Approach to Handling a Problem Resident

JAYA SHANKAR KAUSHIK[1], KAUSALYA RAGHURAMAN[2], TEJINDER SINGH[3] AND PIYUSH GUPTA[4]

From Departments of [1]Pediatrics and [2]Microbiology, Pt BD Sharma Post Graduate Institute of Medical Sciences, Rohtak, Haryana; [3]Department of Pediatrics and Medical Education, Christian Medical College, Ludhiana, Punjab; and [4]Department of Pediatrics and Medical Education, University College of Medical Sciences (University of Delhi), New Delhi; India.

Correspondence to: Dr Jaya Shankar Kaushik, Associate Professor, Department of Pediatrics, Pt BD Sharma Post Graduate Institute of Medical Sciences, Rohtak, Haryana 124 001, India. jayashankarkaushik@gmail.com

Many medical postgraduate teaching programs have residents with professional and personal problems that may limit their performance. A Problem resident is the one who does not meet the expectations of the training program owing to deficits in knowledge, skill or attitude. Medical administration and faculty of every institution must have a system that is sensitized to handle a difficult learner. Problems need to be addressed before they escalate or result in compromise of patient care. The present review discusses a broad approach to recognizing a Problem resident and provides suggestions on remedial measures.

Keywords: *Attitudes, Competency based medical education, Postgraduate training, Professional competence.*

Dr. S joined postgraduate residency in Pediatrics just a few months ago. Soon, the head of the department started receiving complaints regarding him from staff nurses, fellow residents, and patient attendants. He was reported to be rude and aggressive while dealing with children and their parents. He often argued and quarrelled with staff nurses and other subordinates during the work hours. He used to ignore the instructions given by his seniors. However, he behaved extremely well in front of the faculty members; it was difficult for the faculty to believe that he has a problem!

Medical teachers often face situations where students or trainees are problematic or challenging. All clinical teachers want their team members to be competent, compassionate, cooperative and constructive. Medical Council of India (MCI) describes the role of Indian medical graduates beyond being a clinician, to be a leader, professional, communicator, and a lifelong learner who is ethical and committed to excellence [1,2]. Qualities of a 'great resident' or a 'high performing resident' include being trustworthy, hardworking, efficient, and self-directed learner [3]. It is, however, not unusual to encounter trainees with a deficit in knowledge, lack of clinical judgment, annoying behavior, inappropriate interaction with colleagues, or being late or absent. All these serve as significant obstacles in the attainment of the desired competencies [4-8].

Problem behavior of one resident sometimes spoils the reputation of the entire department and hampers training of fellow residents. Such a resident often diverts the time and energy of other fellow residents and faculty members. Improper handling may result in violent behavior to self or others. It is thus essential to recognize the problem resident, and institution of remedial measures at earliest.

DEFINITION

Myriads of terms are used for a problem resident: troublemaker resident, problem learner, difficult resident, the burned-out resident, disruptive resident, and so on [6-8]. A 'problem learner' has been defined as one whose academic performance is significantly below performance potential because of a specific affective, cognitive, structural, or interpersonal difficulty [8]. American Board of Internal Medicine defines problem resident "as a trainee who demonstrates a significant enough problem that requires intervention by someone of authority, usually the program director or chief resident." In simple terms, a problem resident is the one who does not meet the expectations of the training program owing to the deficit in knowledge, skill or attitude.

STATEMENT OF THE PROBLEM

In a study by Reame, *et al*. [5], the prevalence of 'resident in trouble' was estimated to be 9.1%. They observed psychiatric illness, substance abuse, attitudinal problems, interpersonal conflicts and insufficient knowledge to be the common reasons. In another internal medicine residency program, the prevalence of problem resident was estimated to be 6.9%. The most common attributable causes included insufficient medical knowledge, poor clinical judgment, and inefficient use of time [4]. In a

nationwide survey of psychiatry residency program in the United States, it was observed that 3.3% of residents were terminated in a four-year period for unacceptable performance [9]. Data from India on this issue are lacking.

