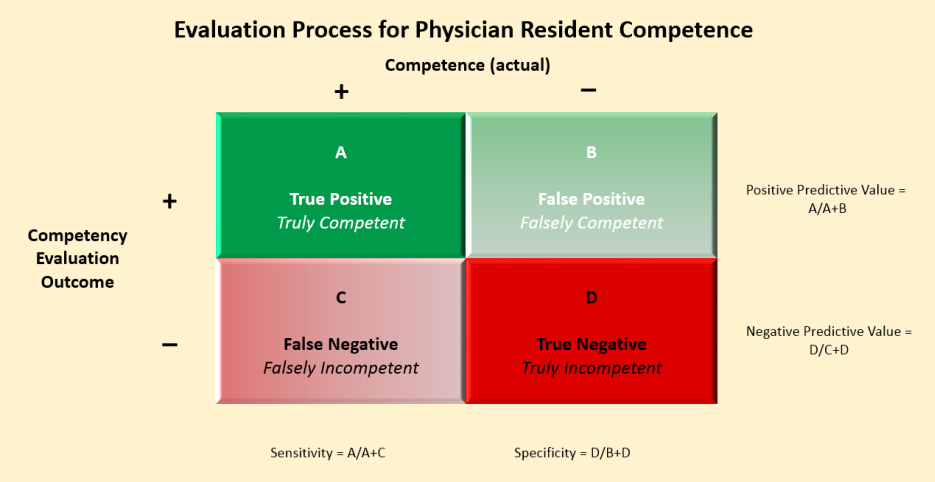
Anatomy of a Resident Lawsuit:
A $50 Million False Negative?

M. Todd Rice, MD, MBA
29 July 2018

We are familiar in Medicine with such concepts as sensitivity, reliability, and false positives in the use of diagnostic tests for disease detection. These terms can also be applied to the evaluation tools for residents in training: subjective evaluations, Milestones, in-training exams, Clinical Competency Committee deliberations. Rather than disease detection, these assessments are designed to detect deficiencies and identify competencies. Diagnostic and evaluative tests are recognized to be imperfect tools, even when run precisely as designed. What can be their predictive value if they are not used as designed? How sensitive are they if applied only partially? What is their validity if certain values are discounted or substituted due to bias?



The ACGME provides requirements and guidelines for resident evaluation and promotion, but there is no gold standard against which to compare the processes utilized by faculty, institutions and residency programs - all of which may exhibit significant inter-rater variability. As a medical community, we hope that the evaluation processes function well, but it is not possible to know how many residents are erroneously determined to be either deficient or competent in any of these performance parameters. Either of these false outcomes may have significant repercussions for physician trainees, residency programs, hospitals, the taxpaying public which funds these programs, and ultimately, for patients.

On June 28, 2018, Dr. Rylan Brantl filed a $50 million lawsuit against the University of Missouri in Columbia, where he had been a neurosurgery resident from 2008 to 2013. He was placed on probation in his PGY-3 year, advanced to his PGY-4 year, then remediated to repeat his PGY-4 year of training, and ultimately not offered a contract for year 5 of the 6-year neurosurgery residency program. This type of recycling and termination of residents may be a familiar story to many, although the specifics are usually unclear. In Dr. Brantl's case, he brings his description of alleged violations of ACGME requirements and University of Missouri due process policies to public attention.

Dr. Brantl's petition describes a learning environment that was often hostile, treatment that was

different from that of his peers, persistent duty hours violations, retaliation for his complaints, and a program director that would frequently demonstrate demeaning, harassing, and threatening behavior. Residents in some programs might think to themselves, "... and how is that any different from what many of us experience every day?" While these types of infractions are certainly violations of a number of oversight bodies' mandates, they can be difficult to prove and correct.

The arguments that may find success are those that focus on more concrete issues. Dr. Brantl needs and is attempting to show that Mizzou failed to provide him due process consistent with ACGME Common Program Requirements and to comply with its own institutional policies and procedures. Some of his claims to that end are found in the 33-page petition:

1. Dr. Brantl's initial PGY-3 probation was in violation of University of Missouri GME policy on multiple counts. His supposed performance deficiencies were not clearly documented to him, thus denying him the opportunity to repair or "cure" them. He was not put into contact with the resident ombudsman, provided a mentor, offered education assistance, or provided the required monthly feedback to monitor his progress. There was no defined probation period. He was never informed whether he did or did not meet the expected improvements, although he was advanced to the PGY-4 year.

2. Dr. Brantl was remediated and made to repeat his PGY-4 year, which may have similarly been a breach of due process. There was no detailed description of his deficiencies, no specified plan for remediation, and the program failed to provide him notice of his opportunity to file an appeal. Despite his having passed the written exam for the American Board of Neurosurgery and receiving good evaluations from multiple faculty at two other institutions, his poor evaluations with his program director and a few core faculty overshadowed his broader performance. These poor evaluations were often submitted when he had not been on service with the evaluators. Additionally, his chief residents verbalized to him positive performance feedback, but they were not permitted to submit evaluations of him. The ACGME and legal precedent require evaluations to be filed from multiple sources (e.g. resident, student, staff) and that a resident's entire record be considered in fair, deliberate fashion.

3. The following year, when Dr. Brantl was terminated (not offered a contract renewal), he filed an appeal. However, Mizzou did not follow the procedure for its own grievance process. The residency program director did not provide him with detailed reasons for his termination, nor did he respond to Dr. Brantl's appeal within 30 days. Dr. Brantl was denied legal representation, a full hearing, witness testimony with direct and cross examination, and was ultimately offered just one hour to make his case. Dr. Brantl was notified on a Friday that his hearing would take place that coming Monday,... while he was out of town. Also of note, the department had already accepted a transfer resident in his stead, as if the appeals process were a mere formality - a predetermined verdict against him.

It may take years for the courts to decide if Dr. Brantl was appropriately terminated or if he was

a false negative in the evaluation process for resident competency - erroneously identified as lacking competence through the flawed, subjective, improperly applied procedures that he alleges. In the meantime, his case can heighten awareness for residents, institutions and the public regarding potential abuses of evaluation and due process that are demanded in resident contracts, ACGME requirements, and institutional policies and procedures. If these tools are improperly applied, the diagnostic tests for competency become meaningless, if not harmful. When we hear that a resident has competency issues, perhaps we should ask how that was determined and by whom.