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Special Series: Working with Residents in Difficulty

A Prerogatives-based Model for Assessing and Managing the Resident in Difficulty

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This paper describes a comprehensive, well-tested approach to managing residents with vexing noncognitive performance and attitudinal difficulties. Frustrations surrounding such cases often stem from inadequately defining and acknowledging the boundaries of faculty and resident prerogatives. Conceptual order is brought to these ill-structured problems by dividing nonroutine assessment into two cycles; a work-up cycle for suspected problems in which the resident is the primary decision maker, and a probation cycle for more serious issues in which faculty are the primary decision makers. By replacing adversarial positioning with a "let's find out" approach, the model encourages faculty to raise suspected issues early while supporting resident autonomy and professional responsibility. Finally, it recognizes the absolute discretion of faculty to judge trainee performance, to impose special requirements, or to terminate a resident's contract for cognitive or noncognitive deficiencies. Application of the model is illustrated through sample dialogues.

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In a recent survey, residency directors reported spending an inordinate amount of time on their problem residents, often to the detriment of other residents.[1] Management strategies included waiting for improvement over time, providing direct feedback, counseling, remedial programs, and referrals for psychotherapy. In some cases, several faculty pursued independent, uncoordinated strategies with the same resident. Among residents with attitudinal or psychological problems, all interventions seemed futile, leaving faculty with feelings of despair and frustration.

The terms "resident in difficulty" or "problem resident" are inadequate to distinguish among three kinds of difficulties that have different ramifications. "Academic" problems require the evaluation of cumulative information by faculty.[2] They include behavioral and attitudinal performance as well as cognitive and psychomotor performance which faculty are, in the consistent judgment of the Supreme Court, "uniquely qualified" and empowered to assess.[3-5] "Disciplinary" problems include infractions of explicit rules or laws, such as drinking on duty or stealing drugs. For these, the resident is presumed innocent until proven otherwise. Unlike academic problems, the resolution of disciplinary issues requires formal hearings, rules of evidence, and legal due process. "Impairments" generally refer to diagnosed handicaps or burdens, including depression, alcoholism, or drug dependency. As with other handicaps such as dyslexia or deafness, the program may be challenged by the provisions of the Americans With Disabilities Act to provide special consideration and resources for the impaired resident.

This paper is concerned with managing academic deficits in residents, recognizing the likely overlay of mental health and situational stressors that complicate residents' lives. These academic deficits include attitudinal and interpersonal difficulties that often lead faculty to feelings of despair and frustration. These behaviors trigger strong emotions in faculty, in part, for fear that such residents will "...not make good doctors because they lack the ability to empathize and form alliances with patients and colleagues."[6]

Assessing these types of behavior is especially difficult because the assessment requires high-level inferences, almost always open to multiple interpretations, from observed behavior. Standards for resident performance are necessarily unexplicit, and judgments of noncognitive performance are inherently subjective. Faculty members are understandably uneasy about such vagueness and subjectivity in evaluation, especially when confronting a resident who is expected to challenge the assessment.

In this paper I will present a model for dealing with residents in difficulty. I have used this model for more than a decade, and the model has been validated with residents, medical students, staff employees, nursing

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and allied health personnel, and graduate research associates. The term "problem resident" will not be used again, since it unfairly presumes that the resident is the primary cause of the difficulty. I have personally made this error, but discovered through use of the model that one presumed difficult person was in fact a victim rather than a problem.

Overview of the Model

The prerogatives-based model, presented in Figure 1, begins with the assumption that the primary purpose of resident assessment is to ensure that each resident will leave the training program understanding the profession's standards and having the capacity and willingness to adhere to them in the future. The model further assumes that enduring changes in resident attitudes and performance will depend on positive, active involvement by the resident. Finally, the prerogatives-based model attempts to do as little formal evaluation as necessary for residents who need little, but to respond to serious and enduring problems with more elaborate tools and procedures.

Many frustrations of faculty and residents in conflict with one another stem from inadequately defined boundaries between their prerogatives. The answer to the question, "Who is the primary decision maker?" holds crucial implications for the roles of faculty and residents at each stage of evaluation and intervention. This distinction is a key concept of the prerogatives-based model.

