

Graduate Medical Education Compliance Project
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14 September 2023

Dear Appeals Committee,

For background, I am a practicing, board-certified anesthesiologist since 2006, with an array of academic, private and hybrid experience in multiple geographic regions, to include San Antonio, Dallas, St. Louis, Pittsburgh, and now finally, in the lifestyle destination of Hot Springs National Park, AR. While assistant professor at Washington University School of Medicine in St. Louis in 2017, I witnessed failures of program and institutional due process for a number of residents in a local non-affiliate health system. They had been selected in seemingly subjective manner for probation, remediation and/or termination.

These disciplinary actions did not appear to be well-supported, appropriately documented or in accordance with extant policies. Worse still were the retaliatory treatments that would follow as the residents attempted to advocate for themselves through their rightful appeals processes. The maltreatment included department-wide character defamation, purposeful attempts to garner negative evaluations of the residents from other attendings, hyper-criticism of minor issues elevated to significant importance against them which were not deemed noteworthy when similarly encountered with their cohort residents (holding them to a different standard), and an apparent attempt to build a negative case and file against them to retroactively justify disciplinary actions. Often, despite previous evaluations to the contrary, these residents would suddenly be labeled with charged descriptors, like “unteachable” or “unsafe.” What became clear to me is that personal agenda, bias and subjectivity by some powerful attendings could completely derail the career of a resident, even in the absence of significant academic or professional deficit.

As I began to communicate with attendings and program leadership to advocate for following ACGME requirements regarding resident evaluation and due process, I was met with disinterest or resistance. Somewhat shocked to find this dysfunction in our systems, I escalated my concerns to the Designated Institutional Officer (DIO) who was very willing to help, but whom I noted to be entirely ineffectual in the presence of well-established program directors and attendings who held significant institutional power and strong personality traits.

Next, I communicated with the department chair, whom I knew from a few social interactions. He listened, but had no advice other than to trust the system (which I was witnessing to be dysfunctional and unresponsive). From there, I emailed a detailed explanation of events, concerns and documented violations to the dean of the medical school. Ultimately, he would deflect evidences and responsibility by saying that “we have had our site visit” (by the ACGME) and they didn’t find anything wrong.

Out of frustration, in 2017, I set up the Graduate Medical Education Compliance Project (GMECP) webpage, www.gmecomplianceproject.org, to post up resources that I was finding and creating for

residents in distress and to attempt to shame bad actors. The GMECP was not the original name of the project, by the way. After I was sued by the target institution for trademark infringement, I was forced to change it.

Although the website obviously got the attention of people high enough in the institution to sue me, it did not readily alter behaviors or the course for the residents. Interestingly, however, the medical school did eventually outsource a SWOT analysis in which each resident and attending of this particular department was interviewed, and the findings were leaked broadly. The results showed numerous violations of policies, various forms of discrimination and retaliation. Disciplinary actions were subsequently dropped for any of the remaining residents, the program director was replaced, and the new leadership was sent for ACGME training. This was too little, too late for a number of the residents who lost their positions – some of whom never found another residency in their specialty training track.

Subsequently, over the past 6 years I have spoken with and attempted to advise well over 100 residents who have found me through the website. I charge them nothing and gain nothing personally, other than the hope that together we may be improving our own medical education systems and forcing some sunlight into dark places.

For the members of the appeals committee, I would like to share some of the typical failures and violations of ACGME and institutional policies that underpin many resident's plights. As you consider Dr. [REDACTED] case, please compare the processes applied to him with the overly common errors and violations that have been encountered in similar cases.

ACGME Common Program Requirements (commonly encountered violations excerpted):

II.A. Program Director

- II.A.4.a).(7) provide a learning and working environment in which residents have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation;
- II.A.4.a).(8) ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, or not to promote or renew the appointment of a resident;
- II.A.4.a).(9) ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination;

V.A. Resident Evaluation

- V.A.1.a) Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment.
- V.A.1.b) Evaluation must be documented at the completion of the assignment.

