

The Hidden Costs of Failing to Fail Residents

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In 2000, after a decades-long multicontinent medical murder spree, Michael Swango was caught and charged with fraud and murder. He pleaded guilty and will serve the rest of his life in a federal prison. Nine years later, Nidal Hasan was charged with the shooting deaths of 9 soldiers at Fort Hood.

Although the beginning of Swango's problematic behaviors in the late 1970s and Hasan's 2009 arrest are separated by almost 30 years, they share a history. Both individuals were physicians. Both were identified as potentially dangerous at multiple junctures by multiple individuals throughout their medical school and residency curriculum. Both were allowed to continue in their training despite serious concerns on the part of peers, faculty, and others.

These are 2 extreme examples. However, they highlight a problem endemic in medical education—that learners with performance problems are neither dismissed nor truly remediated. They are allowed to persist in medical training despite recognized and even dangerous performance problems.

In this perspectives article, we unpack some of the ways of thinking that lead to these problems and propose alternative ways of thinking to address them.

Most of the time, most residents perform their duties in a way that makes their program and their profession proud. When a resident fails to do so, it is a surprise. Naturally, program directors tend to think of problems as flukes, accidents, and rare events and hope they can be eradicated through exhortation and strong direction. However, our previous work suggests that overcoming noted performance problems permanently is rare.¹

From our experience and investigations, residency program directors are more likely to keep a learner with insurmountable performance problems in a program and allow that person to move on to the next step in training or practice than they are to dismiss a resident whose performance problems were not successfully addressed. Even when they identify a resident whose performance problems cannot be adequately addressed within the training program, they are unlikely to halt the learner's progress.

We suspect that program directors who keep problem residents in their programs do so because of their perceptions of the cost of dismissing versus the cost of keeping a poorly performing resident. That is, we believe that program directors are very cognizant of the costs of dismissing a resident from a program and respond to these costs when making progress decisions, but they may underestimate the costs of keeping an inadequately performing resident in the program. In this article, we acknowledge the real costs of dismissal and illuminate the hidden costs of keeping an inadequately performing resident. We do so in the hopes that program directors will be able to make fully informed decisions when considering the fate of residents with performance problems.

We consider a resident with performance problems to be a resident who has been noticed for negative reasons by more than 1 faculty member. In our previous research, this meant residents whose records denoted disciplinary/remedial actions (not finishing the program, being asked to repeat part of the program, being placed on probation, being advanced to the next year with recommendations for improvement, or having notices of performance problems in the record without subsequent remedial action.) Performance problems can occur in academic (ie, test taking or making presentations), clinical, or professional behaviors. The key to identifying the resident with performance problems, though, is that these residents come to the attention of the faculty or director for negative reasons.²

The obvious costs of dismissing a resident are substantial enough to give any rational program director pause before considering this remedy. There is, of course, a huge cost to the resident being dismissed, in that he or she now must find a new program or a new career, and if the latter, it is unlikely he or she will find a career sufficiently lucrative to justify the debt incurred in medical school. Residents may sue the program if they perceive they have been unfairly treated, yet another cost of dismissal. Removing a resident creates a hole in service that must be filled either by another resident or a faculty member, which will increase individuals' workload. Morale of the remaining residents and faculty will likely suffer, due to increased workload, and on the part of the residents, due to the fear that arises upon any unusual circumstance, including the dismissal of a peer, even if the residents were aware that their peer had performance problems.

The costs of dismissing a resident are clearly high, but it is important to consider the analogous costs—those of keeping an underperforming resident. Of utmost importance is the impact the underperforming resident has

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on patient care. Both professionalism and clinical performance problems lead to serious patient care problems. Program directors may not hear of clinical performance problems because when faculty, staff, or other residents perceive that a resident is not competent to provide patient care, their natural response is to fill in the gaps either with their own labor or by requesting the aid of others who can assist. Thus, the cost is multifactorial: There is risk to the patient when an incompetent provider gives care, and there is overwork and dissatisfaction when others cover for the incompetence. Although less immediately obvious, professionalism problems create an impact on patient care too. These typically manifest in difficult relations with peers or other health care workers¹ and can lead to contention, lower morale, and shifting of work to residents who are perceived to be more amiable.

