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Assessment and Management of Professionalism Issues in Pathology Residency Training: Results From Surveys and a Workshop by the Graduate Medical Education Committee of the College of American Pathologists

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Abstract

Professionalism issues are common in residency training and can be very difficult to recognize and manage. Almost one-third of the milestones for pathology recently instituted by the Accreditation Council for Graduate Medical Education encompass aspects of professionalism. Program directors are often unsure of how and when to remediate residents for unprofessional behavior. We used a case-based educational approach in a workshop setting to assist program directors in the management of unprofessional behavior in residents. Eight case scenarios highlighting various aspects of unprofessional behavior by pathology residents were developed and presented in an open workshop forum at the annual pathology program director's meeting. Prior to the workshop, 2 surveys were conducted: (1) to collect data on program directors' experience with identifying, assessing, and managing unprofessional behavior in their residents and (2) to get feedback from workshop registrants on how they would manage each of the 8 case scenarios. A wide range of unprofessional behaviors have been observed by pathology program directors. Although

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there is occasionally general agreement on how to manage specific behaviors, there remains wide variation in how to manage many of the presented unprofessional behaviors. Remediation for unprofessional behavior in pathology residents remains a difficult and challenging process. Additional education and research in this area are warranted.

Keywords
competency, graduate medical education, milestones, pathology training, professionalism, residents, resident remediation, resident training

Introduction

Unprofessional behavior in medical students and resident trainees across all disciplines has repeatedly been shown to be one of the most significant reasons for disciplinary action, and it is also one of the most difficult to assess and manage.[1-6] This is no less true in pathology residency training. One study found that in pathology, ethical and professionalism issues such as honesty, recognizing and reporting medical errors, interpersonal interactions, and conflict of interest were recognized as being some of the most important issues in our profession.[7] While that study[7] was directed toward pathologists already in practice, these concerns and behaviors are no less important for those in training who will soon enter practice. Other professionalism issues that can manifest during residency training include attitudinal problems, interpersonal conflicts, or other inappropriate behavior toward staff, peers, faculty, or patients.[1-6]

The importance of ethical and professional behavior is underscored by the fact that the Accreditation Council for Graduate Medical Education (ACGME) mandates professionalism (which also includes ethical behavior) as 1 of the 6 core competencies for residency and fellowship training. Recognizing and assessing professionalism are frequently difficult, but the ACGME Pathology Milestones (which are based on the 6 core competencies) devotes 6 of its 27 milestones to professionalism and an additional 2 to interpersonal and communication skills (ie, almost one-third of the total 27 milestones; see, http://www.acgme.org/acgmeweb/tabid/142/ProgramandInstitutionalAccreditation/Hospital-BasedSpecialties/Pathology.aspx). Other ethical and professionalism attributes are also scattered throughout several of the other milestones addressing patient care, medical knowledge, systems-based practice, and practice-based learning and improvement. Thus, it is clearly evident that professionalism is an increasingly important aspect of residency training (and beyond in the practice setting) and needs to be seriously evaluated and remediated along with the other core competencies. However, professionalism is probably the single most difficult competency for program directors and faculty to assess and manage.

Realizing that all pathology residency programs struggle with handling professionalism issues in their residents, the Graduate Medical Education Committee (GMEC) of the College of American Pathologists (CAP) developed a workshop for the July 2014 Association of Pathology Chairs (APC) and Pathology Program Directors Section (PRODS) annual meeting held in Boston, Massachusetts. Entitled, "Professionalism Remediation: A Tough Nut to Crack," the workshop included 2 preworkshop surveys followed by discussions of case scenarios during the workshop. This article presents the survey results as well as basic considerations for program directors and department chairs to consider when confronted with unethical or unprofessional behavior in their resident trainees.

