

## **Interaction Between PHPs and Training Programs: Disruptive Behavior in Residents**

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I began serving as an Associate Medical Director at the Colorado Physicians Health Program (CPHP) just over a year ago. As a former psychiatry residency training director I offer some observations and thoughts on the interaction between PHPs and residency training programs (I focus on residents here, but what follows applies equally well to medical students and fellows).

In my former role as a residency training director, I fully subscribed to the same dual mission as PHPs: support physicians and physicians-in-training as well as protect the public. With respect to the latter, I believe that physicians need to prove every day and in every way that they are knowledgeable, skilled, and professional in their craft. This is not to say that physicians are, or ever will be, perfect, but that when taking responsibility for the health of others the bar is high, and physicians must always be striving to maintain their competence and professionalism. Thus, as a residency training director, my goal was to help my residents succeed in their chosen career path and to provide to the public physicians with whom patients can trust their health and lives.

But residents must do their part as well.

### **The Unprofessional or Behaviorally Disruptive Resident**

It is easy to excuse less-than-professional behavior on the part of residents. We all recognize the stressful nature of medical training, not just in terms of knowledge and skill acquisition but also with respect to developing appropriate maturity and professionalism. Indeed, that is the nature and essence of training. Yet, at the same time, as a training director I held high expectations for resident performance and maturity because patients' health and lives are at stake, and in not so many years the current trainee will be a licensed and practicing physician. As a result, when dealing with difficult residents, I believed that a training program must give each resident a "fair chance"—a fair opportunity to succeed but also a fair opportunity to fail. The latter is required to protect the public.

Not surprisingly, in my time with the CPHP I have generally found residency programs to be very supportive of their trainees and their struggles, whether medical, psychiatric, professional, personal, familial, burnout, or otherwise. This is as it should be, and in the vast majority of cases struggling or difficult residents ultimately become competent professionals. But I have also observed training programs unwilling to set appropriate limits and, if necessary, terminate residents that cannot, or will not, perform as required. Failure to do so is problematic for many reasons.

Of course, an incompetent or unprofessional resident is a potential threat to patient safety, not only within the training program but also after its completion. Also important, however, is the realization that a training program is doing no favor to a resident who really does not have the "right stuff"—

intellectual, professional, ethical, interpersonal, maturational—to be a competent physician. Most of us are slow to make ultimate judgments about a trainee’s future, recognizing his or her youth and the usual developmental progression leading to maturity as well as feeling that he or she needs to be given every opportunity to succeed.

Unfortunately, however, there are situations where the accumulated evidence dictates that a given resident is truly unfit for the medical profession and that this is not a temporary “treatable” setback to be overcome (e.g., a physical or mental health issue, family difficulties, burnout, immaturity, etc.), but a more basic deficit in the knowledge, skills, or attitudes of a physician. The latter may include immaturity, sense of entitlement, poor work ethic, or unacceptable lapses in professionalism including unethical behavior. In addition, some residents may have serious deficits in insight into themselves and their actions, be too defensive to consider and respond to feedback, or simply be unwilling to change problematic behavior. Painful though it may be for the program director and the trainee, apprising the latter of these deficits and advising/requiring him or her to consider another profession is not only in the best interests of future patients but also in the best interests of the trainee.

### **Obstacles to Dealing with Difficult Residents**

Why do some residency programs hesitate or fail to take action with difficult residents? In addition to the emotional stress of terminating a resident as well as the reality that many training program officials have little or no instruction in appropriate limit setting or the process of termination, there are other reasons for failure to do so when it is, in fact, appropriate. Training programs are typically in a workforce bind; terminating a resident means more work and frustration for the residents who remain. Moreover, filling an open residency position with a quality replacement may be difficult. Legal concerns and threat of lawsuit are always of consideration, but a program that has done due diligence with appropriate documentation, progressive discipline, honest opportunities for success, and legal consultation, should not fear legal repercussions. Another consideration is the effect on other residents of a co-resident termination. For some residents, the release of an incompetent or inappropriate resident may be a relief and an indication of a training program’s dedication to patient care and safety and physician professionalism. At other times, however, peers may side with the co-resident and fault the program, especially insofar as the resident is free to say what he or she wants while the training program cannot share personal information.

Training programs find themselves in difficult situations with difficult residents for the same reasons that hospitals or group practices do with full-fledged physicians. The lack of an adequate written code of conduct and training for all (residents, attending physicians, staff) on its content and procedures, lack of adequate documentation of concerns, and failure to take timely or appropriate action are not uncommon, even if easy with which to empathize. These issues relate, again, to what is often less than adequate training for training program personnel, something with which I am very familiar in my own experience as a new residency director.

### **How PHPs Can Assist Training Programs with Difficult Residents**

So, in addition to all the things they usually do, what else can PHPs do to assist training programs with difficult residents?

First, training programs need to be aware of PHPs as a valuable resource and their potential role with difficult residents. PHPs can inform such programs of the utility of a PHP evaluation, which can identify

underlying “treatable” causes of poor performance as well as assist with due diligence and provide independent confirmation of appropriate reasons for termination decisions. PHPs can also use such opportunities to talk about physician wellness, both for trainees and established practitioners.

Second, PHPs can offer residency program officials tips and training in having difficult conversations, appropriate limit setting, and recognizing and responding to resident distress (whether medical or psychiatric, substance induced, family related, interpersonal, or burnout). In my PHP role I have come to believe that PHPs need to offer training programs assistance specifically with behaviorally disturbed or emotionally immature residents. A resident’s lack of professionalism, immaturity, entitlement, or poor work ethic may be related to formal mental or physical illness, but for some residents no medical or psychiatric diagnosis is applicable. Such cases can be especially difficult for training programs as they are often more comfortable dealing with a resident’s medical or psychiatric illness. A number of training directors have told me that they would readily welcome a formal PHP class on such issues.

Indeed, I have found it interesting as a PHP psychiatrist, in dealing with problematic medical trainees, how often training directors appreciate “coaching” that includes both general and specific thoughts on how to handle a given situation, not only with respect to outcome but also to process (“How do we get there from here? What should we do next?). Yes, PHPs must be cognizant of appropriate boundaries, and ultimately, of course, it is the training program’s responsibility to address the future of its residents. Nonetheless, many directors feel that they have had insufficient training for this aspect of their job. For example, advice on limit setting, something that is not frequently discussed in medical training, has often been sought and well-received. This is often accompanied by requests for specific wording in difficult conversations: “How would you say that to a resident?” and “How can I show that I am supportive but be firm at the same time?” While it is not a PHP’s role to administer medical residency programs and our focus is on medical and physical health, we can nonetheless be quite useful to training programs in helping them to think through, identify, and respond to behavioral and disciplinary issues. After all, as PHP members we, ourselves, not infrequently have to confront and set limits on behaviorally impaired physicians. In addition, when dealing with behaviorally disruptive residents, more contact between the PHP and the residency program is often warranted, appreciated, and needed. Such regular contact can serve many purposes, not the least of which is to prevent feelings of being abandoned by the CPHP when there is no clear medical or psychiatric diagnosis.

Finally, PHPs can serve a valuable role in assessing, or helping residency programs to self-assess, their resident work requirements, duty hours, overall stress, and support systems. In so doing, PHPs serve not only a particular resident at a particular time and situation, but also future residents that will follow.