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Residency Program Alert

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10 considerations when handling re-entering residents

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Nearly every medical student I speak with says they have never heard of a medical resident losing his or her residency position, yet over 10,000 medical residents have been subject to dismissal or withdrawal from U.S. medical residency programs between 2005 and 2015. Those who attempt to make their way back into medical residency after an extended leave or departure are generally referred to as re-entering residents, and all parties involved are faced with the daunting task of deciphering what really happened—and if something similar will happen again.

During my own journey of securing and completing my family medicine residency from 2001 to 2004, I witnessed the quiet termination of three fellow doctors during their first months of post-graduate year (PGY) 1. I later learned that this preventable crisis affects over 1,000 U.S. medical residents annually. Termination effectively wipes away thousands of years of accumulated education, and the majority of those affected are foreign-born, leaving them unable to ever practice medicine in the U.S. again.

The subject of re-entering residents is near and dear to my heart due to my own experiences as an at-risk resident. During my ninth month as a PGY-1, standing up for my beliefs put me on the chief resident's radar, nearly costing me my medical career. Had I not acted swiftly by transferring to a more suitable residency environment at the start of my PGY-2, I too would have become a statistic. Thankfully, I only lost one month, ultimately graduating as the chief of Morehouse School of Medicine's family medicine residency program in Atlanta.

My experience made me more determined than ever to grapple with the subject of re-entering residents from every perspective. The crux of this work is summarized

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in the following considerations and tips, geared toward assisting residency program admission committee members who assess re-entering residents.

1. The brain drain associated with unsuccessful residency re-entry attempts should not go unnoticed

Residency departure is an emotionally—and sometimes legally—charged issue. Because victims (both residents and programs) typically do not or cannot speak up about these incidents, there is little data to guide us. In my opinion, the causes of re-entering residents must be addressed in a multidimensional fashion. To start with, our medical educators and program directors must improve the resident interview, selection, remediation, and retention processes.

2. There are many pros and cons of hiring re-entering residents

In my experience, well-qualified re-entering residents can become one of the most valuable assets of a residency program. Most are driven by the common desire to convert their lifetime of experiences into enduring tools that empower their teammates to achieve their potential.

Not all re-entering residents left their former programs on negative terms or were at fault. According to the ACGME Data Resource Book, of the 2,248 residents that left their programs prior to successful completion in the 2014–2015 academic year, 49.2% successfully transferred to another residency (like myself). Only 9.7% were dismissed, and 29.5% withdrew.

Learning the causes of resident dismissal/departure offers an opportunity to improve your resident interview, selection, remediation, and retention processes, as some residents leave even during their final year of residency. According to the ACGME, 320 (30.1%) of the 1,065 residents who transferred did so during their third year, proving that it takes more than the promise of graduation to keep some senior-level residents on track.

Re-entering residents also have the ability to bypass the Match if filling an off-cycle residency vacancy. Filling off-cycle residency vacancies with well-qualified re-entering residents can help ease our nation's physician shortage and maldistribution. For every 1,000 departing residents, an estimated 15,000 patients could have had access to medical care.

- However, there are clear risks and issues with potentially unqualified re-entering residents:
- Properly assessing a re-entering resident for residency is a daunting task, and not every faculty is qualified to do so.
- There is limited GME funding—or possibly none at all.
- Any unresolved issues that led to a resident's dismissal/departure may be carried over to your program.
- A resident's former program director may not be forthcoming with information on the resident's exit from the program.
- Medical malpractice tail coverage will most likely be missing.
- Re-entering residents may not be medically licensable in your state. Even your hospital may balk at offering staff privileges to a re-entering resident with blemishes on his or her record.

