Transactional Competence, Reliability, and Trustworthiness: Essential Attributes of the Successful Program Director

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A social contract exists between the profession of medicine and the public in the United States. This contract includes the responsibility of the profession to prepare the next generation of physicians to meet their health and the health care needs of the public. Execution of that responsibility occurs through the continuum of medical education. In graduate medical education (GME), that responsibility is operationalized in each program as a social contract among the residents, faculty, and program director (PD). The effectiveness of operationalization of those responsibilities is overseen by the Accreditation Council for Graduate Medical Education (ACGME).

Residents relinquish control of some liberties to the social contract of a training program to prepare to enter the practice of medicine in their chosen specialty and/or subspecialty. In this final phase of the formal educational path to practice, the resident places trust in the PD to play a pivotal and multifaceted role, serving as a mentor, advisor, evaluator, and advocate for the resident, while also being charged with the final decision as to the fitness of the resident to graduate, enter clinical practice, and gain eligibility for initial certification by their specialty board.

A "trusting relationship" between each resident and their PD is essential in the establishment of an effective educational culture, provision of safe and effective clinical care (or clinically related services), achievement of the educational goals of each resident, and execution of the PD's responsibility to the public to render decisions regarding preparation for entry into clinical practice. We explore the range of what is colloquially called "trust," discuss the multidimensional trusting relationships that are essential for an effective residency program, and explore through examples of actual program evaluations circumstances where trust or distrust was present between PDs and residents.

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Roles of the Program Director and Residents

Residents and PDs have often complementary and trust-building roles and shared goals (TABLE 1). For instance, residents and PDs share a goal of assuring an effective, high-quality clinical service design and implementation. When such a design is in place, the PD supports the goals of the department through quality clinical service, and simultaneously the residents receive an excellent educational experience that prepares them to provide specialty care in the discipline after graduation. If such effectiveness in design and implementation is achieved across the range of educational experiences, the program functions at a high level. This symbiotic relationship is a manifestation of residents "trusting" the PD to design and implement a clinical care experience that meets their educational goals, and the PD "trusting" the residents to deliver their best efforts to provide outstanding clinical care under supervision, and to study and prepare in order to acquire the knowledge and skills expected. This requires the resident to emulate and manifest professional behaviors consistent with effective professional identity formation.

When disruptions to the educational environment occur or resident performance falters, residents and PDs are expected to provide feedback, with the aim of improvement in program effectiveness or resident performance. Residents "trust" the PD to oversee the curriculum design and implementation, just as the PD "trusts" the residents to actively prepare for and participate in these elements of the curriculum, as well as to give constructive feedback regarding the effectiveness of its implementation. Residents "trust" the PD to design and implement a fair, unbiased, and

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TABLE 1
Symbiotic Roles of the Program Director and Resident

Roles of the Program Director	Roles of the Resident
▪ Design, implement, and oversee the curriculum ▪ Design, implement, and oversee the delivery of clinical service in the context of provision of safe, quality patient care ▪ Role model professionalism for residents, faculty, staff, and patients ▪ Assure fair and unbiased evaluation of each trainee, fulfilling the social contract between the profession and society to assure achievement of competence prior to graduation ▪ Provide fair, unbiased evaluation and feedback to residents on their performance ▪ Receive feedback from residents, faculty, and other interested parties regarding the effectiveness of implementation of the curriculum, educational program, or clinical service delivery; faculty and resident well-being; and improve deficiencies and strive for excellence in each these dimensions of responsibility ▪ Judge successful completion by the resident of the educational program in a fair and unbiased fashion	▪ Actively participate in the curriculum ▪ Actively participate in the team-based and individual delivery of safe, quality patient care ▪ Emulate and manifest attributes of professional behavior and develop professional identity ▪ Actively participate in evaluation of their own effectiveness in the development of competency and work to achieve competence prior to graduation ▪ Receive feedback and modify performance in the development of competency based in that feedback ▪ Provide honest evaluation of the effectiveness of the faculty and program director in design and implementation of the curriculum, educational program, and clinical service delivery; faculty and resident well-being; and to assist in improvement of deficiencies and strive for excellence in each of these dimensions of the educational program ▪ Provide honest evaluation of the sponsoring institution's provision of resources, such as an environment of safety and well-being and confidential mechanisms for residents to report unprofessional behavior

equitable evaluation and feedback system intended to assist the resident in achievement of their educational goals. The PD "trusts" the residents to receive feedback as "trustworthy" information designed to give a fair and unbiased evaluation of performance. Similarly, residents "trust" that when they provide feedback about faculty, clinical experiences, or concerning events, it will be received by the PD as "trustworthy" feedback, and they will be safe and free from harassment or retribution when this feedback is provided.

