

# PD as Societal Gatekeeper: Creating the Opportunity to Fail

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## Learning Objectives

1. Understand the extent and significance of the problem of the “troubled” trainee.
2. Review the barriers to identifying problems and what problems are most likely to be associated poor professional outcomes after graduation.
3. Learn the relevant legal aspects of dismissal as well as strategies for effectively managing the process.

## Disclosures

No relevant disclosures

## Introduction: The Uncomfortable Reality

The poor performing trainee is a reality faced by nearly every clinical training program. In a survey of internal medicine program directors by Yao and colleagues (JAMA 2000), 94% of programs reported having a had “problem” resident. (1) Managing a failing trainee is a critical and challenging responsibility for program directors and clinical programs. These trainees consume a disproportionate amount of time, energy and resources and, when these situations are handled poorly, the outcomes can be, at minimum, deeply demoralizing for faculty and trainees and, at worst, a legal liability to the program.

Limited data exists on the prevalence of the failing trainee. Studies which have relied on program self-report have suggested about 6-7% of trainees faced critical issues.(1,2) A systematic review by Reamy and colleagues analyzing their single institutional experience over 25-years in a family medicine residency program reported rate of 9.1%, suggesting that self-report may under-estimate actual numbers. Similarly, a 1992 report by the American Board of Internal Medicine, based on a review of program site visit data, estimated an incidence of 8-15% based on a review of program site visit data.(3)

## Non-Graduation Rates

Program	Non-graduates (%)	Dismissal (%)
All Programs	5%	0.6%
Anesthesiology	5%	0.9%
Surgery	20%	2%
Psychiatry	33%	1.8%
Obstetrics	6%	1%
Internal Med	3%	0.7%
Orthopedics	3%	0.6%
Pediatrics	4%	0.5%
Emergency Med	2.5%	0.3%
Family Med	7.3%	0.1%

*Data from ACGME Databook 2017-18*

What happens to these trainees has also not been widely studied. ACGME tracks the rates of non-graduation for all training programs. Non-graduates include trainees that transfer to another program, trainees that withdraw, trainees that are dismissed and trainees that fail to successfully complete their program, which includes trainees that die during the training period. Although the data for subspecialty fellowship training program is difficult to interpret due to low overall numbers, for all ACGME programs in 2017-18, 5% of trainees failed to graduate and 0.6% were dismissed from their training program. Rates of nongraduation, vary widely between medical specialties from 2.5% (Emergency Medicine) to 33% (Psychiatry). And dismissal rates also vary, from 0.1% (Family Medicine) to 2.0% (Surgery). (See Table: Non-Graduation Rates). Given this variability, it is difficult to know if we are adequately addressing the issues of struggling trainees and whether or not we are allowing inappropriately prepared physicians into clinical practice.

### **The Risks of Failing to Fail: What's at Stake?**

The risks posed by the failure of our system to recognize and effectively manage the problem of underperforming or mal-performing physicians was highlighted in a recent podcast, Dr. Death. The podcast told the story of a neurosurgeon who injured and killed numerous patients due to his clinical incompetence and sociopathic tendencies and highlighted the medical system that failed to restrain him. Although the program documented numerous failings in our professional system's "self-policing" practices, one striking element of the story is that this physician never actually completed the basics of his training requirements before being graduated into independent practice. This story, while sensational, is a sobering demonstration of the consequences of not having effective gatekeeping in our profession.

Although circumstances like this story are luckily rare, the impacts of "failing to fail" are significant. First, allowing a physician into practice without demonstrating adequate skill sets presents a risk to patients and betrays our professional mission. Second, graduating a trainee without providing them with the needed skills to practice independently is a fundamental failure of our training mission and duty to educate. It is a breach of our contract with our trainees and could potentially be viewed as educational malpractice. Third, our failure to self-regulate our profession jeopardizes the integrity of our profession and undermines the credibility of our training structure. Fourth, our institutional and program reputation is clearly at risk if one of our graduates performs poorly after "successfully" completing training in our program. And finally, allowing a poorly performing trainee to graduate, sets a poor example for other trainees and may have a significant negative impact on overall trainee morale. Trainees are often aware of significant deficiencies in their peers, especially when a colleague's poor performance results in additional responsibilities or challenges for their peer trainees. Not addressing these issues can exacerbate frustrations and undermine faith in the program.

### **A Need for Proactive Recognition**

Trainee problems may not be immediately evident and, in some cases, may be difficult to fully recognize until well into the training experience. According to Yao and colleagues, in 59% of cases of troubled trainees, the recognition of a problem occurred only after a critical incident.<sup>(1)</sup> Not only is this an alarming way to identify a significant issue, it also suggests that underlying dysfunction may go unrecognized and unaddressed if it does not happen to result in a significant event. Reasons for a trainee to struggle and underperform can include academic challenges (due to knowledge, skill, or clinical reasoning deficits) as well as nonacademic/behavioral difficulties (caused by family/personal issues, mental health, inter-personal/behavioral skill deficits, poor professionalism, or lack of confidence).

