A General Framework for Approaching Residents in Difficulty

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Residents in difficulty are common in training programs. They require inordinate amounts of time and effort, yet only about half of program directors in one survey were confident of their program’s ability to manage these residents. Suitable preparation, correct categorization of the problem, and a structured response can mitigate these difficulties.

The general framework we describe in this paper has evolved from the combined experience of the authors who, in their administrative capacities, have dealt with many types of difficulties in three specialties and in several training programs. This framework is supported by relevant literature and, in the authors’ experience, it has stood the test of administrative and legal challenges. The three steps in the framework—preparing for difficulties, categorizing difficulties, and responding to difficulties—are discussed.

Preparing for Difficulties
Preparation includes developing written policies and procedures in anticipation of dealing with residents in difficulty, developing a pool of qualified resource people (e.g., mental health professionals, learning disability specialists, legal advisors), and educating staff and residents about policies and programs (Table 1).

Defining Expectations
The training program should clearly define, in writing, behavioral expectations for the learner. Graduated learning objectives based on the Accreditation Council for Graduate Medical Education (ACGME) core competencies provide a useful framework and should be stratified by postgraduate year (PGY). The document should explicitly identify minimum performance levels below which formal action is necessary. Creating this list is valuable because it provides a frame of reference for a complex and difficult process. Developing the list requires discussion and consensus among the faculty who will be responsible for resident training. The process should be transparent and fair. Each resident and problem will be unique and provide an opportunity to further clarify faculty expectations.

Prerogative-based Difficulties
This list can also be the basis for prerogative-based management of learners with difficulties. Prerogative-based management stipulates that above the minimum level of performance, regular assessment of competence is provided to the resident with constructive feedback. This feedback is to be taken as a suggestion for improvement, and the resident retains the prerogative about what to do with the information and whether to accept an offer of assistance.
Residents who have been told of a prerogative-based concern, but who have not received written notice (the majority), are reminded that this is a suggestion for improvement, is not a formal action, and assistance is offered. Although it is difficult to hear less-than-perfect evaluations, clarifying that change is the resident’s prerogative can increase the resident’s motivation to change.

Critical Difficulties
When performance is below a critical level, concerns explicitly become the program’s responsibility rather than the resident’s prerogative. Instead, formal remedial action and assistance then become the program’s prerogative and are mandatory if the resident wishes to continue in the program. Residents should be notified about this, in writing.

Contracts
Training programs must decide whether to offer new residents 1-year contracts with yearly renewal or full-term contracts for residents in good standing. Annual contracts can facilitate management of a resident with significant difficulties. A contract is an employment agreement, and terminating a contract early has legal implications. Contract renewal should be carefully considered. When in doubt about a resident’s performance, nonrenewal with an offer of renewal if performance improves is an important option.

Other Preparations
Other preparations that may reduce disputes and misunderstandings include introductions to key staff and their roles, clearly articulating supervisory arrangements, and orientation programs where residents and their partners are made aware of early warning signs of difficulty, the process for addressing difficulties, and the availability of assistance programs. Early distinction between employment expectations and satisfactory academic progress is essential.

The issues for potentially disabled resident applicants include: Is the student disabled? Is he/she otherwise qualified? Can the program make accommodations at reasonable cost and without lowering academic standards? Listing the essential job functions for residents in your program is invaluable in resolving issues surrounding disabilities and job expectations. Developing this list forces the faculty to come to agreement on these essentials in advance. The list can be part of the resident contract, with confirmation that they meet these requirements. The essential job functions can also be a meaningful addition to the recruitment process, enabling medical students to understand clearly what will be expected of them.

Categorizing Difficulties

Competence
Learner difficulties fall into three broad areas with three very different approaches (Table 2). The first area, competence difficulties, are professional academic judgments about the ability of learners to perform capably for their level of training. These are the most common type of difficulties. They may be cognitive (eg, poor fund of knowledge, poor integration of material, inability to prioritize tasks) or noncognitive (eg, problems with interpersonal skills, motivation, or work habits).

Underlying the perception of competence difficulties can be issues that are not intrinsically the resident’s responsibility, such as stylistic differences and language and cultural differences. Many competence difficulties are remediable and should be approached as early as possible with feedback and an opportunity for improvement. A major task is to determine if, when, and how to adopt a more-formal approach. Good written records documenting the concerns, requirements for remediation, timeframe, and the failure to meet requirements are essential to this process. A program that bases its action in sound judgments of professional competence, documents well, and avoids discrimination will generally prevail in simple nonreappointment cases. In the case of nonreappointment, the legal burden of proof is on the resident. The courts are reluctant to question the faculty’s academic assessment of clinical competence in a resident.