Materials and Methods

A subcommittee of the GMEC of the CAP developed a 1.5-hour workshop, "Professionalism Remediation: A Tough Nut to Crack," for the Anatomic Pathology and Clinical Pathology4/Pathology Program Directors Section (APCP4/PRODS) July 2014 annual meeting. Eight case scenarios with elements of unprofessional behavior based on real-life experiences (not necessarily unique to pathology trainees), and perhaps also containing some fictional elements to highlight and reinforce certain behaviors, were developed (Appendix 1). All names used in the case scenarios were fictitious, and any other potential identifiers were altered or deleted to protect privacy.

Using Survey Monkey (Palo Alto, CA, USA), the first survey was sent electronically to all program directors on the PRODS listserv in April 2014. Survey 1 gathered information from program directors about the most common unprofessional resident behaviors they had encountered, actions taken to remediate unprofessional behavior, criteria for determining remediation success, and prevalence of resident dismissal.

Survey 2 was sent electronically to those program directors who had preregistered for the workshop as of June 11, 2014 (ie, approximately 1 month prior to the workshop). The 8 case scenarios (Appendix 1) were included in survey 2, and program directors were invited to complete the survey prior to the July 2014 session. For the 8 case scenarios, respondents were asked to select the most appropriate course of action from the following choices:

1. Take no immediate action but continue to monitor resident behavior.
2. Meet with resident to discuss the behavior.
3. Schedule a series of meetings with resident to discuss and monitor behavior change and then escalate to formal remediation if insufficient change occurs.
4. Meet with resident to determine a remediation plan and discuss next steps if insufficient change occurs (ie, probation/nonrenewed contract/dismissal).

5. Request a "fitness for duty" evaluation before allowing resident to return to duties.
6. Place resident on *probation* after meeting with him or her to review behavior.
7. Do *NOT* renew resident contract for the next academic year.
8. Immediately dismiss resident.

These 8 selections are based on the authors' experiences and cover the entire gamut from basically doing little to immediate dismissal. The results of both surveys were tabulated by CAP staff. All individual responses were kept confidential, and only aggregate data or unlinked comments were analyzed and presented.

Results

A total of 29 program directors responded to survey 1. Table 1 details the themes that emerged from survey 1 as well as examples of free-text comments. The most common and/or most challenging unprofessional resident behaviors encountered by respondents can be broadly grouped into 3 main categories: interpersonal interactions (disrespectful/inappropriate behavior) toward others (42%), issues with attendance and tardiness (38%), and dishonesty (21%). Table 1 also details the variety of approaches used by program directors to address unprofessional behaviors in their residents. Talking to the residents face-to-face about their behavior was the approach used by 58% of the respondents, and 24% indicated that formal counseling was used. The importance of documentation was noted by 28%, and probation/disciplinary action was used by 28% of the program directors. Five (17.2%) program directors indicated that they had dismissed a resident for unprofessional behavior (Table 1).

Of the 13 program directors who had preregistered for the workshop, a total of 7 (54%) responded to survey 2 (responses are detailed in Table 2). The individual case scenarios are detailed in Appendix 1, and the response options are detailed earlier in the Materials and Methods section.

Preregistration for the workshop was not required, and the workshop ended up being well attended (approximately 42 of 142 programs were represented). The on-site, real-time case presentations and review generated a great deal of discussion. It is evident from the survey responses (Table 2) as well as from the discussion during the workshop that assessing and managing unprofessional behavior in residents can vary between programs and, except for those few very clear-cut cases, the approach to remediation, probation, or dismissal can vary widely. For example, case 8 (inappropriate access to the electronic medical record [EMR]) was noted to be the cause for immediate dismissal by 4 respondents, probation by 2, and remediation by 1. This case highlights the need to know institutional policies and/or the need for legal/Designated Institutional Official (DIO) consultation, since in many institutions written policies are in place that would support immediate dismissal.

In addition to the variable approaches to handling unprofessional behavior by residents, it also appeared to the workshop leaders that attendees lacked understanding of concepts such as "fitness for duty." The legal aspects of dealing with unprofessional behavior were also an area identified for additional program director development.

