The Program Directors' "Hidden Milestone":

Transforming the Disciplinary Process into an innovative, educational, and inspirational experience

Adrienne Bentman, MD, Institute of Living
Sallie G. DeGolia, MPH, MD, Stanford University
Ann Schwartz, MD, Emory University
Deborah Spitz, MD, University of Chicago

Objectives

- Demonstrate an understanding of the time line, procedures and pitfalls of the disciplinary process
- Follow the construction a remediation plan and composition of a disciplinary letter
- Understand the roles and responsibilities of the program director, faculty, residency committees, and institutional offices and officials.
- Identify means to limit collateral damage among residents

Schedule

Topic	Time
Introduction	5 minutes
Phases in the Disciplinary Process	15 minutes
Remediation Plan / Disciplinary Letter	10 minutes
Pitfalls and Collateral Damage	15 minutes
Facilitated Small Group Discussions	30 minutes
Q & A and Wrap-up	15 minutes

Steps:
Discovery to Resolution

Sallie G. DeGolia, MPH, MD
Associate Training Director
Stanford University

Phases in Process

- Preparation
- Identify Resident with Difficulty
- Progress Improvement
- Remediation
- Probation

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Preparation Phase

- Goals & Objectives for educational activities
- Policies & Procedures for Performance Issues
  - Evaluation Policy
  - Grievance Policy
  - Clinical Competency Committee Procedure
  - Probation Committee Procedure
- Identify pool of qualified resource people
  - Mental Health Professionals
  - Learning Disability Specialists
  - Wellbeing Committee
  - Diversion Program
  - Legal Advisors
  - Supervising faculty
  - DIO
- Educate staff & residents about policies & program

Phases in Process

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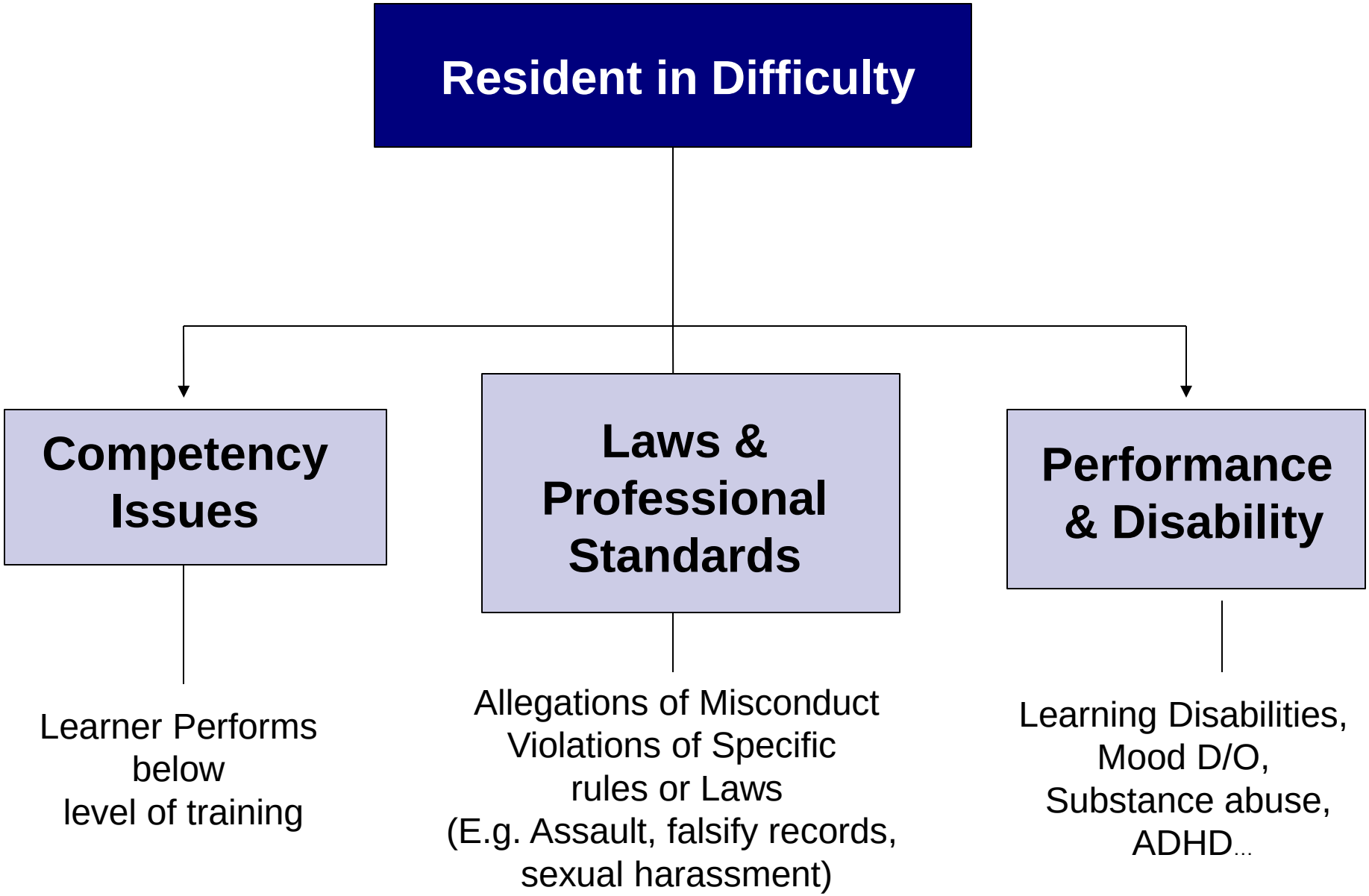

