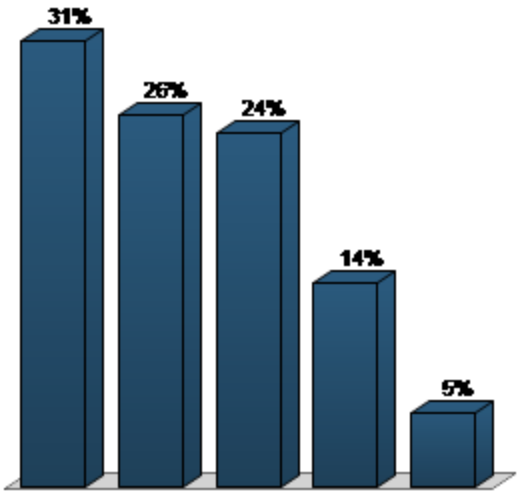
	Responses	
	Percent	**Count**
Excellent (what would I do without him/her?)	71.05%	54
Good	11.84%	9
Satisfactory	6.58%	5
Poor	6.58%	5

Unsatisfactory (you know any good coordinators?)	3.95%	3
Totals	**100%**	**76**



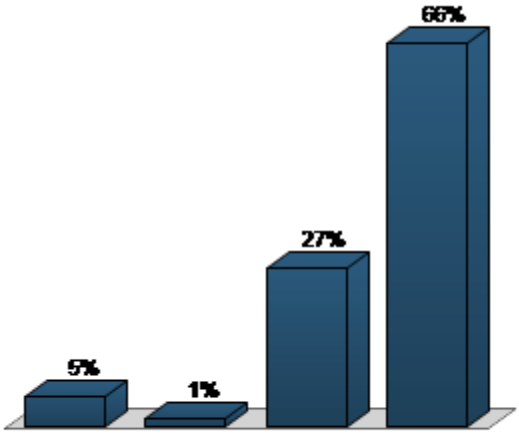
24. The support that our institutional GME provides to me as a program director is: (Multiple Choice)

	Responses	
	Percent	**Count**
Excellent (what would I do without them?)	30.77%	24
Good	25.64%	20
Satisfactory	24.36%	19
Poor	14.1%	11
Unsatisfactory (do they even really know me?)	5.13%	4
Totals	**100%**	**78**



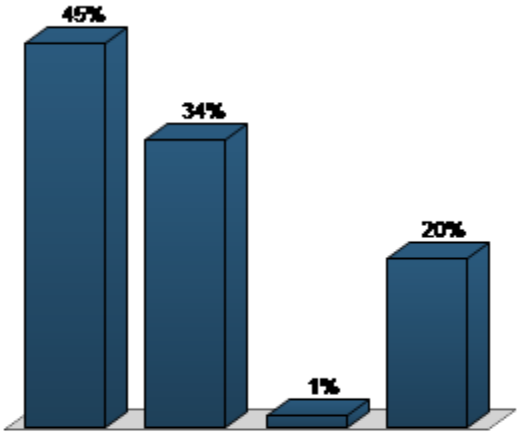
25. Do you search social media sites for information about residency applicants? (Multiple Choice)

	Responses	
	Percent	**Count**
Almost always	5.19%	4
Frequently	1.3%	1
Occasionally	27.27%	21
Never	66.23%	51
Totals	**100%**	**77**