Several factors contribute to delays in identifying trainees at risk. Given the intermittent nature of interactions trainees may have with individual faculty, it may be difficult for patterns of behavior to be readily recognized. Often faculty are reluctant to report concerning behaviors in official evaluations after

only one or two interactions and unless the poor performance meets some egregious threshold. Also, some faculty are reluctant to provide negative feedback due to concerns of disrupting their working relationship with the trainee or of precipitating retaliatory faculty evaluations from the trainee.

As a result, providing faculty opportunities to regularly share their individual experience in both informal and formal forums can be important to allow identification of important behavioral or skill deficits. Program directors need to pay additional attention to any negative feedback, even if apparently minor, as it may provide important data about underlying challenges. This heightened awareness may allow for early identification and intervention with needed remediation and skill building. Personal communications regarding concerns, hallway conversations, can be documented via a verification email. Although formal documentation is always preferred, any documentation, including these informal communications, have been accepted in cases of legal challenges to dismissal.(4)

### **Identifying and Responding to Problems: What is relevant and what is not?**

When evaluating a trainee's performance, several key questions need to be address: 1) Is this performance deficit relevant? 2) Is this performance deficit real or is it a reflection of misinterpretation or bias? 3) Can this performance deficit be remediated?

The first question requires us to define which deficits in trainee skill sets actually predict poor professional performance once the trainee is in practice. Although the ACGME has provided the milestone framework to structure evaluation and development of trainee skills, there is limited data to link these milestones to professional performance after graduation.

Several studies have demonstrated an association between academic performance on knowledge-based exams and professional performance at many levels of training and practice. (5-7) Papadakis and colleagues studied medical student and residents to identify risk factors for future professional disciplinary action.(5) In residents, they demonstrated that high scores on academic testing during training was negatively associated with risk of state disciplinary actions and there was a trend toward higher rates of disciplinary actions in trainees with lower test scores. Similarly, a study of practicing internal medicine physicians by MacDonald at colleagues demonstrated that a failure to pass or failure to take the Internal Medicine MOC exam was associated with increased rates of state disciplinary action. (6)

Although a solid fund of knowledge is clearly important for professional aptitude, it is important to note that a singular reliance on standardized testing to demonstrate clinical knowledge-based skills can be problematic. In a recent article in Academic Medicine, Lucey and colleagues discuss how structural racism impacts MCAT scores and suggests that the utility of these tests is simply to identify the minimum threshold needed to allow success in a specific medical training program. (8). Therefore when utilizing test scores to determine aptitude it is important to recognize that a wide range of test scores are compatible with successful professional careers.

In addition, Papadakis et al demonstrated that behavioral challenges during training may be even more predictive of future problems than academic performance. Residents with poor professional scores during training had a 4% rate of disciplinary action, whereas residents with the lowest academic scores had a 2.5% rate of disciplinary action. The behavioral domains that appeared to be most predictive for future disciplinary action included poor reliability, lack of self-regulation, and poor initiative and motivation. (7) Interestingly, no association was found for domains related to immaturity, poor

#### **3 domains of unprofessional behavior MOST predictive:**

- Poor reliability and responsibility
- Lack of self-improvement and adaptability
- Poor initiative and motivation

#### **Domains NOT predictive:**

- Immaturity
- poor relationships with colleagues
- failure to uphold honor code
- need to be center of attention
- anxiety/insecurity

relationships with colleagues, failure to uphold honor code, need to be center of attention, and anxiety/insecurity. A history of behavior is also significant, as demonstrated in another study by the same group, which found that unprofessional behavior in medical school was associated with a 26% attributed risk of future state disciplinary action.(8)

The second question that must be addressed is whether this assessment of the trainee is accurate. While it is important to proactively identify areas of deficit in our trainees, it is also critical to acknowledge the pitfalls in our evaluation systems that may misidentify or misattribute behaviors as poor performance. Many studies have indicated that unconscious bias can distort evaluations. Backhus and colleagues reviewed how unconscious bias can be counterproductive to the educational mission, by affecting both how trainees view themselves and how faculty view trainees. (10). Mueller and colleagues reviewed qualitative assessments of residents and found that female residents with poor evaluations received inconsistent feedback across faculty whereas male residents received more concordant feedback. (11) The inconsistent feedback received by the female trainees most frequently involved the domains of autonomy and assertiveness. Since qualitative assessments are subject to unconscious bias, it is important to balance evaluations with quantitative measures of performance to enhance the objectivity of the assessment.