PREDISPOSING FACTORS

Knowledge Deficit

One of the most common attributable cause of problem resident is insufficient knowledge [5]. The resident may have poor baseline subject knowledge or is slow to grasp the basic concepts leading to an unsatisfactory performance at work (***Box* I**). The regular internal assessment might detect academic deficiency and provides an opportunity to rectify the deficit. Lack of organizational skills and ineffective time management are some of the other hurdles in acquiring the requisite knowledge.

Skill Deficit

Skills required from clinical residents include the art of history taking, correct method of clinical examination, interpreting the clinical findings to reach a diagnosis, plan investigation and managing the patients. One of the most essential skills is communication of the plan to relatives and ability to discuss the idea with colleagues and taking constructive criticism. Communication difficulties, especially of those who travel from other states to pursue their higher education, might have trouble communicating in the local language. Majority of residents face problem in skills during the first few months of residency that tends to improve with time. Surgical hands-on skills often need constant supervision. The persistent deficit of skill development despite repeated reinforcement leads to a problem.

Box 1 HUNT'S CLASSIFICATION OF PROBLEM LEARNER

Type I (frequent and difficult#)*
- Bright with poor interpersonal skill
- Excessively shy, non-assertive

Type II (frequent and not difficult#)*
- Poor integration skills
- Overeager
- Cannot focus on important issue
- Disorganized
- Disinterested
- Poor knowledge

Type III (not frequent and difficult#)*
- Cannot be trusted
- Psychiatric problem
- Substance abuse problem
- Manipulative

Type IV (not frequent and not difficult#)*
- Too causal or informal
- Avoids works
- Intellectually inferior
- Avoids patient contact
- Does not show up
- Challenges everything
- Awkward

**How frequently do we encounter this problem;*
#How difficult is the problem to handle.

Attitude or Personal Problems

Attitude or personality problems stem from a deficit in motivation. The problem resident often has a poor interpersonal relationship and is not dependable for independent patient care (***Box* 2**). Residents with attitude problems are the most difficult ones to handle.

Problems pertaining to residents

Personal problems like bereavement from loss of loved ones, struggle in the family, or difficulties in personal relations may affect the performance of residents. Poor interpersonal relationships lead to prejudiced work atmosphere and impair learning. Psychiatric illness and substance abuse among residents needs early identification and correction. These problems often result in stress, depression, low self-esteem, and fear of failure.

Many students choose a medical or surgical specialty based on their score rather than their interest. Such discordance may result in a problem during the early days of residency. Few residents have adjustment issues considering the latency of 2-3 years after completion of medical school before they get into a specialty. In a study by Hunt, *et al.* [10], it was observed that most common problem learners were those with cognitive issues and poor interpersonal relationship.

Problems pertaining to teachers

Faculty members with unrealistic expectations, stressful personal life, or working in an unsatisfactory workplace often vent out their anger and frustrations at the resident. The behavior may initiate or exacerbate problems in the resident. An excellent role model faculty produces better professional behavior among residents [11,12]. A problematic faculty; however, is more likely to produce a problem resident.

The teacher is often assigned the dual role of clinician and teacher, and a few fail to live up to the expectations. Few teachers may become oblivious to the problem resident altogether so as to avoid direct confrontation and few may vent out their anger by scolding the resident. On the other hand, few faculty members suddenly become

soft, primarily to avoid any possible personal litigations. Often, faculty members are reluctant to provide an honest assessment of the residents, and mark them as satisfactory despite being problematic [13]. This only aggravates the situation.

Problems pertaining to system

Workplace learning varies widely between different institutions, depending on opportunity, motivation, and capabilities [14]. In government facilities, barriers to effective workplace learning might include deficient infrastructure, deficient manpower, and unmanageable patient load [15]. In addition, lack of access to peer, lack of management support, lack of access to technology, lack of funding, and unsupportive staff attitude are other barriers to workplace learning [14]. Certain institutions despite having excellent infrastructures may lack expertise and teaching exposure required during residency training [16]. Many students migrate from one state to another state for pursuing postgraduate residency. Relocation to a new institution often invites financial concerns, isolation, and social problems leading to resident stress and adjustment issues [17]. All these factors may contribute to the making of a problem resident.