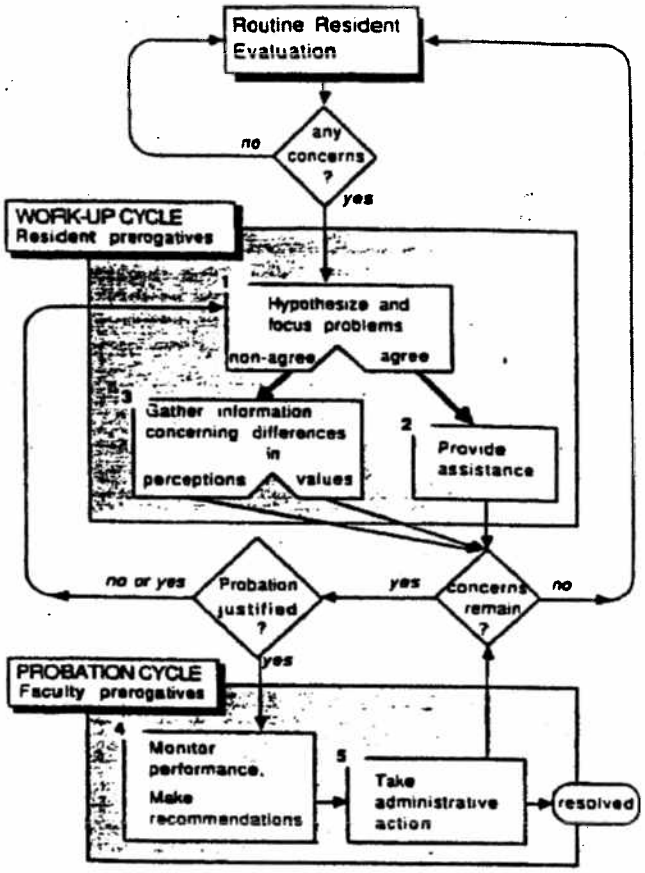
For some issues, the resident serves as decision maker. Concerns such as abrasiveness or quirky dress that are unlikely to affect patient health or to seriously disrupt the functioning of the health care team, are acknowledged to be within the prerogative of the resident to remedy. However irritating they may be to others, these behaviors should not result in faculty-imposed sanctions. Such sanctions challenge the resident's autonomy and invite power struggles in which frustration is predictable and "winning" usually carries an unacceptably high price.

The model instead handles such cases through the work-up cycle, by explicitly acknowledging that the resident retains the choice of modifying such behavior. Faculty members may offer the offending resident their own perceptions and may forewarn of possible consequences without the obligation to be correct in their interpretations. Wherever there is disagreement, faculty can respond, "Let's find out," engaging the resident in open-minded efforts to check out assumptions. Sometimes faculty perceptions prove wrong, and the resident is vindicated. Regardless of the outcome, an open-minded joint search avoids frustrating power struggles and preserves the possibility of meaningful behavior change.

On the other hand, some resident performance problems are serious enough to jeopardize patient health or to seriously disrupt team functioning. When such cases are suspected, the work-up cycle can allow both resident and faculty to test their assumptions and perceptions in the hope that voluntary, mutually satisfactory remedies will be found. However, should the work-up cycle fail to yield this result, and should faculty remain concerned about the seriousness of the problem, then the information and decision-making needs of the faculty, not the resident, are paramount. They are then addressed through the "probation cycle." Here, faculty are obliged to define their concerns and inform the resident, to formally investigate and document the extent of the problem, and to reach decisions concerning the consequences to the resident. U.S. medical faculty have been given absolute discretion by the

Figure 1

A prerogatives-based model for assessing and managing the resident in difficulty



federal courts to exercise their professional judgment, however subjective, and to make binding decisions concerning the resident's academic progress.[5]

The model is intended to help faculty draw more consistent distinctions between resident and faculty prerogatives. By clarifying the ground rules and procedures of each cycle, both residents and faculty can avoid the kind of dispiriting impasses that can erode a program's morale.

In the following section, the model is discussed in detail and illustrated with typical resident cases. Though the model was built initially to deal with exasperating behavioral and attitudinal problems, it is equally applicable to more straightforward academic performance problems such as deficits in knowledge or dexterity.

Description of the Model

Routine Performance Assessment

All residency programs are required to establish procedures for observing, assessing, and informing residents of their progress. The prerogative-based model assumes that such procedures are in place. The model deals with concerns emerging from routine resident evaluations.

Faculty members detecting vague or sporadic early warning signs of potential problems often refrain from discussing these concerns with residents until enough experience has been gained for a fair, defensible assessment. But, by waiting until the behavioral data base is solid enough to make fair judgment, the advisor may inadvertently appear to be building a case against the resident. With damaging evidence already in hand, the advisor's attempt to solicit the resident's acknowledgment of problems is apt to trigger defenses. Consider this example of an exchange between a resident and a faculty advisor following several documented incidents of a potential behaviorial problem.

FAC: *Pat, you're managing the work load well, but I have some concerns about your relations with some patients.*

RES: *What do you mean? (typical defensive response)*

FAC: *Well, (taking out a folder of notes) remember Mr. Applegate? He asked you several times whether all his X-ray studies might cause sterility, and each time you only said, "Don't worry about it." On the 17th, Mrs. Briar was a bit impatient and you told her, "I think you need some sedation." Then, last Tuesday you...*

RES: *I didn't know big brother was watching. Where was your candid camera when Mrs. Henry gave me those cookies and Mr. Kurt sent me that nice note?*

FAC: *Now, Pat, I am just trying to get your input on this. Do you think there is a problem here?*

RES: *(Silently) Why is he following me around?*

By not discussing the problem incidents after each occurred, the faculty member has fortified his or her own position but endangered communications with the resident. In the interest of establishing a respectful working relationship between faculty and residents, sharing inconclusive concerns is more effective. For example, the following dialogue might occur between faculty and resident after very limited observation.