Resident in Difficulty
Competency Issues
Laws & Professional Standards
Performance & Disability
Learner Performs below level of training
Allegations of Misconduct Violations of Specific rules or Laws (E.g. Assault, falsify records, sexual harassment)
Learning Disabilities, Mood D/O, Substance abuse, ADHD…

Phases in Process

- Preparation
- Identify Resident with Difficulty
- Progress Improvement
- Remediation
- Probation

Competency Issue
Learner Performs below Level of Training

Meeting with PD

- Understand resident's side
- Provides clear expectations

Clinical Competency Committee

Progress Improvement Plan

Corrected performance

F/u with CCC

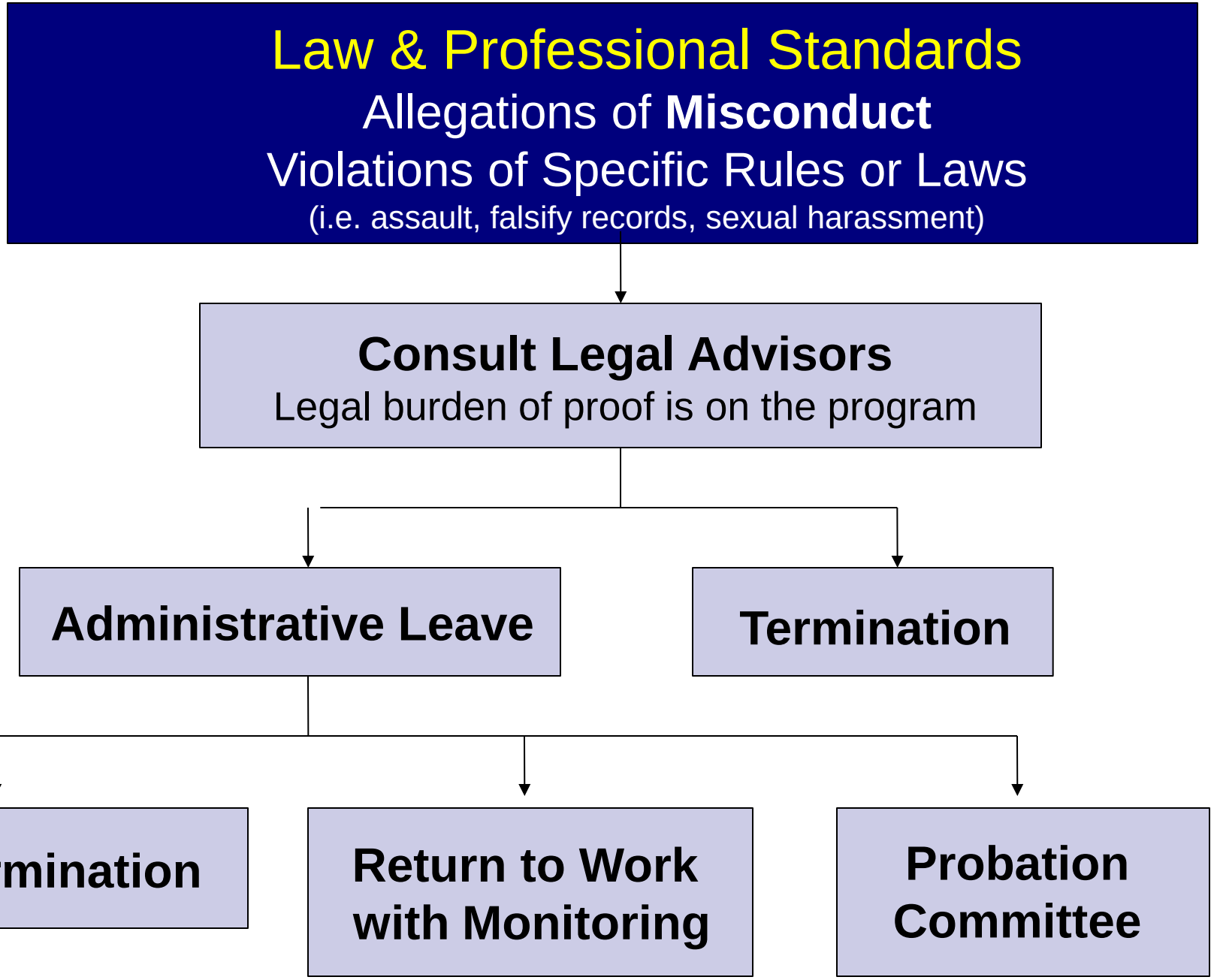
Remediation Plan

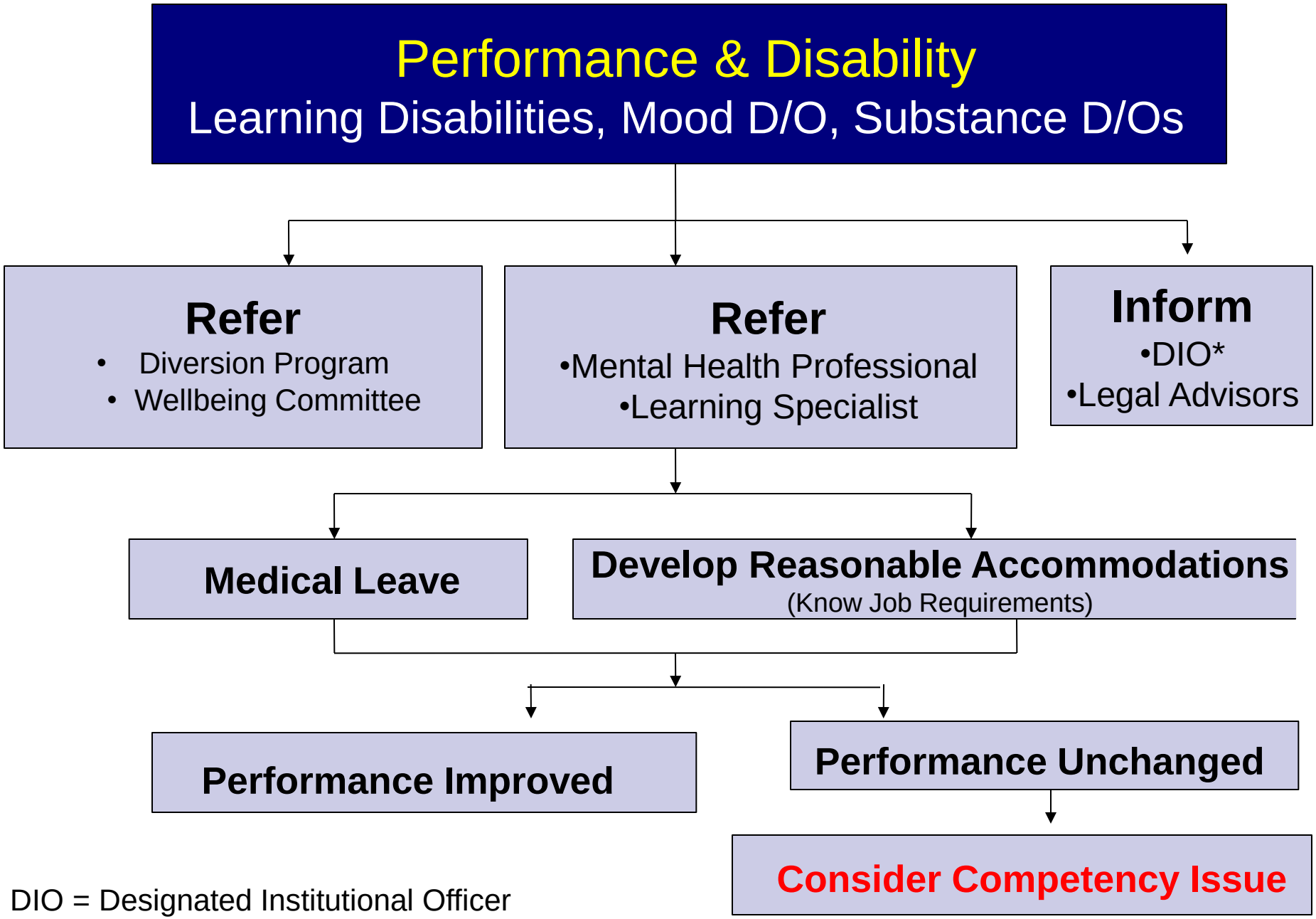
Must document in PD Final Ltr

Probation Committee

Revised remediation Plan

Must document in PD Final Letter


Law & Professional Standards
Allegations of **Misconduct**
Violations of Specific Rules or Laws
(i.e. assault, falsify records, sexual harassment)
Consult Legal Advisors
Legal burden of proof is on the program
Administrative Leave
Termination
Termination
Return to Work with Monitoring
Probation Committee



DIO = Designated Institutional Officer

Roles of the Involved Players

Ann Schwartz, MD
Residency Training Director
Emory University School of Medicine

Involved Players

- Supervising faculty