Unprofessional Behavior

Some of the professional etiquettes expected from residents include being courteous to your colleagues and seniors, being on time to work, wearing appropriate clothes to the hospital, showing appropriate gestures while speaking to patients, and most importantly to keep one's grudges and egos away while dealing in a professional atmosphere. Unprofessional blogs and social media posts such as binge drinking, posting sexually appealing photos, sharing patient videos on social media, posting raw or confidential data of institute, and personal comments on faculty members or peer colleagues are some of the commonly encountered problems [18,19]. Fabricating patient reports to meet preoperative criteria, and verbal or physical abuse of junior doctors are some of the extreme behaviors encountered among few residents [20]. There is rising intolerance about relations of doctors with pharmaceutical companies or private laboratories for some financial or other favorable incentives [21].

Box 2: CASE SCENARIOS OF FICTITIOUS PROBLEM RESIDENTS

Fictitious Dr. Y

- She is very hard working, comes early to wards, leaves very late.
- Unfortunately scores poor on assessment. She takes many hours to analyze a patient's history and still does not make any sensible plan for individual patients.
- She does not understand the instructions of seniors at one go. They need to repeat it multiple times.
- She often writes wrong doses of drugs or sends false samples of a patient.
- She is never able to understand the rationale behind the choice of investigation and management.
- Owing to this, She is considered disorganized at work and faculty prefers not to assign any vital work to him.

Fictitious Dr. K

- He often reports late to his duty or may be absent without any prior information, and he usually keeps his mobile phone switched off.
- There are frequent complaints from other supportive staff regarding his rude behavior with patients and his colleagues.
- He tends to fight, use abusive language, and gets into confrontation mode when into an argument.
- He is often lazy, avoids works, gives lame excuses and tends to blame others for his non-performance.
- He passes on his share of work to next relieving resident.
- He is often spotted chatting over his mobile phone during the working hours. He shows little interest during the clinical rounds and is often seen wandering away from the wards during his duty hours.

ADDRESSING A PROBLEM RESIDENT

The first step in the evaluation of a problem resident is to be sure about the diagnosis [7]. A single adverse incident, personal grudges, and overheard conversation may end up in wrongly labelling a resident as a problem resident. Residents obviously do not like to be outcasted as a problem resident [22]. It affects their relations with peers, patients and teachers. A resident erroneously blamed for any wrong happenings results in denial, anger and loss of self-confidence [6].

Sharing all concerns over a faculty meeting is essential [23]. A group consensus on a resident being a problem resident is necessary before proceeding to determine the problem and its remedial measure. Once the problem is identified, it would be useful to determine how frequently do we encounter this problem, how difficult is it to handle this problem, and how much is it affecting the

ongoing learning of the student and his/her peers [10]. For example, a resident who is frequently absent from his duties owing to excessive alcohol abuse is not a frequent but quite a difficult problem to handle. Likewise, a disorganized first year with poor knowledge base is quite a common problem, but it improves with interventions (***Box* 2**).

Talk to the resident

The resident should be called for a meeting with the program director who should list the concerns without criticizing or discriminating the resident [23]. Perception of the problem by resident and its possible remedial measures that he/she perceives should be considered. Enquire about personal problems of the resident, including those from family.

Talk to colleagues

Feedback from other supportive staff including peers, nurses, support staff, and patient attendants might help [12]. It is essential to identify the occurrence and frequency of problem and situations where such a problem emerges. History of drug or alcohol abuse needs to be ascertained from the peers [24]. Inter-resident scoring cards are used to assess a resident as perceived by their peers in an objective manner.