Unconscious bias in our training environments may affect trainee learning experience, opportunity for skill building and autonomy and overall confidence all of which can impact perceived performance. In a study of thoracic surgical trainees, Meyerson and colleagues found that, faculty reported giving women trainees a lower degree of autonomy than men (30% vs 37%) and women trainees rated of the level of autonomy they were allowed was significantly lower than their male colleagues (19% vs 33%) (12). Nevertheless, faculty rated women and men trainees equally on measures of reliability and entrustability. This discrepancy treatment and training experience fosters the impression of less competence in some trainee groups and may impact trainee confidence in their skills. Women in CT surgery rated their self-perceived readiness for independent practice lower than their male colleagues. (12).

In the previously discussed survey of PDs conducted by Yao in 2000, many PD expressed the perception that troubled residents were more likely to be under-represented minorities, international medical graduates, or older (>35yrs) trainees. This perception presents a concerning potential for bias that could negatively impact the way a trainee is treated, performs, and is evaluated. As our current national dialogue has highlighted, programs that fail to create an inclusive and equitable environment can inadvertently add additional hurdles for trainees who are under-represented in their field. These challenges may interfere with learning and subsequently result in low confidence and poor performance in otherwise talented and capable trainees.

In addition, underperforming trainees may struggle due to a multitude of underlying issues that can impact performance and professional behavior. Shanafelt and colleagues (13), in a study of medical students, reported a significant correlation between burnout and self-reported unprofessional behaviors. For many struggling trainees, performance challenges may be a reflection of fatigue, demoralization/burnout, mental health issues, personal/family challenges, or behavior skills deficits in areas such as time-management, organization, and communication. Recognizing the underlying causes of the behaviors is important to creating the right strategies of support.

The third question that needs to be addressed is whether or not the deficits displayed by the trainee can be remediated. Currently there is no unified approach toward remediation and program are encouraged to follow the guidance of their institutional GME. Although remediation programs vary across institutions, structured remediation efforts have been demonstrated to be a highly useful to help manage struggling trainees. Reamy et al reported on the results of their single institutional experience with a structured remediation program and reported a 90% success rate.(14) They concluded that although remediation can be time-intensive, it can be highly successful for a broad range of deficiencies, including attitude problems, interpersonal conflict and knowledge deficits. Guerrasio and colleagues reported a structured remediation program used at U of Colorado that focused on correcting clinical reasoning deficits. (15) Although many faculty in the program expressed skepticism about the efficacy of

remediation, 96% of trainees in this program were able to pass a post remediation skill assessment and nearly all trainees eventually graduated. These programs suggest that remediation can and does work.

### **When Dismissal/Non-graduation is needed: How to approach this difficult conversation**

Even after extensive remediation efforts, some trainees just are not able to meet the minimum standards for independent practice. This can be a painful and challenging decision, but once made there are ways to make the process as smooth as possible. Schenarts and colleagues provide a nice framework for approaching dismissal.(4) I have reviewed a few main points here.

First, program directors should be aware that legally it is very difficult to challenge a decision to dismiss or to not graduate a trainee. Multiple court cases have upheld the principle of “Academic Deference” which states that academic faculty are uniquely qualified to judge all aspects of a trainees performance.(4) In *Stretten v. Wadsworth Veterans Association*, the court upheld the decision of the program to dismiss trainee for “abrasive interactions” and in *Marmion v. Mercy Hospital* for the potential risk to patients posed by inappropriate behaviors.

Second, program directors should ensure that they have “Just Cause” for dismissal. Just Cause involves 4 main components:

1. That program expectations have been clearly communicated to the trainee
2. That sufficient warning has been given of the consequences of not correcting the poor performance
3. That warnings have been documented in a formal manner such as in the semiannual review.
4. That reasonable opportunity was given for the trainee to correct the behavior.

Third, it is critical that program directors follow “due process” when taking actions such as dismissal or non-graduation, to demonstrate that the decision to dismiss is not arbitrary or capricious. This means that the program must demonstrate that standard processes and policies were followed with regard to termination decisions. The few cases where dismissal has been successfully challenged have involved violations of due process (ie. the dismissal involved unfair procedures) or violations of substantive due process (ie. the dismissal was incorrect, arbitrary, or capricious).