- Chief resident (CR)
- Advisor / mentor
- Clinical Competency Committee (CCC)
- Chair (Executive Committee)
- Graduate Medical Education Committee (GMEC) and Designated Institutional Official (DIO)

Involved Players: Supervising Faculty, CR and Advisors

- Pre-event
  - Charged with responsibility of reporting lapses to PD or APD (or other)
  - Feedback
- Post-event
  - Reporting to PD / APD
  - Roles in remediation may vary
  - Documentation

Roles of CCC in the Disciplinary Process

- **Establish standards of managing and remediating problems**
- **Early warning system / identification**
- **Follow residents across rotations and sites**
  - Often little continuity from rotation to rotation
  - Lapses could be subtle or overlooked
- **Support trainee**
  - Knowledge deficits
  - Time management and organization
  - Professionalism concerns
- **Assist with warning letters, remediation plans, etc**

Importance of Documentation

- Documentation is essential!!
- Necessary for remediation, probation or dismissal
- In case of legal action by trainee, supporting documentation protective
- Barriers to documentation

Involved Players: GMEC and DIO

- **Establish and implement house staff policies and procedures manual**
  - May vary between institutions (overall similar)
  - Outlines disciplinary actions
- **Involvement depends on Policies & Procedures Manual**
  - Prior to probation