Discussion

Residency and fellowship training are the last opportunities for remediation before trainees enter the practice of pathology as competent physicians who are able to practice without direct supervision. Program directors and their faculty colleagues thus have the tremendous responsibility to ensure a resident's transformation into the realm of competency, and this can include the remediation of professionalism issues that may have plagued the resident throughout medical school, undergraduate college or university, or even earlier.[6,8] We recognize that failures of professionalism are too often ignored, understated, or "passed up the line" and may not be properly addressed prior to graduation. Failure to properly address performance and professionalism issues can have long-lasting negative consequences that can adversely affect not only an individual's quality of life but also their patient care and collegial interactions.[9,10]

Previous studies have examined various remediation approaches in different specialties of medicine, and it is not our attempt here to extensively review this literature.[11-17] In using PRODS survey data as well as case discussions in an open forum workshop format, we attempted a unique "group advice or feedback" approach to help educate and inform program directors on how to approach and manage breaches in professionalism. Our study underscores that professionalism issues can vary widely in scope and degree and that program directors will very likely have variable approaches to managing these issues. While there is rarely a "one approach fits all" solution to unprofessional behavior—except when such behavior runs counter to clearly delineated legal or institutional policies—our study provides basic education and awareness, and suggested approaches to dealing with these difficult issues. For many of the cases presented here, there may be no clear-cut, definitive approach to addressing the unprofessionalism behavior because there most probably are multiple personal and personality issues and circumstances unique to any individual resident which would need to be taken into account. Thus, it may be overreaching or too dogmatic to say that there is only 1 right answer or approach to addressing some of the unprofessional behavior detailed in these case scenarios, since individual circumstances underlying each case can be quite variable. However, it should be relatively clear that if patient care or safety is at risk then that resident must be removed from clinical duties until the issue is appropriately resolved.[6] It is important for program directors to always consult with their DIO and/or legal resources when severe breaches in professionalism occur, when a fitness for duty action is contemplated, or when patient care or safety is at risk.[6]

Table 1. Responses to Survey 1.

Please describe the most common and/or most challenging unprofessional resident behaviors you have encountered.	
Theme	Example Comments
Inappropriate comments about fellow employees (21%)	"Accusing other residents of improper behavior" "Badmouthing of faculty to other residents" "Inappropriate comments about resident peers, faculty or fellow employees in general"
Poor attendance/tardiness (21%)	"Lecture attendance issues" "The most common unprofessional resident behavior is tardiness. Nevertheless, it is also the most common attending behavior."
Being disrespectful to support staff (21%)	"Disrespectful or unprofessional attitude (ex. Poor attitude towards/interactions with support staff)" "Contentiousness and interpersonal conflict among residents or between residents and support staff over work roles."
Dishonesty (21%)	"Lying; falsifying documents" "Dishonesty"
Not attending conferences (17%)	"Not attending conferences" "Most common - missing conferences"
What actions do you take to address unprofessional resident behavior?	
Theme	Example Comments
Talk to the residents involved (58%)	"Call the trainee to have a face to face conversation" "Face to face discussions with the trainee, providing direct feedback and asking each trainee for his or her action plan to address these behaviors."
Document unprofessional behaviors (28%)	"Documenting unprofessional behavior in evaluations" "Documentation is clearly most important."
Probation/Disciplinary action (28%)	"Use professional integrity office, use of "impaired provider program", documentation!!!!." "Leave of absence" "Monitoring of resident behavior"
Counseling (24%)	"Counseling Behavioral therapy Self reflection with journaling" "Start with counseling; progress to "professionalism probation" in extreme cases"
How do you determine if remediation is successful?	
Theme	Example Comments
The behavior does not repeat (52%)	"End to inappropriate behavior" "See outcomes" "No repeat transgressions"
Observation/feedback from faculty (28%)	"Observation of repetitive behavior" "Very difficult. input from all faculty and chief residents" "Would be dependent upon the individual situation and may include – personal observation, monitoring feedback from faculty, achievement of specific behavioral goals (attendance, timeliness, etc)"

Have you ever dismissed a resident for professionalism issues?
5 respondents (17.2%) had dismissed a resident for professionalism issues:

- 4 of these respondents indicated that, Efforts were made to remediate the resident's unprofessional behavior before termination.
- 1 respondent indicated that, The resident was terminated immediately due to egregiously unprofessional behavior.