- V.A.1.c) The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must:
 - V.A.1.c).(1) use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and,
 - V.A.1.c).(2) provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice.
- V.A.1.d) The program director or their designee, with input from the Clinical Competency Committee, must:
 - V.A.1.d).(1) meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones;
 - V.A.1.d).(2) assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and,
 - V.A.1.d).(3) develop plans for residents failing to progress, following institutional policies and procedures.

V.A.3. The Clinical Competency Committee

- V.A.3.b) The Clinical Competency Committee must:
 - V.A.3.b).(1) review all resident evaluations at least semi-annually;
 - V.A.3.b).(2) determine each resident's progress on achievement of the specialty-specific Milestones; and,
 - V.A.3.b).(3) meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress.

VI.A.2. Supervision and Accountability

- VI.A.2.a) Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.

VI.B Professionalism

- VI.B.5. Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is psychologically safe and that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff.

Background and Intent: Psychological safety is defined as an environment of trust and respect that allows individuals to feel able to ask for help, admit mistakes, raise concerns, suggest ideas, and challenge ways of working and the ideas of others on the team, including the ideas of those in authority, without fear of humiliation, and the knowledge that mistakes will be handled justly and fairly.

Questions regarding the function and compliance of the Clinical Competency Committee,
based on the ACGME's CCC Guidebook, 2nd edition (which can no longer be found online).

- Pg 9 Have the CCC members received training in evaluation, data quality and interpretation, Milestones development, and their member roles which "... will typically include the need for substantial faculty development."
- Pg 13 Does the selected Chair of the CCC "best solicit broad input... and ensure all voices are heard?" Does s/he encourage a "positive working environment and open communication from all members" or does s/he have tendencies to dominate with personal opinion, promote a particular rater bias, entrench groupthink, or even disallow dissenting opinion? Are other CCC members intimidated into agreement or silence, due to the Chair's power positions or personality?
- Is the Chair "the Milestones expert"?
- Does the Chair "use best practices in effective group processes (per pg 21),..." e.g. using structured formats and seeking junior member inputs first?
- Is there a "plan for professional development of CCC members"?
- Pg 14 Does the program director "detract" from the participation of other CCC members, or prematurely insert his or her perspective, or predetermine residents' Milestone performance then bring them to the CCC for "ratification?" Are the roles and power of the CCC appropriately balanced?
- Pg 15 Do the Milestones ranking of residents tend to be arbitrary, or scored with too little or a particularly over-weighted faculty input? "Faculty members should reach a common understanding on the meaning of the narratives of each milestone in the context of the specialty."
- pg 27 Are the resident assessments produced by the CCC supported by written evaluations? If not, "... it should consider revising its assessment tools or processes and/or faculty development to solicit better written/recorded information." Are the findings transparent to the residents via timely and personal feedback?

- Pg 29 Has the CCC been annually re-evaluated on the basis of its purpose, model, procedures, and potential for groupthink or drift from its purpose?
- Pg 30 High quality feedback. Is the CCC feedback overly general, lacking specificity, to the point of adding little value in directing a resident's development? Is it balanced for construction, as well as correction? Are residents assisted to create and execute Individualized Learning Plans (ILPs), which are "critical to professional development"?
- Pg 35, 39 Are keys components of due process provided to residents, to include "a careful and deliberate decision-making process" while reviewing all available inputs, a specific list of any noted deficiencies, and the opportunity to improve/cure those deficiencies?

I appreciate the opportunity to share insights from my experience with residents facing disciplinary actions. As established physicians, we all hope that our systems are high functioning and in compliance with meaningful policies and procedures. Inherently, however, many of us understand that is not the reality. As a result, all too frequently, residents are deprived of feedback, unbiased and meaningful evaluations, opportunity to cure deficiencies, and/or the due process that they are owed and promised through ACGME and institutional policies. In addition, these processes can be subverted by a single or small number of attendings with out-sized power and personality, pulling others along with subtle intimidation and/or groupthink. As Dr. [REDACTED] career and future are being considered, please take the time to insure that he is offered unbiased consideration regarding the continuation of his residency training.

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