FAC: *Pat, you seemed disinterested in answering Mrs. Smith's question about her diabetes.*

RES: *What do you mean?*

FAC: *I'm not sure, but I suspect that something about her pushed one of your buttons.*

RES: *Hmmm, I don't think so.*

FAC: *Maybe something else was going on between you and Mrs. Smith. Why don't you try and tune in on any hitches in your relationships with patients like Mrs. Smith? Let me know if there's anything I can help you with.*

RES: *Sure, thanks.*

The tentative tone of the second discussion is less accusatory and more concerned with understanding and helping the resident. The faculty member is merely opening a door, not arguing a case. The resident, with less need to defend, has more freedom to reflect and respond. Relieved from the obligation to be correct, faculty can employ this intervention very early.

In most programs, residents meet periodically with a faculty advisor to review recent evaluations and to plan future rotations. An especially effective review process is to have residents rate themselves prior to the meeting using the same instrument that faculty use. When resident and advisor can compare perceptions on each item, the discussion usually becomes more comfortable and more productive for both parties. The resident knows the agenda in advance and is an equal participant. Agreement in areas of excellence can be acknowledged rapidly, agreement in problem areas can be flagged for immediate remedies, and areas of disagreement between faculty and resident can become the focus for further inquiry.

Work-up Cycle

When does a suspicion arising from the routine assessment of residents become a difficulty appropriate to address in the work-up cycles? The threshold for activating the work-up cycle is deliberately low. The guiding rule is that when faculty inquire of others about a resident's suspected difficulties and hear corroborating suspicions, it is time to activate the work-up cycle. Faculty members need not agree about the nature of the concern. The work-up cycle can also be activated by the resident's own concerns.

Task 1: Hypothesizing and Problem Focusing

Residency faculty, trained as observant and insightful helpers, are at risk of responding to residents in difficulty as though they were patients–with a rapid, insightful diagnosis and a treatment plan. But residents in difficulty often reject the faculty's proffered formulations and solutions, seeking instinctively to avoid the danger presented by the dual faculty roles of authority and helper. Even when faculty perceptions are correct, interventions are virtually certain to fail until resident and advisor concur on the nature of the problem. To omit the stage of mutual problem identification in search of objective evidence or prescriptive remedies is to invite frustrations for the faculty member and resentment by the resident.

When routine faculty observations uncover possible performance problems, these should be regarded as fallible impressions open to multiple interpretations. By entertaining several possible interpretations, including the resident's, faculty can encourage open exploration and avoid a stand-off. In the example below, a routine evaluation has resulted in a low rating on the evaluation item:

Relationship with Patients

RES: *I don't think it's fair. These are just a few cases.*

FAC: *Let's assume there were just a few cases. Can you shed any light on why others thought you had trouble with these particular patients?*

RES: *No, they were just difficult patients.*

FAC: *(long silence)...Try.*

RES: *Chronic lungers bug me sometimes. They brought it on themselves, and they're noncompliant. I don't think anyone else could have done any better.*

FAC: *You seemed to do very well with Mr. Clark and his emphysema.*

RES: *Maybe it has more to do with their dependency. Mr. Clark was really a gem.*

FAC: *Let's see if that explanation really works. Jot down the names of all the COPD patients you can remember working with recently. Then give them each a score–from plus three to minus three. Minus three meaning they bugged you a lot; plus three meaning you really enjoyed them.*

RES: *(After completing the task) Well, it looks like I got along better with the men than the women.*

FAC: *Yes. That's interesting; but let's not be satisfied with just one explanation. Do you see any other ways to explain why the list sorted out this way?*

RES: *I think what I said earlier about dependency still holds up. And one more thing...*

In preparation for this discussion, it is helpful to seek the speculative interpretations and insights of other observers. Since perspectives will vary, the exercise can help an advisor appreciate that alternative views are legitimate. When the foundations of problem definition are laid out as hypotheses, several advantages follow. First, resident and advisor keep pace with each other in mutual exploration of the issues. Both begin to discard oversimplified notions. Second, the advisor's sincere effort to understand the issues communicates a sense of respect for the resident. Third, by their joint exploration, the resident and faculty member are more likely to agree on mutually acceptable plans for addressing the problem. Being less onerous and requiring less data than a reproach, an exploratory, hypothesizing approach is more comfortable to initiate early.

The hypothesizing and problem-focusing discussion is brought to closure by sorting the issues into two groups: (a) those issues on which advisor and resident agree, and (b) those issues on which they retain differences of opinion. We now rejoin their discussion.