Even more difficult to quantify, but also more alarming, is the message the program sends to other residents, coworkers, and the general public when an underperforming resident is tolerated. The message that this behavior, whether it is incompetent performance or inappropriate professional behavior, is allowable diminishes the profession. When the program spends excessive time attempting to remediate an underperforming resident, the message is that the fate of this individual is more important than patient care, the function of this program, the morale of those who work with him or her, or any other consideration.

This is not to say that programs should never attempt to remediate a resident with performance problems. Instead it is to say that the costs and benefits of doing so should be carefully calculated, and the time spent attempting to remediate performance problems should take into account the fact that most remediations, although they may be successful in the short term, are unlikely to be successful for the long term in situations where the resident is no longer under close scrutiny of residency program faculty. They should thus take into account not only the patients the resident will encounter in the program but also the patients the learner will encounter in subsequent unsupervised practice after graduation. Programs should make deliberate decisions about the amount of extra faculty time and effort that will be spent attempting to address the resident's problems. The profession needs to conduct research to determine the actual costs of remediation in faculty and staff time and to determine long-term outcomes of these interventions so that this information is known and can be factored in when making deliberate decisions about whether and how to remediate residents. We suspect that the costs in faculty and staff time are much higher and the ultimate outcomes (resolution of the problem versus the problem is sustained into independent practice) are less positive than commonly believed, especially for professional behavior problems. Regarding clinical performance problems, there is not enough information available to even hazard a guess. In short, more evidence is needed to predict the future of the

resident with performance problems and thus to support residency program progress decisions.

It is clear that a program cannot simply dismiss a resident immediately upon noting a performance problem. Most programs will engage in some remedial effort. We recommend the approach described by Hickson et al.³ In this approach, the underperforming practitioner is put on notice, first with a peer-led "cup of coffee" conversation, then increasingly authoritarian interventions combined with offers of assistance in finding resources to address the problem. Most notable about this approach is the fact that the practitioner is in control of the situation—the person bringing the problem to his or her attention never assumes responsibility for fixing the problem—and consequences are clear for not addressing the problem.

Probably the most pressing question for program directors is at what point does one say "enough is enough?" Clearly the response to this question is program dependent; however, we offer the following questions to help guide consequential progress decisions.

1. What issues of patient safety have come to your attention?
2. Do hospital staff, other residents, and faculty have to change their own practices to accommodate this resident's deficiencies? How much extra effort will be required on a continuing basis?
3. How frequently does this resident come to your attention for negative reasons compared to other residents in your program?
4. Which faculty members have noticed a problem? Is it only your usual hawks, or have the moderates/doves also noticed a problem?
5. How do other members of the health care team behave when working with the resident? Are they tense or relaxed? Guarded or safe? Engaged in redundant practices to ensure appropriate patient care, or certain the resident will do what he or she is supposed to?
6. How much faculty time, effort, and good will have already been expended to address the resident's problems? How much extra effort will be required on a continuing basis?
7. Residency is a time of practice under close supervision. If this resident's performance improves as a result of additional interventions during residency, what is the likelihood that these changes will be sustained into postresidency practice when supervision is reduced?

We recognize that a program must balance many issues, including legal and due process issues, when considering whether to dismiss a resident with performance problems. Other scholars have addressed these questions.⁴⁻⁶ The purpose of this article is to urge program directors and faculty to consider both the apparent costs of dismissing a disruptive

resident and the hidden costs of not doing so. We hope that by fully considering these hidden costs, program directors will be better able to continue the important work of developing physicians who serve the public and their profession.

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