Medical school is a highly selective and competitive process that is designed to identify those who will be most likely to succeed as physicians. This selection process gets further refined as the students graduate and choose a residency for specialty training. Those of us who spend a significant amount of time teaching always enjoy when trainees are eager and willing to learn our craft, act professional, conform to the norms, and progressively advance so that they are capable of becoming independent practitioners. In this issue of the journal, Domen comments that during this period, enthusiastic, not-yet clinically competent medical students become competent practitioners.

Trainees benefit by knowing more about themselves. Knowing your personality type and flaws is very important to manage day-to-day activities and understand how you will react when there is stress in the environment. As part of a career seminar series for pathology residents and fellows at Emory University School of Medicine, we perform a short personality assessment, and more than half of our trainees have a very similar personality type. This is not surprising; the enormous attention to detail that pathologists have to give to each specimen or task in the clinical laboratory requires the level of responsibility in which people with this personality type thrive. However, there could be times when the trainee is not capable of dealing with the challenges and stresses of residency and, in those situations, the trainee may not achieve the learning level expected or may not be able to complete the responsibilities assigned and thus will conflict with faculty and other residents.

Residency is a particularly trying time as residents have to cope with having to learn large amounts of information, go from having minimal responsibilities to having progressively more ownership of the cases, learn to function in a work environment, deal with money, and manage expectations at work and at home. Most residents are capable of going through this process, although there are always some who struggle. The frequent situations that lead to problems in the transition include the six Ds (distraction, depression, deprivation, dependence, disordered personality, and disease). If trainees recognize that they are having problems, they may be able to identify the cause and seek help. However, it is much more frequent that those who struggle are incapable of recognizing they have a problem and its possible cause or nature. In these situations, it is imperative for faculty to identify the problem, adequately document it, and communicate this to the residency program director, who will then meet with the trainee and devise a corrective plan.

In this issue, Domen reviews his experience with resident remediation, probation, and dismissal as a residency training director. He comments that faculty need to have the tools to function in the role of effective teachers, mentors, and evaluators. In many instances, this is where residency training directors struggle as faculty may complain about a particular resident performance, but when it comes to evaluating and documenting the performance or behaviors in question, there is very poor documentation. It is here where Domen indicates there is urgent need for faculty development. Faculty need to understand what are the core competencies and milestones expected from a trainee. Faculty should be able to appropriately document the specific problem so that it can be presented to the trainee and program director and adequately addressed. When documenting, faculty should describe what the issue is and refrain from using words that can be damaging for the future of the trainee.
problems is the responsibility of the entire teaching faculty, but since not all the faculty will have the necessary training to address the problems, they should not attempt to remediate but rather bring the problems to the attention of those who have the training to work with the trainee to improve performance. By each accredited training program having a clinical competence committee, as recently determined by the Accreditation Council for Graduate Medical Education, the burden of responsibilities regarding remediation, probation, and dismissal is now shared.

A survey of internal medicine residency training directors conducted by Dupras et al\(^\text{3}\) indicated that deficiencies in knowledge and performance are usually the easiest to identify and remediate. In-training examinations, sign-out, and other activities give faculty the opportunity to hone in on these issues quite readily. On the other hand, professionalism issues may be more subtle and also harder to remediate. Unprofessional behavior during medical school has been associated with future disciplinary action by a state medical board. Thus, identifying and correcting professionalism problems early is critical before the resident graduates. We need to remember that today’s trainees will become our future colleagues, and thus remediation of professionalism is valuable not only for the trainee but also to the profession and the work environment in our institutions and our societies. Unfortunately, if professionalism issues are not adequately addressed early and the trainee goes on to graduate and moves to another institution where his or her behavior is not known, the unprofessional behavior is perpetuated. Professionalism issues not addressed during residency are bound to continue as the graduate joins other institutions and lead to substantial problems that will affect overall performance and even patient care. To address these issues, Emory Healthcare developed a “pledge” as part of the care transformation model.\(^\text{4}\) We need to remember that to provide successful patient care, we are all in this together for more than just training.

References