FAC: ***I think we've brought this picture into better focus. I'll try to summarize. (Agreement items) First, we agree that your knowledge of pulmonary problems is excellent. Second, we agree you need better strategies for managing patient dependency and third, we agree that the program has not provided much training in handling patients with chronic low-grade depression. (Nonagreement items) We are not in agreement on your handling of patient requests. I still have the feeling your relationships with these patients began to deteriorate when they insisted on changes that were not part of your plan. You see yourself as being appropriately assertive with noncompliant patients. Have I gotten the issues right?***

Task 2: Providing Assistance

When faculty members summarily diagnose the resident's performance problems and offer their remedy, residents react predictably with feelings of resentment. A simple rule to apply is this: never try to remedy a resident's problem until you and the resident agree on what the problem is. Agreed-on problem formulations serve as opportunities for faculty to intervene constructively. Such assistance builds trust and invites acknowledgment of other problems. Returning to the discussion between Pat and the faculty advisor, the advisor plans strategies for some immediate assistance in the areas of agreement.

FAC: *So it seems we have a plan. You will phone Dr. Abramson tomorrow and have her suggest a few references on dependency. Also, you'll ask her to emphasize managing dependency during her psych rounds this month. I will schedule a noon conference on low-grade*

depression. Then we'll meet again in a month and see if there are any more things we should do.

RES: These things might help.

The types of helping interventions are limitless, but the process should follow these guiding rules: (1) The intervention should be planned jointly by the resident and faculty, continuing the collaborative effort begun in the hypothesis and problem-focusing stage. In fact, conscientious help and collaboration with easily acknowledged problems may help to narrow differences on larger problems. (2) The intervention should involve specific commitments to tasks by both resident and faculty member. Follow through on commitments gives each a way to gauge the sincerity of the other. Commitments broken by residents may indicate more serious problems and should be discussed with the resident just as any other performance problem. Faculty members must avoid undermining trust by failing to deliver on their own promises. (3) The intervention should be monitored for effectiveness and terminated before efforts fade away. Although attitudes and habitual behavior change slowly, short-term intensive interventions may be preferable, reducing chances that either resident or faculty will feel that the other "dropped the ball."

Task 3: Tailored Information-Gathering Concerning Differences

Differences of opinion include both frank disagreements and matters on which one party reserves judgment. Having clarified the points of difference, nonagreements will eventually resolve into one of two types, labelled here as either perception differences, or value differences. Perception differences are disagreements about what is true. They can be resolved by collecting information to find out whose perception is more nearly correct. Value differences are disagreements about what is important. By their nature, they do not yield to empirical evidence. The two kinds of conflict need different approaches, but each needs a tailored work-up.

Perception differences

When a perception difference emerges after hypothesizing and focusing on problems, the advisor should engage the resident in a rational search for information to determine whose perception is closer to the truth. The appropriate kind of information to collect usually becomes obvious once the difference has been precisely identified. For example, if an advisor believes a resident to be abrupt with patients, and the resident disagrees, then observations of several patient encounters would be informative. However, if a resident admits to being abrupt, but denies that this behavior is resented by patients, then anonymous interviews with patients of the resident might be more pertinent and helpful. Whatever data are collected, the evaluation protocol is developed for the particular questions at hand and with the resident's participation. The resulting information must be credible to the resident, who remains the principal decision maker.

In Pat's case, the problem is so vague that a formal assessment would be premature. The assessment tool will be a simple anecdotal record. The conclusion of the discussion between Pat and his/her advisor follows:

FAC: Let me summarize. You believe you were demonstrating appropriate assertiveness with noncompliant patients, and I suspect you were being unnecessarily rigid. Suppose I keep an eye peeled for a month to look for examples of what I'm driving at. If I see examples in which you seem unnecessarily rigid, I'll note them. Then you can fill me in on the entire history, and we'll review the management together.

RES: So, you are going to be watching me pretty closely, huh?

FAC: To get a decent sample of cases, why don't you alert me to your least compliant patients?

RES: I should tell you when I'm expecting to get in trouble?

FAC: If you're being appropriately assertive, don't you want me to recognize it? And if you're being unnecessarily rigid, don't you want to know another approach? Neither of us can claim the truth, so let's find out.

RES: I'm not sure I like this. You're pushing me to change my style.

FAC: Not at all. Do exactly what you think you should. The point is better patient care; not who was right in the first place. We'll both be smarter about this in a month.

The dialogue above illustrates three key rules of problem assessment when perception differences exist: (1) Identify the relevant issues and behaviors jointly, (2) Collect data on future events, (3) Analyze the data jointly. Pat's advisor has worked to demonstrate that they are engaging in mutual exploration of a specific issue. When they meet again in a month, their attention to the issue should have clarified the views of both and, one hopes, given rise to new areas of agreement.

Assuming that the faculty member was correct about the initial concerns, the concerning behavior may simply disappear under scrutiny. In fact, both the resident and faculty advisor have advanced the issue; the resident, by demonstrating the ability to be flexible or tactful, and the advisor by presumably inducing a positive behavior change. Faculty who are chagrined by such changes under scrutiny should examine their motives: is it more important to "get" the resident or to induce an improvement, however temporary? It is also

possible that the resident's view was correct all along. If so, it has been to the advantage of all that faculty concerns were expressed and that the resident dispelled them.