Four of the respondents who dismissed a resident also provided the following comments:

- "This was very difficult to do and requires extensive documentation"
- "Greater than 10 years ago. Was a mixture of professionalism and academic issues that led to non-renewal of the contract."
- "A resident who clocked in another resident who did not come in for the day.(Human Resources dept got involved and it was an immediate dismissal.) I believe that the consequences were too severe but the human resource dept took over and it was a breach of hospital policy."
- "The drug addiction case was largely out of my hands—had to follow institutional policy and state regulations. Resident was put in state mandated rehab—which was successfully completed and resident returned ... "

Our findings suggest that programs may want to periodically assess their ability and knowledge to recognize, evaluate, and address unprofessional behavior by residents and fellows. The case scenarios presented here (Appendix 1) could be used as a starting point, and modified as necessary, to stimulate discussion and to help identify faculty and program director development needs in specific areas such as fitness for duty guidelines and procedures, legal considerations, establishing remediation policies, and so on. Teaching and evaluating professionalism can be difficult, but most institutions have

Table 2. Responses to Survey 2.*

Selected Response Option	Response Frequency
Case scenario 1 (poor attendance/tardiness/lack of attention)	
Schedule a series of meetings with resident to discuss and monitor behavior change, and then escalate to formal remediation if insufficient change occurs	4
Meet with resident to determine a remediation plan and discuss next steps if insufficient change occurs (i.e., probation/non-renewed contract/dismissal)	2
Meet with resident to discuss the behavior	1
Case scenario 2 (alcohol on breath)	
Request a "Fitness for Duty" evaluation before allowing resident to return to duties	4
Meet with resident to determine a remediation plan and discuss next steps if insufficient change occurs (i.e., probation/non-renewed contract/dismissal)	1
Schedule a series of meetings with resident to discuss and monitor behavior change, and then escalate to formal remediation if insufficient change occurs	1
Place resident on Probation after meeting with him/her to review behavior	1
Case Scenario 3 (seizure disorder/medication effects)	
Request a "Fitness for Duty" evaluation before allowing resident to return to duties	6
Schedule a series of meetings with resident to discuss and monitor behavior change, and then escalate to formal remediation if insufficient change occurs	1
Case scenario 4 (disrespectful to others/dishonesty)	
Meet with resident to determine a remediation plan and discuss next steps if insufficient change occurs (i.e., probation/non-renewed contract/dismissal)	3
Place resident on Probation after meeting with him/her to review behavior	3
Meet with resident to discuss the behavior	1
Case scenario 5 (disrespectful/poor interpersonal skills)	
Schedule a series of meetings with resident to discuss and monitor behavior change, and then escalate to formal remediation if insufficient change occurs	3
Meet with resident to determine a remediation plan and discuss next steps if insufficient change occurs (i.e., probation/non-renewed contract/dismissal)	3
Meet with resident to discuss the behavior	1
Case scenario 6 (unprofessional use of social media)	
Immediately dismiss resident	3
Place resident on Probation after meeting with him/her to review behavior	2
Meet with resident to determine a remediation plan and discuss next steps if insufficient change occurs (i.e., probation/non-renewed contract/dismissal)	1
Meet with resident to discuss the behavior	1
Case scenario 7 (poor interpersonal skills)	
Schedule a series of meetings with resident to discuss and monitor behavior change, and then escalate to formal remediation if insufficient change occurs	5
Meet with resident to discuss the behavior	2
Case scenario 8 (unprofessional/illegal access of the EMR)	
Immediately dismiss resident	4
Place resident on Probation after meeting with him/her to review behavior	2
Meet with resident to determine a remediation plan and discuss next steps if insufficient change occurs (i.e., probation/non-renewed contract/dismissal)	1