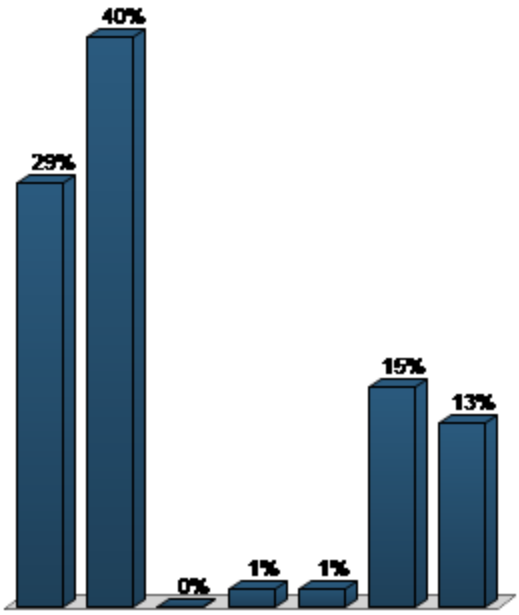
26. Last year, 96% of you responded that you have an Assistant/Associate PD. If you do, answer the following question about protected time: (Multiple Choice)

	Responses	
	Percent	**Count**
We each get the full time recommended, no need to share the time or split between us.	45.07%	32
We split the time between us, not equally but fair.	33.8%	24
We have to share that time and we split it equally.	1.41%	1
We don't even get the protected time ACGME says we should get.	19.72%	14
Totals	**100%**	**71**



27. As program director, what keeps you up at night worrying as you train the anesthesiologists of the future?: (Multiple Choice)

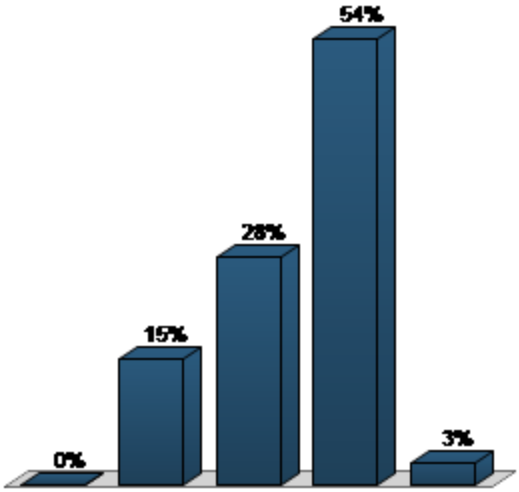
	Responses	
	Percent	**Count**
What will be the next ACGME “thing” (new mandate, site visit, resident survey, etc.)?	29.49%	23
Are we coddling our residents too much?	39.74%	31
Are we too tough on our residents?	0%	0
Will there be enough of them to care for patients?	1.28%	1
Will there be too many of them?	1.28%	1
Are we preparing them for changes in healthcare?	15.38%	12
I don’t lose too much sleep worrying about any of this (please share your secret)	12.82%	10
Totals	**100%**	**78**



28. What would YOU do? (Assuming that your response might depend on the previous behavior of the resident…) (Multiple Choice)

	Responses	
	Percent	**Count**
Do nothing	0%	0
Reiterate the policy, no punishment or penalty.	15.28%	11
Reiterate the policy, and create an internal punishment/penalty (examples?)	27.78%	20
Inform the ABA	54.17%	39
This resident's previous behavior has NOTHING to do with my	2.78%	2

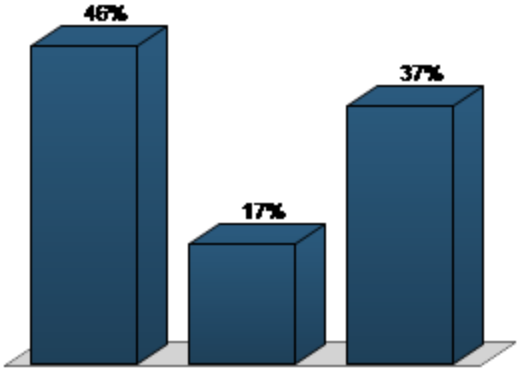
response		
Totals	**100%**	**72**



29. For fellowship interviews, PDs have responded that 28% of residents use vacation time, 52% are given 1-3 “free days” and 20% are given >3 “free days”. Answer the following: (Multiple Choice)