Depending on the complexity of the problem, it might be necessary to cycle through the process of hypothesizing, focusing, and information-gathering several times until the problem is resolved. In each recycling, there is opportunity to re-hypothesize and re-focus based on new information, opportunity to distill out more areas of agreement and assistance, and opportunity to collect further information to resolve the remaining differences. Resident rejoinders such as, "That's only your opinion," need never end in a stand-off. Faculty can always say, "We don't agree; let's find out."

Now suppose that Pat is observed for a month and that anecdotal notes have been written on five observed contacts with COPD patients. Results suggest strongly that Pat rigidly resisted suggestions and requests from two female patients who wanted reasonable alterations in their regimens. Pat becomes angry during the review of the anecdotes and rejects the anecdotal records as untrue, exaggerated, or failing to consider aspects of the case that the advisor did not consider. We pick up the dialogue between Pat and Pat's advisor at this point.

FAC: *Yes, Pat, I suppose you're right. This is just a handful of cases, and they might well be biased or incomplete. It looks like we need a more objective way of assessing things in order to reach agreement.*

RES: *I really don't think it's worth the trouble.*

FAC: *Gaining compliance in chronic disease management seems pretty important to me. Instead of my anecdotal notes, I think I can arrange to get some videotapes of you with your older female patients. Let's try for 10 incidents. Then we'll sit down and review them together.*

RES: *I still don't think we would agree. We would be looking for entirely different things.*

FAC: *You've got a point. We need a more structured format. Let's put together a simple form for reviewing the tapes. You develop two or three items you think I should watch for, and I will put down two or three items I think you should watch for. We'll combine them and have a fairer way to assess the tapes.*

RES: *I still don't think we'll agree.*

FAC: *We probably will on some things. If we fail to agree on something important, we can ask someone else to look at the tapes and use our rating scale.*

RES: *We would still be guessing about the patients' part in all of this. After all, that's the heart of the matter, isn't it?*

FAC: *Let's not lose the focus. Right now, we're looking into whether you are appropriately firm with noncompliant patients or inappropriately rigid when patients challenge you. Let's make the tapes and review them. If we identify issues that patients could help us resolve, we can certainly involve them. How does that sound?*

RES.: *You're really serious about this, aren't you?*

FAC: *Aren't you?*

This exchange illustrates a recycling through the work-up phase. The anecdotal records added important documentation of the disputed issue. They crystallized previously vague disagreements. No new areas of agreement were found, so no new assistance was offered. The anecdotal records, for all their behavioral specificity, did not remove the specter of subjectivity. The videotaping attempt at information-gathering is to be more narrowly focused on female patients and more extensive. The escalation of evaluation methodology to video and checklist is justified because the problems originally sensed by the advisor now appear to be substantial. In reviewing these information-gathering developments, note that (1) relevant behaviors are still being identified jointly, (2) data are still being collected on future events, and (3) plans still call for joint analysis of the information. The intent of the process is that by close examination of his/her own behavior, Pat should conclude that a voluntary change is warranted. For all issues in the work-up cycle, Pat remains a decision maker to be convinced, not a subordinate to be coerced.

Value differences

When resident and advisor agree that a certain behavior took place but disagree about the importance of the behavior, a value difference exists. Consider the following statements by residents:

RES: *I know the progress note is illegible, but that's my handwriting. If legibility is so important, residents should have a dictation system.*

RES: *I'll treat my own patients for STD, but what happens with their partners is not my business.*

RES: *Lots of people get divorced. It's not a medical problem, and I have no time for whiners.*

Unlike perception differences, value differences cannot be resolved by empirical tests, nor is there much payoff in trying to convince a resident that his or her values are inappropriate. Because they are so personally held, value differences can lead to some of the most heated and intractable disagreements between residents and faculty.

How can performance problems arising from value differences be addressed? The first step is to acknowl-

edge the resident's sovereignty over his or her values and the faculty's lack of power or authority to revise them. After this point, an advisor can engage a resident in a detailed exploration of the resident's value positions and the implications for the resident's role, responsibilities, and professional obligations in light of those values. The resident's responses to probing but respectful questions can often force a deeper consideration of those values.

As an outcome, the advisor should strive for the modest goal of getting the resident to fully articulate his or her value perspective. With this information, both resident and advisor can anticipate resident behaviors that fall within limits acceptable to the program, and behaviors that will lead predictably to conflict. The program can then spell out, as policy applicable to all, the likely consequences of out-of-bounds behavior. Residents retain the choice to behave as they will, with full knowledge of the consequences.