#### **Managing the Dismissal Conversation**

- **Preparation**
  - Review all written documents included in the individual's file
  - Plan out and practice what will be said in the exit interview
  - Be able to answer any question the resident might have about the termination
  - Prepare a list of all hospital belongings that should be returned on termination, including keys, identification cards, computers, cell phones, and so on
  - Write a termination letter for the employee in advance
  - Consult legal counsel with questions about termination
  - Obtain a check that covers any back wages, vacation, or other benefits
- **Exit interview**
  - Treat the resident with respect and dignity
  - Bring in a witness for the exit interview
  - State why you are dismissing the resident
  - Remind them of the warnings you gave
  - Be brief and to the point, keeping just to the facts
  - Bear in mind that dismissal is embarrassing, allow the resident to save face by enabling him/her to collect their personal effects on the weekend or after hours
  - Avoid use of platitudes, such as “I know how you feel.”
- **Strategies to avoid potential defamation and other types of lawsuits:**
  - Listen but do not argue with the resident. Things said in the heat of the moment may come back to haunt you later
  - Avoid the temptation to call the resident incompetent or dishonest
  - Do not discuss the circumstances surrounding the termination with anyone other than the resident
  - Document in writing what occurred

*Adapted from Schenarts, et al. 2017.*

And fourth, to ensure that the termination conversation goes smoothly, program directors should plan and prepare appropriately. Prior to the conversation all the documentation should be reviewed, legal counsel consulted, and the conversation planned out. Administrative and logistical issues such as collecting pagers, badges, and keys and organizing final paycheck need to be organized ahead of time. When meeting with the trainee, the program director should arrange to have a witness to be present and carefully document the encounter. The discussion should avoid any defamatory remarks and simply state the reason for the dismissal and remind the trainee of the warnings that they had previously been given. After the conversation it is important not to discuss the circumstance of the dismissal with anyone else. Note, you are not allowed to proactively reach out to other programs with information about the trainee, but you may respond to questions if programs contact you about the concerns regarding dismissal.

## Conclusion

Balancing our responsibility to support, educate, and nurture the trainee with our responsibility to serve as the gatekeeper for our profession can be a challenging task for program directors. Supporting our program directors to fulfill both these roles requires providing adequate information about the required processes. More studies are needed to help programs 1) better understand the ways that trainees struggle, 2) create more effective ways to manage these issues, and 3) recognize what deficits actually predict poor future professional performance. Remediation programs, as well as counseling to help provide alternatives and support for trainees that are unable to meet the expectation of professional practice are important both for the trainee and for the program directors responsible for them.

## REFERENCES

1. Yao DC, Wright SM. National survey of internal medicine residency program directors regarding problem residents. *JAMA* 2000;284:1099–104.
2. Roback HB, Crowder MK. Psychiatric resident dismissal: a national survey of training programs. *Am J Psychiatry* 1989;146(1):96-8.
3. The problem resident [videotape]. Philadelphia: American Board of Internal Medicine, 1992.
4. Schenarts, PJ, Langenfeld S, The Fundamentals of Resident Dismissal. *The American Surgery* 83 (2017): 119-126.
5. Papadakis MA, Arnold GK, Blank LL, et al. Performance during internal medicine residency training and subsequent disciplinary action by state licensing boards. *Ann Intern Med* 2008;148: 869–76.
6. MacDonald FS. Et al. The American Board of Internal Medicine Maintenance of Certification Examination and State Medical Board Disciplinary Actions: a Population Cohort Study. *J Gen Intern Med* 33(8):1292–8
7. Teherani A, Hodgson CS, Banach M, et al. Domains of unprofessional behavior during medical school associated with future disciplinary action by a state medical board. *Acad Med* 2005;80 (Suppl):S17–20.
8. Lucey CR, Saguil A. The Consequences of Structural Racism on MCAT Scores and Medical School Admissions: The Past Is Prologue. *Acad Med*. 2020 Mar;95(3):351-356. doi: 10.1097/ACM.0000000000002939.
9. Papadakis MA, Teherani A, Banach MA, et al. Disciplinary action by medical boards and prior behavior in medical school. *N Engl J Med* 2005;353:2673–82.
10. Backhus LM, Lui NS, Cooke DT et al. Unconscious Bias Addressing the Hidden Impact on Surgical Education. *Thorac Surg Clin* 29 (2019) 259–267.
11. Mueller AS, Jenkins TM, Osborne M, et al. Gender differences in attending physicians' feedback to residents: a qualitative analysis. *J Grad Med Educ* 2017;9(5):577–85.
12. Meyerson SL, Sternbach JM, Zwischenberger JB, et al. The effect of gender on resident autonomy in the operating room. *J Surg Educ* 2017;74(6):e111–8.
13. Dyrbye L., et al (Shanafelt). Relationship Between Burnout and Professional Conduct and Attitudes Among US Medical Students. *JAMA*. 2010 Sep 15;304(11):1173-80.
14. 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(4):252-7.
15. Guerrasio J, Aagaard EM. Methods and Outcomes for the Remediation of Clinical Reasoning. *J Gen Intern Med* 29(12):1607–14.