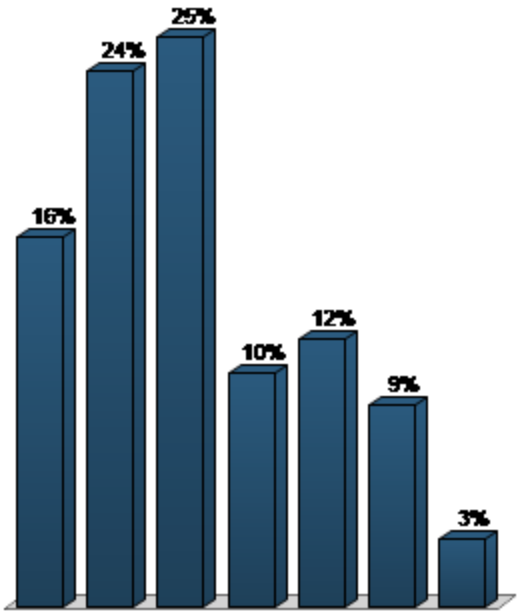
	Responses	
	Percent	**Count**
Interview time away from program is fine, no major changes to the process are needed .	45.71%	32
Interview time away from program is not OK, but no major changes to the process are needed.	17.14%	12
Interview time	37.14%	26

away from program is not OK and major changes to the process are needed.		
Totals	**100%**	**70**



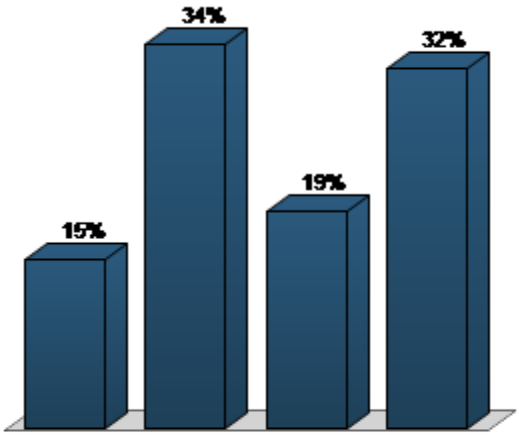
30. For current Core Program Directors, I have been in this role for: (Multiple Choice)

	Responses	
	Percent	**Count**
Less than 1 year	16.42%	11
1-3 years	23.88%	16
4-6 years	25.37%	17
7-9 years	10.45%	7
10-12 years	11.94%	8
13-15	8.96%	6
>16 years	2.99%	2
Totals	**100%**	**67**



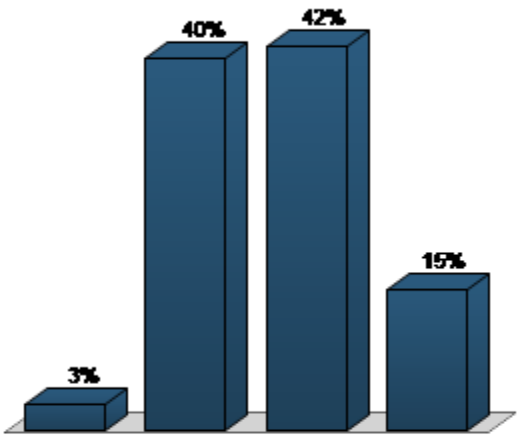
31. For those who are less than six years in the role, my mentoring for this job was: (Multiple Choice)

	Responses	
	Percent	**Count**
Superb	14.89%	7
Pretty good	34.04%	16
Not very good	19.15%	9
Non-existant, I was just thrown in	31.91%	15
Totals	**100%**	**47**



32. When it comes to my life as a PD: (Multiple Choice)

	Responses	
	Percent	**Count**
Everything is awesome!	2.78%	2
I feel like a duck (looks calm on the surface, but paddling like crazy beneath the water)	40.28%	29
Meh, I'm doing OK, could be worse	41.67%	30
The Forces of Evil are winning	15.28%	11
Totals	**100%**	**72**


40%
42%
15%
3%