By dignifying the resident's point of view while encouraging reflection, a resident's values may evolve toward greater compatibility with the program's. The scribbling resident may eventually decide, for example, that legible charting is a professional responsibility. Few values are absolute, so a resident may also decide that the cost of challenging the program's insistence on legibility is too great. Inducing reconsideration takes longer than issuing directives, "Write legibly or else!" but is more lasting and preserves the adult relationship between resident and faculty.

Residents who won't participate

If a resident in difficulty refuses to engage in the work-up cycle, what are the options for faculty? First, the notion that the work-up cycle involves assessment for resident decision-making must remain intact. Residents are eventually more likely to respond in their own best interests if their autonomy and responsibility are acknowledged. Consider the following dialogue, in which the advisor recognizes the resident's control and responsibility, states his own intentions, and avoids a regressive power struggle.

FAC: Terry, we've talked about your style, which I see as abrasive, and you've declined to look into it. I'd like to say that it truly is your choice. Your style may make life less pleasant for you and others, but it's not likely to slow your progress through this residency because your patient care is fine. But I am going to continue to let you know when I see your style getting in your own way. My hope is that someday you'll decide to address it. If that happens while you're still a resident, I'll be ready to help.

RES: Don't hold your breath.

Probation Cycle

When faculty are concerned that a resident's behavior might jeopardize patient health or seriously disrupt the functioning of the residency program unit, then the program has an obligation to see that the issue of concern is resolved to the faculty's satisfaction. The probation cycle is reserved for such performance problems. Educational probation is a formal process of close monitoring that is instituted when a pattern of substandard performance is suspected. The probation cycle does not depend on the resident's voluntary participation. In cases of potentially unsafe or disruptive behavior, the courts have encouraged medical faculty to intervene before actual harmful consequences occur.[4] In deciding whether a resident's problem merits entry into the probation cycle, the faculty should answer the following two-part question:

(1) If the faculty were correct about their suspicions of substandard resident performance, and

(2) If the resident's performance were to continue unimproved,

Then, could the program justify intervention: for example, by requiring remedial activities or by nonrenewal of a contract, irrespective of the resident's wishes?

In practice, it is difficult for faculty to answer this question with confidence until the problem has passed through the work-up cycle at least once, yielding reliable information about the problem and the resident's interest in improvement. If the answer to the hypothetical two-part question is "No," then the problem reverts to the work-up cycle, where analysis and information-gathering serve the decision-making prerogatives of the resident. Irksome behavior patterns may profoundly influence a resident's professional satisfaction yet may still not be grounds for unilateral action. Under these conditions, faculty may be absolved of responsibility to provide accurate and objective assessments or to induce effective change. Faculty should instead be more concerned with cultivating an environment in which residents will heed subjective feedback and advice.

If the answer to the two-part question is "Yes," then the problem should enter the probation cycle. Probation does not imply that the faculty's view has prevailed, or even that all faculty concur in their assessment of the resident's performance. It signifies instead that a more formalized and intensive method of surveillance of the particular resident's performance will begin, designed to meet the decision-making needs of the faculty.

Let us assume for now that Pat's videotapes have revealed persistent problems with defensiveness, especially in communicating with chronic disease patients. Some faculty worry that the problem now appears to be greater than originally suspected. In accordance with the procedures established by the program, the faculty meet for a probation review.

Figure 2

Example letter informing a resident in difficulty of the outcome of a probation review

To Dr. Pat Jones:

After lengthy consideration of your case, the faculty has determined that your extreme defensiveness, both with some patients and with faculty, appears to impair your judgment. If such defensiveness were to continue into the future, the academic remedies imposed in the interests of patient health and the program's integrity might range from an additional closely supervised clinical preceptorship to nonrenewal of your contract.

I have appointed Dr. John Holden to head a panel of three faculty who will establish criteria for acceptable performance and set up methods of monitoring your performance in the future. The panel will undertake an intensive two-month monitoring of your patient contacts and make a recommendation to me at that time. Regardless of that recommendation, the review panel will monitor your behavior less intensively until further notice. Your advisor will be available to help you understand and meet the criteria to be set by the panel. Your advisor is interested in continuing to help you meet the high standards of the residency. I sincerely hope you will take advantage of her knowledge and her personal concern for you.

Sincerely Yours,

Residency Director

For illustrative purposes, two concluding scenarios are presented. First, imagine Pat's problem is judged not to warrant unilateral action, even if uncorrected. In this case, Pat receives a letter to this effect from the program director, explicitly acknowledging that the problem remains Pat's prerogative to address. In this scenario, Pat's advisor will discuss the letter with Pat. Where honest disagreements persist, faculty can still say "Let's find out." Whenever Pat and faculty reach agreement about the nature of a performance problem, help should be available to remedy it.

Now imagine a different outcome to the probation review. In the second scenario, the faculty consensus or director's conclusion is that if faculty suspicions about Pat's performance were correct and if Pat's performance remained unimproved, then patient care could indeed be seriously compromised. Meeting the two-part criterion for probation, Pat is informed in writing by the letter in Figure 2 of the particulars of the probation decision.