Designing remedial measures

Fictitious Dr. Y was disorganized and had a gross deficit in knowledge and skills (***Box* 2**). Owing to repeated complaints from casualty team members, she was rotated to the general pediatric ward. She was tagged to a mentor faculty and chief resident who would intensely monitor his progress. They would conduct one to one tutorial, assign her the additional reading task with fixed timelines, and supervise her examination skills at the bedside. Her analytical skills were sharpened by use of simple methods like one-minute preceptor model [25]. Considering the hard-working nature of Dr. Y, she had an excellent performance at the end of 3 months and then was rotated back to the casualty team. She was tagged to a senior shadow peer for next two months before she was assigned independent duties.

Fictitious Dr K had a major problem in attitude that led to a negative and unprofessional workplace environment (***Box* 2**). He was called for a meeting with the program director and all faculty members. Problems encountered were enlisted, and justification for the same was sought. A verbal warning was given, failing which a written memorandum was issued. His parents were informed of the minutes of the meeting. His responsibilities during clinical postings were delineated, and he was not allowed to switch on his mobile phone during work hours. His interactions with patients, peers and nurses were video recorded. He became conscious of his actions being recorded. These video records were reviewed in a subsequent meeting with the resident, and corrective measures were suggested to him. A timeline was provided for correction of his actions, failing which he was warned of possible termination of his candidature for the program. He was tagged to a role model teacher and peer with whom he worked for next three months. His behavior improved dramatically. He was more polite, respectful and considerate in his actions at the workplace. He would finish all his work before leaving the ward.

Teaching medical professionalism is challenging, but essential part of medical training. One of the most effective ways to teach professionalism to residents is to foster faculty role modeling [23]. Residents often look up to a positive role model to imitate his/her professionalism. Majority of problem residents improve with appropriate and timely remedial measures. Remedial measures must define the deficiency, provide a pathway for its rectification, set minimal benchmark goals or expectations in an acceptable timeline, and evaluation based on set goals [13].

Broad identification of problem into cognitive, behavioral or a combination of both is essential to design specific cures. Majority of attitudinal problems require extensive close monitoring and feedback, and, in some situations, require psychological help. The structured reading session can be planned for those with the poor knowledge base (***Table* I**). The Problem Resident needs to be involved in identifying the problems and designing their remedies, based on his/her priorities.

Three golden rules for correction include "act early, maintain confidentiality, and document everything" [7,22]. The plan should be individualized. Set up achievable goals and devise a timeline for each of the desired goals. It is essential to identify the red flag signs that require psychiatric consultation, including suicidal tendency, harm to patient, and substance- or alcohol-abuse. Finally, ensure that a problem resident graduates out of the department *sans* his/her problems.

PREVENTION

Can we predict at the outset that a resident will be problem resident? Robust educational system ideally should have rigorous screening mechanism for recruiting residents for the teaching program. A problem resident is often recognized within the first year of residency, or more often they come to attention when a resident has poor performance in the ongoing assessments. Periodic

assessment of residents should ideally include core medical knowledge, interpersonal skills and communication, practice-based learning, and professionalism [23].

Few problems come to attention following a complaint about the resident in some adverse event like fights with colleagues or patient or when there is gross mismanagement for any patient. Indian system recruits medical postgraduates through common written entrance examination that often lacks personality assessment [26]. Moreover, with the advent of online admission sessions, while allotting postgraduate seats, institutions have no control over the recruitment of students. Even resident with adverse remarks on the conduct certificate during graduation years can safely land in prestigious institutions solely based on cognitive abilities [27]. The selection procedure for residency should not only look for core medical knowledge, but also the past performance during the undergraduate course, the opinion of teachers and peers. Screening for personality traits, motivation, character, affective domains and communication skills need to be incorporated in the selection process [28].

Once a resident is inducted into the system, an orientation plan should be in place. It should include orientation to the clinical postings and their expectations from residents. Importance of socialization should be emphasized. They should go to movies, go to dine outside, and have regular birthday parties even at the workplace – during the lunch hours. Mentoring a resident is an essential aspect of medical training [29]. It shapes the personal and professional development of the resident. Effective incorporation of mentorship program during residency could avert emergence of problem resident. Mentors selected by free choice have been shown to be better than assigned mentors [30]. A broad approach to handling a problem resident has been summarized in ***Fig*. 1**.