3. Initially view "dismissed," "unsuccessfully completed the program," and "withdrawn" as the same, then investigate

In my experience, the reason why only 9.7% of residents who left their programs are classified as "dismissed" is because disgruntled program directors typically tell extremely poor-performing residents (behind closed doors) to voluntarily withdraw from their program or otherwise suffer the consequences of an immediate termination (i.e., dismissal). Whether this is done due to the recommendation of legal counsel or some other reason, it typically results in a dismissal letter that is more supportive of the affected resident joining smaller, more rural, and/or less intense residency programs in the future.

To me, "dismissed," "unsuccessfully completed," or "withdrawn" all send the same initial message: "The resident was no longer wanted at that residency." But

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we don't get an explanation as to why. Therefore, it is extremely important to establish whether the resident was fired (typically due to ACGME core competency issues and therefore worrisome), or voluntarily left a program (not as worrisome).

4. Treat a re-entering resident with a significantly higher level of scrutiny

Before the interview, ask candidates for copies of their most current Electronic Residency Application Service (ERAS) applications, all supporting documents, and additional documents at your discretion. Have a high index of suspicion for red flags, including:

- Inconsistencies, misspellings, and grammatical errors.
- Extended gaps (longer than six months), disciplinary actions, or probations of any sort during medical school or medical residency—these all require written explanations.
- Attendance in multiple medical schools or medical residencies.
- Blank sections of the application. Pay particular attention to responses in the "reason for leaving" section.
- Performance indicators that are not teachable.
- Signs of any past training or full medical license (candidates may not realize that a training license is an actual license to practice medicine). If a license was ever granted, search the issuing state's online licensed physician database and look for any disciplinary actions or disposition of licensure.

Since re-entering residents require a higher level of scrutiny, inform applicants that a typical specialty-specific and superficial personal statement will not suffice, that your admission committee will want to read about the root cause of their re-entry in their own words, and that (if accepted into your program) their re-entering status will not be a problem.

- Also ask applicants to submit the following:
- At least four recent (within the past 12 months) U.S. letters of recommendation. Instruct applicants to have the letter writers include assessments of the applicants' clinical performance pertaining to ACGME core competencies.
- A copy of the final letter written by the applicant's former program director, which can range from a modified recommendation letter to a full-scale dismissal letter addressing specific examples of ACGME core competency issues.
- A clear and detailed explanation, in writing and on a month-by-month basis, of all work and activities applicants have been involved in since departing from their former residency.
- The probationary board's performance reviews, if the applicant was ever placed on probation.

It is also a good idea to Google an applicant's full name and the name of his or her former residency. Dig deep (up to 10 pages) for any negative search results.

During the interview, your program director must be the first person to speak to the applicant. Let the applicant talk for the majority of the interview, and ask him or her challenging, yet open-ended questions such as:

- Why do you believe you were dismissed?
- Did you leave on your own, or were you encouraged to leave?
- How can I reassure my colleagues that you will not be a liability?
- May I contact your former program director to ask about what happened?
- What will your former program director or chief resident say about you?
- Were you ever placed on probation, investigated, or arrested?
- How many medical schools have you attended?
- Is there anything that you decided to not disclose to us in your residency application?

Rapidly determine applicants' consistency between their responses and what they disclosed in their residency application. Failure to readily and proactively disclose any detail about their history during these pivotal interviews may serve as a warning that the same behaviors may continue if the applicant is accepted to your program. Assess applicants' communication skills and

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whether you sense any fault in their logical reasoning. Ask yourself the basic question, “Do they sound like their application?”

After the interview, if you are still interested, do not hire the candidate without securing the support of your residency faculties and at least your chief resident(s)—but preferably all of your residents. Invite the candidate for a two- to four-week clinical rotation and assign him or her to your inpatient and outpatient teams. Do not immediately have the candidate come in contact with patients, as the ability to do so relies on many factors. Candidates will be limited to shadowing/observership if:

- Your parent institution requires you to only offer observerships (i.e., prohibits non-employees coming in contact with patients)
- You are unable to secure professional liability insurance with specific coverage for medical graduates who have not completed U.S. residency prior to coming in contact with patients, including tail coverage
- The candidate has ever held a license to practice medicine (training or full) in a U.S. state outside of yours (due to the risk of unlicensed practice of medicine in your state)

If you are not interested in the candidate, do not justify or explain your decision, as doing so may have legal or HR implications. Instead, say something to the effect of, “We were unable to come to a unanimous decision about your candidacy,” or “We will contact you if our board makes a unanimous decision to bring you in for a second interview.”