Task 4: Probationary Monitoring

As illustrated in the letter in Figure 2, once a resident is placed on probation, a monitoring panel is appointed. The panel protects the interests of patients, the profession, and the residency program during the probationary period. The initial job of the monitoring panel is to (1) set up performance criteria or expectations, 2) arrange for specific methods of monitoring the relevant performance, (3) describe the process it will follow in preparing recommendations, and (4) negotiate its liaison with the resident's advisor. The products of the panel include a documented report of the resident's performance and recommendations to the program director, both based on the results of its monitoring.

A panel of three members works well, especially if it includes at least one impartial outsider. Otherwise, the objectivity of faculty who have been dealing with the resident in difficulty may be influenced by prior interactions with the resident. Neither the resident's advisor nor the program director should be included. The advisor should instead continue in the helping role, taking care not to abandon the resident at a time when other faculty may appear to be "gunning" for him or her. By keeping the director's ultimate decision-making role separate from the panel's responsibility for monitoring performance and making recommenda-

Table 1

Key Points of the Prerogatives-based Evaluation Mode

Routine Resident Evaluation. Provides regular opportunities for assessing, guiding, and reassuring residents, as well as identifying problems requiring further work up.

Work-up Cycle. For suspected problems that remain the resident's prerogative to resolve.

Task 1: Hypothesizing and problem focusing
- Discuss with the resident several hypotheses about the problematic situation.
- Acknowledge and respect the resident's perspective, however improbable, by giving his/her hypotheses full consideration.
- Sort the issues that emerge into areas of agreement and areas of non-agreement, to the resident's satisfaction.

Task 2: Providing Assistance
- Plan help jointly with the resident, only in areas of agreed need.
- Exchange specific commitments with the resident.
- Monitor help for effectiveness and terminate special arrangements explicitly.

Task 3: Tailored information gathering concerning differences
- Separate perception differences from value differences.
- With perception differences, work with the resident to collect relevent data on future events.
- With value differences, help residents to articulate their value positions, identify the resident behaviors likely to result in conflict, and communicate as policy the likely consequences of out-of-bounds behavior that might stem from divergent value positions.

Probation Cycle. For suspected problems that remain the faculty's prerogative to resolve.

Task 4: Probationary Monitoring
- Appointed Monitoring Panel members survey resident performance and investigate any pertinent incidents according to an agreed-upon protocol.
- The monitoring panel reports findings and recommendations, not decisions, back to the faculty or director.
- The helping relationship between resident and advisor is preserved during probation.

Task 5: Taking Administrative Action
- Separate performance monitoring and recommendations from administrative decision making.
- Final judgments and decisions, though well-informed, remain subjective.

tions, the program is more likely to perform each of these tasks with independent and appropriate judgment.

The formal process of instituting probation usually has a galvanizing effect on residents in difficulty. The boundaries of acceptable behavior become clear to all, as do the likely consequences of overstepping them. Experience suggests that most residents placed on probation will either quickly overstep the boundaries in challenge, or quickly pull back. Either response speeds and simplifies the decision-making for faculty.

Task 5: Taking Administrative Action

The final task of taking administrative action usually belongs to the program director, who is informed by the record of probationary monitoring and the independent recommendation of the monitoring panel. Tough administrative actions are rarely needed since most problems are resolved at earlier stages. But residency directors must periodically exercise their duty to maintain professional standards through imposed academic remedies. Though such judgments remain subjective and fallible, the community expects training programs to make them.

Barriers to Implementation

This model for assessing and managing the resident in difficulty seems complex and time intensive. But experience suggests that it actually saves time by engaging residents with suspected difficulties earlier, by maintaining an appropriate focus for the involved resident and faculty, by reducing powerless hand-wringing among faculty, and by reassuring other residents, who tend to feel vulnerable when one of their peers is under scrutiny. Residents who truly feel misjudged welcome the "let's find out" openness conveyed by the model. Residents unwilling or unable to meet their program's standards will prefer a poorly defined or haphazard process instead of the model's order and progress. The true difficulty in employing the model lies not in its time requirements but in maintaining a clear focus in meeting one of the most challenging responsibilities of residency faculty.