One common difficulty is the amiable learner with poor integrative skills. This may not manifest until after internship because, prior to that, senior residents insulate the learner, and motivated learners are able to compensate with interpersonal skills and hard work. Other cognitive difficulties may include: (1) written communication (poor reading ability, poor

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Table 1
Preparation Checklist

- Develop a list of graduated learning objectives (by PGY level) and provide a written copy to each resident. (See example at http://depts.washington.edu/uwmedres/policies/handbook/training/appreqs.htm.)
- Develop a list of essential job functions and provide a written copy to each resident.
- Develop a pool of qualified resource people.
  - Mental health professionals
  - Impaired physicians’ program
  - Learning disability specialists
  - Legal advisors
- Introduce key staff during orientation and describe reporting and assistance programs.

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(3) poor fund of knowledge (memory difficulties or poor preparation). Formally testing should be considered early in residents with apparent cognitive difficulties because a substantial minority are explained by neuropsychological impairments. If a program requires and pays for the evaluation, the program retains the data. If residents pursue independent testing, the results remain theirs to share. In the authors’ experience, most residents who understand the implications of data ownership opt for obtaining and paying for testing themselves. Concerns about procedural competence frequently surface for the first time in residency training.

Another common difficulty is the bright learner with poor interpersonal skills that influence his/her perceived competence. This is an example of noncognitive academic difficulties, which include (1) affective, (2) attitudinal, and (3) interpersonal problems. Residents with affective difficulties are dealing with personal adjustment to external events (eg, life or job transitions, illness, or death in the family). The affective state can cause avoidance of learning, memory problems, withdrawal, and lower aspirations. Residents with affective difficulties may also be poorly organized, inefficient, and have poor time management. Residents with interpersonal problems may be especially difficult to deal with. They can be unmotivated, defensive, manipulative, condescending, or have racial, ethnic, or gender prejudices. For the learner with noncognitive difficulties, early specific feedback and an offer of assistance or referral are critical. A substantial proportion will have substance abuse or overt psychiatric difficulties.

### Laws and Professional Standards

The second area of difficulty is laws and professional standards. While residency is largely an academic endeavor, subject to professional opinions about academic performance, it is also an employment relationship. Laws and professional standard difficulties are allegations of misconduct and violations of specific rules or laws. They require understanding and frequent revisiting of the provisions of the employment contract and assurance that staff is aware of the appropriate procedures for potential episodes of misconduct. Some episodes may be blatant and easily identified, such as assault, while others may be more difficult to determine, such as falsification of records, substance abuse while working, or sexual harassment. These are addressed as employment issues and can lead to “termination for cause.” The legal burden of proof is on the program. In such cases, the program’s response is complicated by unfamiliarity and discomfort with these procedures. Programs may get into difficulty by not following their own contractual agreements or by

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ADA—Americans With Disabilities Act
mishandling due process. Considerable assistance with disciplinary difficulties is usually available from the sponsoring institution’s legal and human resource departments.

Performance and Disability

The third area of difficulty is performance and disability. These are difficulties the learner has in meeting the program’s essential functions and requirements of the job. These requirements are program specific and not defined by the discipline or the residency review committees. Residency training represents an intense and stressful period for physicians because of the long hours and rapid increase in clinical and teaching responsibilities. The work is physically demanding, can unmask learning disabilities, and can contribute to mood disorders and substance abuse.

The response to performance difficulties must follow established statutes such as the Americans With Disabilities Act (ADA), often requiring special considerations and resources. Time spent in development and dissemination of essential job functions will prove invaluable in this process. Understanding certain implications of the ADA are essential. The focus must be on job performance and not diagnosis, the resident must request accommodation prospectively, and the resident must be able to meet the essential job requirements with the accommodation. The program is not required to train a resident who cannot meet essential job requirements.

Responding to Difficulties

Faculty in a program that has not carried out the preparation step find it harder to respond to resident difficulty. Ask yourself, “Do we have policies and procedures established for residents with difficulties?” “Are all residents’ performance reviewed regularly by faculty?” “Who are the qualified resource people?” This preparation supports a response that is more effective and less disruptive.

Competence

Simple difficulties can be dealt with using developmentally appropriate feedback. Competence difficul-

Figure 1

A Model for Conceptualizing Different Faculty Roles With Residents in Difficulty

The model is located on two axes based on familiarity with the details of the case (detailed to overall) and on whether the goal is to maximize resident performance or protect patients, the program, and the discipline.
ties that may require probation are best handled by a team approach. We have adapted a sports metaphor (Figure 1) to conceptualize the different faculty roles we believe are required.18

Two continua are important here—how familiar the team member is with all the facts in the case and whether his/her primary role is to maximize resident performance or to protect patients, the program, and the discipline.

The two roles with detailed knowledge about the case are the “coach” and the “referee.” The coach is the faculty member designated to work closely with the resident and provide specific suggestions and feedback focusing on improving performance. Also close, but focusing on protecting patients, the program, and the discipline, is the referee (usually a review panel), who must ensure competence and avoid negative outcomes.