Abbreviation: EMR, electronic medical record.
*Potential responses receiving no votes were not included in the Table. See the Materials and Methods section for all possible responses.

resource individuals who can be called upon to help develop educational curricula and assessment programs as part of faculty development.[17-20] In addition, surveys or focus groups of faculty and residents can help identify skills that need to be addressed (eg, communication skills, respect for others, setting expectations, etc) as well as effective teaching strategies (eg, role modeling, assessment of behaviors, formal lectures, case scenarios, etc).[20]

The primary limitation to our study is the relatively small number of completed surveys, but it is not clear whether a larger number of completed surveys would have altered the general ambiguity and individual responses expressed by program directors surrounding the remediation of unprofessional behavior or if greater clarity would have been achieved. We suspect the former as, unlike the objective assessment of a resident's fund of medical knowledge, assessing and managing unprofessional behavior is not always a cut-and-dried exercise but often contains many uncertainties and gray areas. However, additional study in this area is certainly warranted. In addition, comments made by participants during the workshop were not captured and could not be specifically analyzed. Also, while every attempt was made to provide a cross-section of case

Table 3. Potential Future Areas for Research and Education in Professionalism.

- Organize national workshops and seminars to provide open forums for discussing best practices, assessment tools, and approaches to remediation of professionalism
- Perform detailed and extensive surveys of program directors, faculty, and residents to ascertain their perspectives on what constitutes unprofessional behavior and how best to address it
- Validate and standardize multiple case scenarios and remediation approaches that could be presented to faculty and residents at multiple institutions and the results compared and shared
- Develop and validate on-boarding and orientation programs incorporating significant amounts of ethics and professionalism education
- Develop webinars or other online education programs to provide easy access to ethics and professionalism education to faculty and residents at multiple institutions
- Study and validate the utility and efficacy of the Pathology Milestones in assessing ethical and professional behavior
- Incorporate examination questions related to ethics and professionalism in in-service examinations given to residents and fellows (eg, RISE, TMISE, FISHE, etc) and score/result these as a separate category for ease of interpretation
- Develop and research a variety of education and assessment tools for ethics and professionalism such as narrative self-reflection, case portfolios, utility of focus groups, utility of "teachable moments" at the scope and the bedside, and so on
- Study the role/importance of faculty mentors and role models in influencing and shaping residents' education and practice of ethical and professional behavior
- Study how a "culture of professionalism" could be developed and promoted within departments and training programs
- Develop methods to incorporate critical thinking skills into educational efforts related to ethics and professionalism
- Develop faculty development tools for assessing residents' professionalism, interpersonal, and communication skills
- Research the presence and significance of a "hidden curriculum," as it relates to ethics and professionalism in pathology training

Abbreviations: RISE, resident in-service examination; TMISE, transfusion medicine in-service examination; FISHE, fellow in-service hematopathology examination.

scenarios, there are very likely many more that could be presented that would provide an additional casuistic educational approach.

The various approaches presented here will hopefully provide program directors, faculty, and their Clinical Competency Committees a basic or suggested framework for approaching resident remediation for unprofessional behavior as well as a point of departure for establishing their own internal guidelines and educational venues in addressing these very difficult issues. Additional studies are needed on how best to instill ethical and professional qualities into our trainees as well as proven evaluation tools and remediation approaches. As a start, a more ambitious workshop or plenary session is planned for an upcoming annual APC/PRODS meeting where additional case scenarios will be presented, a panel of "experts" will be utilized, and notes of the comments and discussion threads will be recorded. Additional studies might include more detailed and extensive surveys of program directors, faculty, and residents to ascertain their perspectives on what constitutes unprofessional behavior and how best to address it. Additional insight could also be obtained through the presentation of a validated set of case scenarios and remediation approaches that could be presented to faculty and residents at multiple institutions and the results compared. The efficacy of onboarding and orientation programs incorporating significant amounts of ethics and professionalism education could also be developed, studied, and validated. The utility and efficacy of the Pathology Milestones in assessing professionalism would be another research area worthy of pursuit. Suggestions for further research and educational efforts are detailed in Table 3.