  - Possibly with written warnings / remediation

Involved Players: GMEC and DIO

- **Supportive**
  - Assist with paperwork, letters
  - Remediation plans
  - Review documentation
  - Referral to resources
  - Liaison to legal advisor

The Remediation Plan & Contents of the Disciplinary Letter

Deborah Spitz, MD

Education Mission Director

Program Director Adult Psychiatry

The Remediation Plan

Must include:

- What is the problem
- What are the goals
- How to get there

What is the problem …

- How to identify the problem
- How to spell it out
  - Be concrete!!
  - Describe in non-judgmental terms
  - Give examples

What are the goals …

- What must the resident achieve to demonstrate that the problem is resolved?
  - Be concrete
  - Operationalize
  - Give examples

How to get there …

- Specific activities the resident must undertake to improve
  - Rotations
  - Supervision
  - Readings
  - Other
- Involving other faculty

Consequences …

- Time line—how long a period? Reevaluation at what points along the way?
- If improvement, then …
  - When will probation end?
- If no improvement, what then?
  - Continue probation?
  - No promotion
  - Termination from the program

Pitfalls and Collateral Damage

Adrienne L. Bentman, MD
Adult Program Director
Institute of Living/Hartford Hospital

Why Do We Ignore or Fail to Identify Unsatisfactory Performance?