CONCLUSION

Resident doctors face a variety of professional and personal problems, including deficits in knowledge, skills or problems with attitude. Faculty members and institutional heads must be sensitized to handle these problems. Remedial measures need to be individualized

TABLE I REMEDIAL MEASURES FOR PROBLEM RESIDENTS

Deficit domain	*Remedial measures*
Knowledge deficit	One to one mentorship, faculty tutorials, creating reading assignments with the timeline, peer support, increased frequency of formal meeting with program director during the first year of residency, regular reassessment, increased faculty advisor meetings, identifying the best teacher or role model who could probably sail through the tough time.
Skill deficit	Skill training, hands-on training, peer mentorship, supervised or tagged resident, formal mentorship program tagging them to likeminded faculty members, increased supervision by case discussion, review of patient management problems, faculty mentor to periodically monitor the gain of skills.
Psychiatric issues	Psychological and psychiatric consultation, appropriate documentation of all meetings, the involvement of family members is essential, consultation and remedial measures in a temporary file can be helpful; medical clearance before the resident can be brought back to work; can extend the training period for 3-6 months till health is returned.
Adjustment issues	Time is an effective healer. Majority respond and adjust to new environment. Peer and faculty support helps. Providing easy rotation in the beginning, monthly off days. providing leave of absence, home sickness resolves with time once they start enjoying residency, bringing parents to the hostel to spend some more time till he gets adjusted.
Attitude problem	The probationary period during the residency program would be a useful addition to observe for behavior and attitudes. Direct observation of good patient-doctor interaction, video recording the session and correcting the mistakes (videotape reviews).
Unprofessional behavior	Stringent punitive action like a warning, issue of the memorandum, seeking a written explanation for misbehavior, temporary suspension from the program, the involvement of legal cell of the institution to decide a plan of action.
Problems at the faculty level	Faculty orientation workshops on dealing with Problem Residents, increased incentives for faculty involved in teaching, effective feedback from students.
Problems at the system level	Decreasing work hours, providing conducive workplace, setting up problem box in each department in which residents can confidentially give honest feedbacks, feedback to system director regarding the work environment.

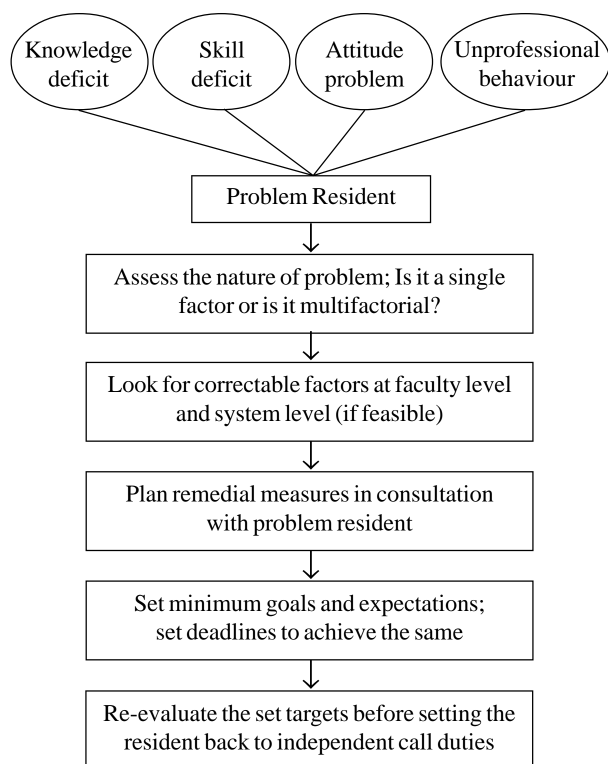

FIG. 1 *Approach to a problem resident.*

and must be framed with the involvement of affected resident. One-to-one faculty mentorship, peer support, psychological consultation, rotating the resident out of difficult workplace, stringent monitoring of their behavior, and providing effective feedback are some of the remedial measures to handle a problem resident. Providing enjoyable learning experiences should be the goal of every residency program.

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