Employers consistently rate areas of professionalism—for example, honesty, interpersonal interactions, knowing when to ask for help, and so on—as being critical attributes in their hiring of the newly graduated pathologist, but a significant percentage of new hires are often deficient in professionalism attributes.[21-25] It is imperative that the pathology profession continues to foster research and education efforts in ethics and professionalism in residency education.

Appendix 1. Case Scenarios*

Case Scenario 1

Dr Rachel Ghoulardi is a postgraduate year (PGY) 1 pathology resident about to enter her PGY2 year. The Clinical Competence Committee (CCC) met at the end of May to review each resident's summative evaluations and academic progress. Dr Ghoulardi's evaluations were generally average or meeting expectations, but several faculty rated her performance as marginal or not meeting expectations—particularly in the area of professionalism. Concerns were raised about her preparedness for surgical pathology signout as well as her participation in the unknown surgical case conference. She has missed several of these conferences during the year, but she always seemed to have a legitimate excuse. However, when she did attend it was noted that she was often 10 to 15 minutes late and would frequently be observed texting on her cell phone during the conference or dozing when the lights were dimmed. On her blood bank rotation, one attending noted that her consultation and progress note write-ups were marginal at best and very often late in getting into the EMR. One of the Pathology Assistants (PAs) in the gross room recently complained to the program director that on a couple of occasions Dr Ghoulardi failed to follow proper procedures for grossing and accessioning surgical specimens that caused important tissue samples to be lost or only marginally useful and that on several occasions she was nonresponsive to pages or "unavailable" for long periods on her grossing days.

Case Scenario 2

Dr Douglas Fuldheim is a PGY2 pathology resident who is seeing you first thing on a Thursday morning for his semiannual evaluation. He has been noted to have difficulties during his

most recent surgical pathology rotations, despite having done extremely well in his first year. Several attendings have informally commented that he seemed inattentive and "bleary eyed" during sign out and that he was missing important details in his gross descriptions. He recently cut himself in the frozen section laboratory during a frozen performed at night while on call. A few days ago, while walking through the residents room, you overheard one resident ask how his weekend was to which he replied, "Man, I got so wasted I barely made it into work today. I've got a wicked headache this morning." His evaluations for other rotations have been satisfactory, but there has been a noticeable drop-off in performance across the board since the previous year. When he shows up for your meeting, he is 10 minutes late and looks disheveled. He states that his alarm clock didn't go off and he had to roll out of bed to hurry into the hospital to meet with you. After beginning to go over his evaluations, he gets defensive and angry, blaming the attendings and other residents for making him look bad. When he leans over to point out something in his file, you detect alcohol on his breath.

Case Scenario 3

During the second year of his Surgery residency at a prestigious program in his distant hometown, Dr Brendan Haines experienced the new onset of a seizure disorder that obligated him to interrupt his training and to complete the year doing research. After completing an additional year in research, he decided that he could not resume surgery training and so sought APCP4 training. He was open and honest about his condition. He had been a brilliant student throughout, had great letters, and interviewed well so was ranked to match.

Upon arriving in the program, problems began to be noticed. He tended to act out when challenged, becoming angry in work settings. His medications disturbed his sleep to the point that he was frequently late for duty, and there was a question about his being able to read enough to stay on top of expected learning. He was unable to drive a car so was dependent upon his wife for transportation. Most concerning, he was observed by many attendings to blank out at work and had a witnessed fall on a stairway. Unsatisfactory evaluations began to roll in. During the first year of APCP4, his wife became frustrated with his neediness and pressured him to request to change his track to Clinical Pathology3 (CP3) so that they could move back to their hometown sooner. He comes to you to discuss this plan.