- **Institutional structure and organization**
  - Amorphous lines of authority
  - “Leaderless” or disorganized GME/ Clinical Competence Committee

Subtle Inhibitors of Identifying Need for Remediation

- Belief that deficit will improve over time
- New faculty or residency leadership
- Timing - during recruitment, RC Survey
- Perception that evaluations and/or the remediation process are unfair
- Demoralized faculty or chief resident
- Faculty or chief resident assume an incident is an isolated instance

Subtle Inhibitors cont.

- Fear of legal repercussions
- Must take on a popular or powerful figure
  (resident, faculty, department leader)
- Requires time, endurance, & finesse

Avoiding Pitfalls

- GME office is not involved early enough or does not provide supervision
- Letter of Deficiency does not contain the core elements described previously
- Remediation is not provided or plan not followed, feedback is infrequent, documentation of progress inadequate

Misconduct vs. Professionalism

- What's the difference?
- Misconduct: Improper or unacceptable behavior, or neglect of duties
- Medical professionalism: A set of values, attitudes, and behaviors that results in serving the interest of patients and society before one's own. Honesty, integrity, humility and accountability

Why does it matter?

- Misconduct can be managed differently by the Clinical Competency Committee
- A “never again” warning with an explanation may be all that is needed for misconduct, rather than remediation
- Misconduct can lead directly to termination

Consider Misconduct IF:

- **Breach of institutional Code of Conduct**
  - Their parents should have taught them this
  - This is something they should have learned at their first job as lifeguard, wait staff, or camp counselor
  - It's really a police matter
  - A patient could get injured
  - Remediation seems irrational

Collateral Damage

- Residents often surprised
- A confidential process….not really
- Paranoia – why? What form does it take?
- How do we understand this?
- Can we prevent, ameliorate the damage?

Cases

Case I

- PGY II resident recently transferred in from another accredited psychiatry program having finished her PGY I year. From the very first rotation, the resident appeared to have clear organizational difficulties with getting notes in on time, presenting cases clearly, and taking longer than expected to work-up patients. Given that it was a new environment and system for the resident to work in, she was given some time to acclimate (of note, she took two of the first 4 weeks for vacation).

- On her next rotation, the resident worked very hard to improve her skills as acknowledged by the nursing and medical staff and actively sought out feedback and incorporated it into her practice. Unfortunately, the resident developed a severe depression requiring a 2-month medical leave after her second month in the program.

- Despite feeling much better on her return, she continued to have difficulties with organization, presentations and other issues on a busy C/L service. She would take well over 4-6 hours to work up a single consult case. As a result of her lack of efficiency , she was limited to one new case/day. Some of the errors experienced during the C/L rotation included missing a recent h/o a severe dystonic reaction and possible laryngospasm in a delirious patient which led to her prescribing low dose Haldol. The patient had a recurrence of the dystonia. When confronted with these or any other "missed" facts, she noted "I had the facts, I just forgot to present them." In addition, it was reported that the resident didn't know the medications her patients were taking, even though she only picks up 1 patient per day and had a total of 3 patients. She exhibited extremely limited knowledge of what she was prescribing, how medications are metabolized, drug-drug interaction, side effects, etc. The resident insisted that she just needs more practice "to increase my self-confidence." The resident appeared very receptive to clear, direct feedback on a daily (sometimes hourly) basis.

Case II

- PGY II resident who finished his PGY I year with a mediocre fund of knowledge requiring him to retake a medicine rotation, took 6 months off to study for USMLE II which he had previously failed. His situation was complicated by a variety of personal issues involving illness and other misfortunes. Though he was able to barely maintain a passing level fund of knowledge and organizational skills, he had a difficult time managing patient interviews. He was described as having an inappropriate interview style characterized by being too "chatty" and interjecting personal information. He was found to personalize patients' problems and compare them to his own difficulties. He would also spend well over the appropriate & expected time in working up or seeing patients in psychotherapy. Because of significant concern with regards to his seeing long-term psychotherapy cases, he was asked to video-tape all patient sessions in order to accurately assess what was happening in the session. Though he was warm, caring, and very eager to receive & utilize feedback, he was not able to maintain clear, professional boundaries.

- In addition, the resident failed 4/4 CSVs taken during his PGY II year.

Questions??