Faculty with two other roles have only overall familiarity with the case and are more distant to the monitoring and oversight. These are the “cheerleaders” and the “team manager.” The resident is under stress during this process and benefits from general encouragement in efforts to improve from the cheerleaders, although sometimes these cheerleaders need to be reminded they don’t have detailed knowledge of the situation. The team manager needs to keep some distance for a different reason. This individual is charged with the responsibility of deciding whether this resident “stays on the team,” has to participate in some additional training, or even leaves the program. This role entails not only a duty to the resident but also to the program, the discipline, and the public. This is usually the program director, but it could be a department chair or director of graduate medical education at the institution. Program directors often struggle with the need to maintain some distance from the problem, being more accustomed to being in the coach or referee role with residents.

Laws and Professional Standards

Academic progress should always be separated from contractual obligations, and law and standard difficulties are employment matters. To clarify, not offering a reappointment contract to a resident or credit for a training period because of faculty concerns about their professional competence is an academic opinion and does not require formal due process. Occasionally, faculty members have concerns that negative evaluations will lead to legal action against them by the resident. Residents provide implied consent to evaluation by agreeing to participate in an academic program. As long as the evaluation relates to performance, is descriptive, clearly separates observation from interpretation, and is not communicated to outside parties, it will be supported in the courts.19

Terminating residents while their contract is in force requires termination for cause and, even if for academic reasons, must follow the formal due process for the institution. If misconduct is alleged, it may be necessary to include notice of charges, witnesses (sworn testimony and cross examination), evidence, and attorneys. All involved faculty should review pertinent employment policies, procedures, and the resident contract. Written communications are preferred and should include the specific unacceptable behavior, the required steps and timetable for remediation, and the possible consequences of noncompliance. A clearly delineated policy for appeals can “help to avoid the lengthy, expensive, and potentially serious consequences of such situations.”20

Performance and Disability

In the United States, several laws must be taken into account when considering accommodations for the resident with performance difficulties. These include section 504 of the Rehabilitation Act for any teaching institution that receives federal funding21 and the Americans With Disabilities Act.22,23 Once the resident requests accommodations, the program in consultation with affected institutions must decide whether it is possible and, if so, how the program will respond to these needs. In all cases, the resident must be able to complete the essential job requirements. Programs may need to be creative in working with a resident to find reasonable accommodations. These may include physical modification of work environments, changes to the schedule, modification of duties, allowing for medical treatment or counseling during the work day, or even extending the length of training. Outside local agencies may be helpful in obtaining or providing equipment or aids for residents. Residents with a preexisting disability will often know what accommodations they require.

Learning disabilities are an important category of disabilities. Learning disabilities occur in approximately 3% of medical trainees and may be difficult to recognize.14 Telltale signs include when the learner’s verbal skills and knowledge base are strong, but they have a history of trouble with standardized tests and written communications.14 Medical schools provide the most-common accommodation for learning disabilities—extra time and separate space for examination.24 This can put a residency program in a challenging position since the accommodations provided in medical school may not be possible in residency training while still meeting the essential job functions. This is one reason it is useful to include the list of essential job functions with the residents’ contract.

Disabilities that arise or are uncovered during residency training require careful administrative management. Most of the short-term disabilities that arise during residency—broken legs, appendicitis, even pregnancy—are not covered by the ADA and are managed with sick leave, schedule adjustment, and rearrangements as needed. Some will fall within the protections of the ADA.
A resident with a suspected medical or psychiatric disorder should be offered the opportunity for formal evaluation and may request special accommodations based on that evaluation. Each state has its own statutes for physicians with drug or alcohol problems. The program should review and support the guidelines of the state’s medical board (e.g., providing same-sex urine screening monitors). There is no ADA requirement for accommodation of ongoing drug or alcohol abuse. The accommodation applies only to ongoing treatment to maintain a drug-free and alcohol-free state. The focus of the program should always be on the ability of the resident to perform the job requirements—not the diagnosis or treatment of the resident.

Conclusions
Each resident’s difficulty within a given training program is unique. A general framework such as we have described can only provide guidance for the program’s specific response to the difficulty. However, we have found that the structure provided by this framework has helped the program to organize and streamline their response to the resident with difficulties and to avoid missing critical elements in that response.

In our experience, many training programs have not established workable policies and procedures until after their first resident with difficulties. This leaves faculty confused and divided. The critical first element of this framework is the development of graduated learning objectives and essential job functions before dealing with learner difficulties. This activity by the faculty responsible for resident training often reveals differences in basic values and styles. It is useful to take the time to negotiate these differences before the pressure of an actual resident in difficulty adds haste and divisiveness to the proceedings.

The second critical element of this framework is to make a distinction between different types of difficulties (competence, laws and professional standards, and performance and disability) because they are handled very differently. Finally, it is useful for the faculty to make an explicit distinction between what is minimal performance and what is desirable performance so that the less threatening prerogatives-based approach can be used for the most common competence difficulties.

References