Case Scenario 4

Dr James Blundell is a PGY3 pathology resident and is on his third blood bank/transfusion medicine rotation. His performance has been generally average to above average. However, during his first rotation, he was observed by an attending to be verbally abusive to one of the apheresis nurses because she questioned one of his orders on a pediatric patient. He was counseled by the program director, and an incident report was completed and placed in his file. No further incidents occurred. During this rotation, it was discovered that he failed to obtain proper informed consent on a patient undergoing hematopoietic stem cell collection, and after the procedure was over, and the patient had left the unit, he added language to the consent form that he had initially omitted. This incident came to your attention because one of your other residents witnessed the event. During your discussion with this resident you also learn that Dr Blundell is notorious among the residents for looking up cases in Co-Path prior to the surgical pathology unknown conference.

Case Scenario 5

Dr Maria Faithful is a PGY2 pathology resident whose evaluations have generally been good, but a few concerns have been raised about her interactions with others, particularly with her fellow residents. Residents have raised their concerns with you that Maria has called in sick on several occasions, often on busy rotations and at the very last minute, forcing other residents to pick up her duties for the day or two or three that she is gone. When she returns, she rarely acknowledges the effort made by her peers. In addition, residents have noticed her condescending and sometimes belligerent attitude toward them and not infrequently toward laboratory technologists and clerical staff. One incident related by the chief resident concerned Maria's "personal space issues" with a fellow female resident in the resident's room that would have resulted in a physical altercation had another resident not intervened. One resident who has tried to reach out to her related that Maria told her that "It is none of your business, this is who I am, and sometimes I forget to take my medication." None of the residents want to work with her and are tired of covering for her. In deeper conversations with the faculty you also learn that there is a general feeling that Maria has an "attitude" that she can be "difficult" to work with and that she has been known to "walk out" during sign out with at least one attending because the cases were "boring."

Case Scenario 6

Dr Goode is a PGY1 pathology resident on his third straight month of autopsy rotation. He is being supervised by Dr Frank who is a PGY4 resident and who also needs to increase his autopsy numbers. The autopsy is on a 4-month-old baby who died as a result of multiple congenital abnormalities. Before the autopsy, the 2 residents are joking around and they both take multiple pictures of the baby with their cell phones and later post them on Facebook along with derogatory and insensitive comments about the baby, their attendings, and the department (without naming names). Several other residents see the photos and also post comments.

Case Scenario 7

Dr Roy is a PGY3 pathology resident who recently had a romantic relationship with Dr Annie who is a PGY2 resident

in pathology, until Dr Roy broke off the relationship. Their interactions were tense for a month or so afterward but, eventually, Dr Annie moved on to another boyfriend outside the hospital and seemed happy with her new situation. Then Dr Tara, a PGY1 pathology resident, begins to date Dr Roy. Dr Annie finds out about it when flowers are delivered to the resident's room on Valentine's Day from Dr Roy to Dr Tara. Dr Annie proceeds to make Dr Tara's life extremely difficult and intentionally tries to get the other residents to take her "side." It becomes a source of great tension among all of the residents as Dr Annie is relentless and continues to "stir the pot" and to create "drama" among the residents. You (the program director) have already counseled Dr Annie once in the past when she said to a rotating medical student who was considering pathology as a career, "I heard you're struggling to get in the groove here. Make sure and let me know if there's anything I can do to help." The comment was followed by a smirk. Other team members standing close by heard the comment and saw the smirk.

Case Scenario 8

The DIO of your institution informs you (the Program Director) that one of your PGY3 residents, Dr Jay Smith, has been found to have accessed the EMRs of several female residents in the hospital and in some cases multiple times over the past several months. The DIO has met with the female residents and none of the EMR accesses were authorized. The DIO has also verified with the Chief Information Officer that none of the EMR visits were related to justified pathology or laboratory test result reporting. You schedule a meeting with Dr Smith for later that day.

*All names used in these case scenarios are fictitious.

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