5. Credit offered for past residency training may not be up to your program

Permissions for issuance of credit vary by each American Board of Medical Specialties–governed specialty. For example, the American Board of Pediatrics (ABP) states, “Residents who experience an interruption in general pediatrics training for greater than 24 continuous months and who wish to re-enter residency training in general pediatrics must petition the ABP to determine whether credit may be awarded for prior training. The request for credit must be submitted by the candidate or the residency program director before the candidate re-enters residency training in general pediatrics.”

6. Help eliminate the need for residency transfers, dismissals, or withdrawals by preventing the loss of residents in the first place

A consistent, culturally aware interview candidate selection system that is free of bias is essential for reducing resident transfers, dismissals, and withdrawals. Do not deviate from this system by offering courtesy interviews to family and friends; most program directors who do this later regret it.

Once you have established a reliable interview selection system, focus on retaining your talent by actively looking for possible signs of contention. Set up workshops and pop quizzes, and have residents correlate signs of a “resident in trouble” with the corresponding ACGME core competency. Encourage residents to try to resolve issues unrelated to the core competencies on their own before getting faculty or the program director involved. This will help build confidence, trust, and a newfound level of respect for differing cultures and beliefs.

7. Residency programs are employers and residents are employees, so train your team on how to be productive and practical workers

Look for warning signs in re-entering residents’ applications or interviews. Strong residents may not necessarily be strong people managers; therefore, always practice watchful delegation of even the simplest HR duties (or better yet, ask your HR department if delegation is permissible).

You can improve your residency applicant selection process by constantly updating your residency selection committee on the latest patterns in ERAS applications, especially the more challenging application packages submitted by foreign international medical graduates (IMG) due to our limited ability to verify the content of the ERAS application submitted. Do not take residency application package inconsistencies or red flags lightly. In many retrospective studies, residency programs identified warning signs in application packages.

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You can also improve your residency interview process by having your HR department train your residents and faculty on how to interview, legal and illegal questions, and how to gear most questions toward ACGME core competencies. If communication issues affect the way the candidate presents during an interview, those issues will only worsen as the pressures of residency rise.

8. Forbid any residency program employee from speaking about a "resident in trouble" or "re-entering resident" with anyone inside or outside of residency

Getting on the "residency radar" is nearly a death sentence for most residents in trouble. When a resident is marked as being in trouble, most other residents will pre-judge that resident, which will accelerate the chances of failure.

9. Always consult with your HR department before referring a resident to a probationary board or discussing with the residency attorney

Even though ACGME core competencies are essential, residents are employees and have rights. For example, if a female resident asks for several days off, don't put the resident on probation for lack of professionalism or poor work ethic. You may find out later that she used the days off to see an OB-GYN for a high-risk pregnancy, meaning she is most likely protected by the Americans with Disabilities Act (ADA). Your residency program must do everything it can to avoid violating the ADA's protections. Discuss any concerns with your HR professional before making such decisions, and familiarize yourself with employee laws.

10. IMGs re-entering residency pose even a greater challenge to programs

Although matching with IMGs can help programs and their communities cultivate diversity, not all programs are equipped to provide IMGs the tools and support needed for rapid acculturation. This problem is most prominent among non-U.S. IMGs, especially those who have not had the opportunity for lengthy visits to the United States and haven't assimilated into its culture.

Failed acculturation attempts can be devastating for both IMGs and programs and can put all parties at risk. Programs may be able to avoid dismissing IMG residents by establishing early acculturation and even reverse-acculturation programs for residents and faculty who are unfamiliar with cultures abroad.

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