The establishment and maintenance of "trustworthiness" by the PD with the residents is challenged by the duality of responsibility of the PD, who is not only a mentor and advisor to the residents but also the individual ultimately responsible to render high-stakes decisions that influence residents' prospects and future. This duality of responsibility by the PD may disrupt trust with individual residents in settings where disagreements over evaluation of performance emerge.

It is in the circumstances where expectations of either the residents or the PD are not met that questions of trust arise. In this article we discuss the circumstances where challenges in the program result from failure of the PD to establish or maintain the trust of the residents, with resultant disruption of the educational environment sufficient for it to be called to the attention of the ACGME Review Committee in that specialty.

Framework for Understanding the "Range of Trust" Required to Effectively Lead a Residency Program

To better understand the dynamic between PDs and residents, we must explore the range and nature of the cooperative relationships between them. PDs and residents come together over tasks and achieve their symbiotic goals in a setting where there is a reasonable expectation of cooperation and professional deportment. Residents make reasonable (or more) efforts to fulfill assignments and fulfill expectations, and the PD makes reasonable (or more) efforts to create circumstances and opportunities for residents to achieve their goals. They come together in real world circumstances where achievement of each other's expectations around tasks varies.

An attempt to highlight tasks based on the nature of the relationship between the PD and residents is presented in TABLE 2. As can be seen, residents and the PD come together over transactional tasks, tasks that require reliance between them, and tasks that require trusting relationships.

Transactional Tasks

Tasks related to work or education requiring administrative effectiveness or structural implementation of the program usually lie in this category. Routine items such as issuing of identification badges, call schedules, or parking passes are examples of tasks that residents expect to be completed. The basic organization and

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TABLE 2
Tasks Shared by Residents and Program Directors Based on the Nature of Their Relationship Required for Effective Education and Program Success

	Transactional	Reliance	Trusting
Requires:	Competence Efficiency	Predictability Fairness	Trust-worthiness Trust-willingness
Centers around tasks of:	Routine administrative or structural nature	Personal/professional significance	Personal/professional risk
Examples:	Issue ID badges, parking passes Basic operational effectiveness of the program	Curriculum compliant with ACGME and certification board standards	Trusting the motivation of the program director in remediation events Demonstrating fairness and absence of bias
If accomplished:	Establishes capability and permits reliance	Establishes reliance and furthers engagement	Establishes, enhances, or solidifies trust
If not accomplished:	Repeats request or find another source	Disappointed, questions reliability, or fairness	Breach of trust
If repeatedly not accomplished, or disastrously performed:	Annoyance	Frustration Cynicism	Betrayal Hostility Active distrust

Abbreviation: ACGME, Accreditation Council for Graduate Medical Education.

operation of the program, its rotational schedule, electronic evaluation systems, and other administrative functions are included in this category. They are a manifestation of administrative competence, efficiency, and are the building blocks on which higher levels of relationship are based. Residents find workarounds for failures in this domain, and these failures frequently cause annoyance in residents. Transactional task failure is not uncommon, even in settings where the relationship between residents and the PD is strong.

Reliance-Related Tasks

A higher level of relationship is required in the context of tasks of personal or professional significance. For instance, residents rely on the PD to assure design and implementation of a curriculum compliant with ACGME standards and American Board of Medical Specialties or American Osteopathic Association certification board requirements. Effective curriculum design and implementation, demonstrating reliability, predictability, and fairness builds reliance and furthers engagement by the residents. Residents may find workarounds for failures in this domain, but they are very difficult, and failure breeds disappointment and questioning of reliability and fairness of the PD. Frequent or severe disruption of reliance can undermine the relationships between residents and the PD, and frequently manifest as accreditation-related issues. Cumulative failure in reliance-related tasks may make it impossible for residents to establish higher level relationships over tasks or goals that require trust.