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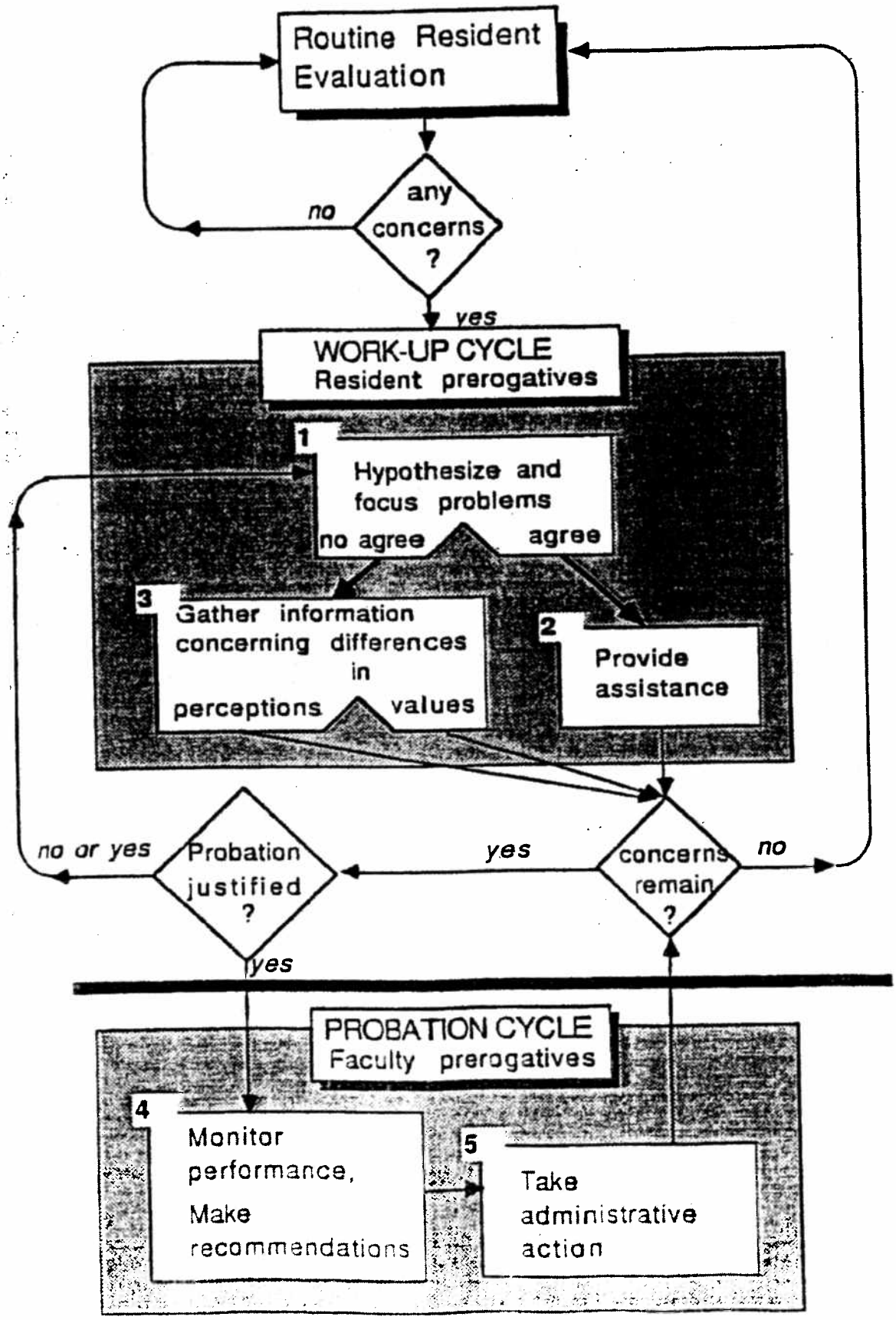
Assessing and Managing the Resident in Difficulty



Key Points of the Prerogatives-based Evaluation Model

Routine Resident Evaluation. Provides regular opportunities for assessing, guiding and reassuring residents as well as identifying problems requiring further "work-up."

Work-up Cycle. For suspected problems that remain the resident's prerogative to resolve.

Task 1 — Hypothesizing and problem focusing

- Discuss with the resident several hypotheses about the problematic situation.
- Acknowledge and respect the resident's perspective, however improbable, by giving his/her hypotheses full consideration.
- Sort the issues that emerge into areas of agreement and areas of non-agreement, to the resident's satisfaction.

Task 2—Providing Assistance

- Plan help jointly with the resident, only in areas of agreed need.
- Exchange specific commitments with the resident.
- Monitor help for effectiveness and terminate special arrangements explicitly.

Task 3 —tailored information gathering concerning differences

- Separate perception differences from value differences.
- With perception differences work with the resident to collect relevant data on future events.
- With value differences, help residents to articulate their value positions, identify the resident behaviors likely to result in conflict, and communicate as policy the likely consequences of out-of-bounds behavior that might stem from divergent value positions.

Probation Cycle. For suspected problems that remain the faculty's prerogative to resolve.

Task 4—Probationary Monitoring

- Appointed Monitoring Panel members survey resident performance and investigate any pertinent incidents according to an agreed-upon protocol.
- The Monitoring Panel reports findings and recommendations — not decisions — back to the faculty or director.
- The helping relationship between resident and advisor is preserved during probation.

Task 5—Taking Administrative Action

- Separate performance monitoring and recommendations from administrative decision-making.
- Final judgments and decisions, though well informed, remain subjective.

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A Model for Conceptualizing Faculty Roles with Residents in Difficulty

Scott Smith, MD, Boise VA Medical Center

Adapted from Bayer Patient-Doctor Communication Course