Tasks That Require Trust

Trusting relationships occur in settings where 2 individuals come together over a task that is essential for one (the trustor) who does not have the unilateral ability to complete the task, and the second individual (the trusted) agrees to provide the expertise and effort required to assist the trustor in completion of the task. We as physicians are accustomed to this type of relationship with our patients, but a similar relationship must be present between the PD and residents in order to achieve the professional and personal tasks to be completed, and for the personal and professional goals of the residents to be realized. A resident must trust the PD in the setting of required remediation, not only for a fair and confidential evaluation, but also for a good faith effort in the design and implementation of a remediation program. Fairness, reasonableness, and evenhandedness in disciplinary actions for breaches of rules or norms are essential. Individual or systemic bias must be avoided. Successful implementation enhances or solidifies that trust, and failure to provide the resident with the opportunity to succeed or be perceived as being treated unfairly may lead to a sense of betrayal, hostility, or active distrust of the PD.

It must be noted here that distrust is not merely the absence of trust. It is an active state of wariness and withdrawal that results in disruption of the relationship between that resident and the PD. In settings

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where distrust of the PD exists among the residents more broadly, integrity of the educational program may be called into question. Even a single episode of disruption of trust can severely undermine the relationships between residents and the PD, and frequently leads to complaints to the ACGME and/or negative responses in large numbers to the annual ACGME Resident/Fellow Survey. Accreditation action frequently follows.

Illustrative Cases

As the following actual cases (edited to render them unidentifiable and illustrative) demonstrate, lapses in transactional competence, reliability, and trust may be so significant as to trigger an ACGME site visit at the request of the Review Committee or prompted by a complaint from a program stakeholder, resulting in an accreditation action.

Case 1

The ACGME Review Committee requested a full site visit of this program due to declining performance on all domains of the Resident/Fellow Survey. The site visitor noted the following situation with the program.

The current chair served as the residency PD for the first 8 years of their tenure. The chair then recruited an individual from outside the institution to the position of PD. The chair described the PD as a protégé. Over the ensuing 4 years, significant negative changes in the climate of the program emerged, resulting in declining performance on the Resident/Fellow Survey. At the time of the site visit, residents were reluctant to speak up, eventually characterizing the environment as permeated by a “culture of fear.” Prior to the site visit the designated institutional official (DIO) suggested that a change in PD be made after it was acknowledged that the current PD’s strengths had become liabilities. For example, the chair described the PD as an impeccable manager who always followed the rules. This evolved into significant rigidity and an apparent lack of empathy and compassion with respect to the approach to accommodating residents’ needs and requests.

The following incidents were related to the site visitors by the residents:

- A resident’s child with asthma was a patient in the emergency department at another hospital. The resident called the PD to say that they were unable to come directly to the hospital. The PD required the resident to report for duty.
- A resident whose mother passed away was not allowed to take leave. The resident was needed to cover the service because 2 other residents were attending meetings.
- Several residents went to great lengths to arrange off-site selective experiences, including finding their own funding and writing a prior learning assessment, only to be told by the PD at the last minute that they would have to find another experience.
- According to the chair, the PD had a history of issues with other personnel, especially the operating room team. These issues culminated in a formal complaint to the US Equal Employment Opportunity Commission, leading to an investigation that resulted in a 40-page report. The chair noted that the PD was ordered to get coaching but was unsure if it happened. The faculty expressed concerns about the PD, noting that they were not included in collaborative decisions about the program.

Outcome: The Review Committee placed the program on “Probationary Accreditation.” With support of the DIO and Graduate Medical Education Committee, the chair resumed leadership of the program and appointed a well-respected mid-career faculty member as the associate PD. At its next site visit the program achieved “Continued Accreditation” and was commended by the Review Committee for making substantive improvements. The program has maintained “Continued Accreditation” for several years.

There are numerous lapses in trustworthy leadership exemplified in this case. Transactional competence and reliance were not met by the PD in the attributes of fairness and reasonable flexibility in dealing with residents, for instance those who were experiencing the stresses of family health crises or bereavement. A trusting relationship was not established by the PD with the residents in the program and with staff members as exemplified by the circumstances in the operating room of a demanding persona who failed to model respectful and collaborative teamwork. This ultimately led to active distrust of the PD by both residents and operating room staff.

The yearslong challenges presented by the PD’s mismanagement and poor leadership and judgment were not effectively addressed by the chair, resulting in loss of trust by the residents and faculty in the leadership of the entire department.

Case 2

The Review Committee requested a full site visit of this program due to declining performance on several domains of the Resident/Fellow Survey. The site visit

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report described the following issues with the program:

- The residents expressed frustration over the lack of open communication among program leadership, residents, and faculty. The residents explained that the PD did not meet with them as a group, by class, or individually on a regular basis to provide information about current issues pertaining to their education or to solicit their suggestions for program improvement. The residents agreed that when they raise concerns to the PD and/or assistant PD, they usually respond with a dismissive comment. When residents brought forward suggestions for program improvement, the PD and/or assistant PD usually responds by indicating that their suggestion was not feasible.

- The residents went on to describe many longstanding issues that impaired the operation of the program and the education of the residents. Continued unprofessional behavior by a senior faculty member went uncorrected. There was a lack of professional accountability for a resident with egregious absences from clinical duty. Residents seeking a fellowship were favored by 2 of the fellowship-trained faculty in the desired subspecialty and were given more hands-on clinical experiences than other residents. Residents lead didactics without faculty oversight. Teaching faculty were not required by program leadership to participate in didactic events. The program lacks a resident continuity clinic.

- The PD was dismissive, explaining to the site visitor that the residents were prone to complaining about insignificant issues that did not impact their education. For instance, the PD noted that they believed a continuity clinic provided minimal educational value for the residents and would be difficult to schedule.

Outcome: The program was placed on "Continued Accreditation with Warning" with multiple citations related to transactional competence, reliance, and trust issues that resulted in lack of substantial compliance with ACGME specialty standards.

There are numerous lapses in trustworthy leadership exemplified in this case. The site visit confirmed a failure of transactional competence and reliance on the part of the PD as evidenced by failure to implement a faculty-directed didactic curriculum with active engagement of faculty members, failure to hold 2 fellowship-trained faculty members accountable for giving preferential treatment to some residents, and failure to implement a continuity clinic.

Failures in reliance and trust were manifested by the PD in permitting ongoing unprofessional behavior by a faculty member and failure to assure evenhanded management of professionalism-related performance issues by a resident. Failure to establish a trusting relationship between the PD and residents, as exemplified by the unwillingness to engage in meaningful dialogue with residents over issues and opportunities for improvement, exacerbated the issues of distrust that emerged in this program.

Discussion

The trustworthiness of the PD, as viewed by the residents, is an essential element of a well-functioning GME program. We have attempted to articulate some of the competing values and responsibilities that characterize these critically important and frequently undervalued concepts in medical education and leadership. The ability to manage the daily administrative infrastructure, the interface with the clinical learning environment, and the personalities of all engaged in the program requires transactional competence. The PD must also have reliable knowledge of and skills in implementation of peer-developed standards in accreditation, certification, licensure, compliance, and other domains essential for the smooth and effective operation of the educational program. Finally, the PD must demonstrate professionalism, fairness, evenhandedness, and altruism in addition to clinical competence to instill and maintain the trust of residents over the course of their educational journey in the program.

PDs' success in leading the residency or fellowship experience requires fairness, transactional competence, reliability, and trustworthiness as the leader of the educational program. These leadership attributes enhance and promote a trusting relationship among trainees, faculty, and others in the clinical learning environment. This level of trust is required for all to accomplish their goals.

We offer these practical suggestions to assist PDs in meeting the challenges of their leadership roles.

- Meet with the DIO on a regular basis to be sure that your program meets all ACGME institutional and specialty requirements and to discuss strategies for implementation of program improvements.

- Develop a network with other PDs to learn best practices and brainstorm management of challenging situations/issues.

- Have at least one trusted mentor whom you can call upon for counsel.

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- Maintain effective communication with residents and faculty. Be honest and forthright when suggested changes cannot be implemented due to systemic or other reasons.
- Work with residents and faculty to implement at least one positive change and/or innovation each year.
- Role model trustworthiness by engaging residents in the design of elements of the training program, trusting that the residents will act as partners in conducting a successful program.
- Invest significant time and energy into working with your residents and faculty so they become skilled evaluators who deliver bias free evaluations.

PDs are not merely technicians or accreditation managers. They are the leaders of an educational effort that is pivotal in the context of the relationship between the medical education profession and society. They are also one of the most important people in the lives of each resident they accept into the program. The role is both challenging and rewarding, and trustworthiness is at its core.

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