Protecting the Residency Training Environment: A Resident's Perspective on the Ethical Boundaries in the Faculty-Resident Relationship

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Objective: *This article explores ethical complexities that underlie resident-faculty relationships. The faculty-resident relationship is as complex as that between a therapist and his or her patient, but it has been far less well studied.*

Methods: *From data obtained from psychiatry residents and faculty members regarding their experiences in this relationship, the authors present five vignettes that illustrate unethical conduct in the faculty-resident relationship.*

Results: *Ethical lapses described in this article are problematic for two reasons: first, personal and professional harm may come to individual residents who find themselves interacting with an errant faculty member; and second, ethical lapses have the potential to damage the overall training environment itself. Once the terms of the faculty-resident relationship are discussed and accepted by all participants, unintentional or inadvertent ethical problems will be prevented, and residents will be in a position to identify faculty behaviors that do not conform to these agreed-upon expectations.*

Conclusions: *This article highlights the importance of incorporating education about ethical responsibilities and faculty-resident boundaries into the training curriculum. The authors offer suggestions for understanding faculty members' responsibilities to residents in their training programs.*

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The faculty-resident relationship is as complex as that between therapist and patient, but it has been far less well studied and understood. Faculty-resident relationships constitute an important aspect of training in a psychiatry residency program. Faculty members assume a variety of roles in these relationships: they may supervise residents, provide feedback about performance in nonsupervisory contexts, encourage residents to act with appropriate (i.e., skill-based) autonomy, support residents during difficult patient encounters or personal crises, and serve as role models for both personal and professional development (1). Despite the possibility of conflict among these multiple roles, ethical issues in the faculty-resident relationship have received little attention in the literature (2).

We begin with the premise that the relationship between faculty member and resident should be an ethical relationship. By "ethical relationship," we mean a relationship that is shaped by an active awareness of the manner in which roles create duties and expectations, and a corresponding commitment to behave in ways that satisfy those obligations. In particular, an ethical relationship is one in which each party accepts the reciprocity of intrinsic value: that is, each acknowledges the other's intrinsic value, and each refrains from using the other merely instrumentally (simply as a means to an end) (3). Such relationships are characterized by the values of respect, fidelity and responsibility. In the faculty-resident relationship, these values direct action toward the global development of the resident, not only as a clinician but also as a competent professional.

The burden of maintaining the integrity of faculty-resident relationships falls mostly on the shoulders of the

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faculty members. Faculty members have greater autonomy and authority in the relationship than do residents, and thus are in a position to prevent or at least to mitigate situations that might prove harmful to residents. In some respects, the faculty-resident relationship resembles a fiduciary relationship: residents are expected to place their trust in the expertise of the faculty, and they also must trust that faculty members will use their greater power and expertise appropriately. This fiduciary-like foundation requires that residents be informed and protected, and not be exploited or coerced. The primary ethical challenge in the relationship is for both parties to develop and accept a common understanding of what counts as "appropriate" use of faculty authority.

Each of the five vignettes below presents a situation in which a faculty member or training director fails to satisfy an important obligation to a resident under his or her supervision. In presenting and analyzing these examples of presumptively unethical conduct, we suggest three ways to identify and address the ethical issues involved: 1) appealing to interests and goals shared by faculty members and residents alike, 2) appealing to the meaning and coherence of fundamental concepts involved in the relationship, such as "evaluation," "confidentiality," "intellectual property," and 3) appealing to mutually agreed upon ethical principles or policy guidelines (e.g., American Psychiatric Association [APA] Principles of Medical Ethics With Annotations Especially Appropriate to Psychiatry and the Accreditation Council for Graduate Medical Education's [ACGME's] Policy Manual). Although it is not necessary to use all of these approaches to identify and resolve a single instance of unethical conduct, we do so in the first case to illustrate the consistency of their results. However, as the remaining vignettes illustrate, any of these approaches can be used to clarify and resolve ethical problems in the faculty-resident relationship.

Ethical Problems That Can Arise in the Faculty-Resident Relationship

Power

Kerry is a first-year resident who, during his inpatient rotation, asked his training director to assign him a patient for weekly therapy. Kerry spoke with the unit chief to schedule his patient and supervision time so that these sessions would not conflict with his other duties.

Three weeks later, the director of inpatient services asked Kerry to review 300 charts of patients for a study the director was conducting. Because the chart review had to be done at times that coincided with Kerry's outpatient therapy and supervision time, he explained that his schedule would not allow him to participate in the chart review. A week later, his chief resident told Kerry that the director of inpatient services had complained about his refusal. The training director suggested that if Kerry had no time to assist with the research project, perhaps he was too overburdened to see a patient for therapy. Kerry was then given two options: either to stop seeing his outpatient case or to continue working with his patient and also find time to review the 300 charts.

Analysis. A faculty member may certainly ask a resident to participate in other activities beyond those specified in training requirements, particularly if those endeavors, such as participation in research, are likely to have value as educational experiences in their own right. The question of ethical misconduct arises only when it is not clear whether the request is in fact a disguised imperative that must be obeyed regardless of the resident's other responsibilities, and when the goal appears to benefit the faculty member more than the resident. To insist that the research project is more important than an approved therapy experience designed to enhance the resident's clinical expertise violates the faculty member's obligation to place the resident's training needs above his or her own need for assistance. By treating the resident as a means to the completion of his research project, the faculty member fails to acknowledge that the resident's wish to gain more experience in therapy is legitimate. Finally, it is dishonest to present the request as if the resident has a genuine choice when in fact the faculty member demands compliance. The concept of choice requires that options under consideration be real alternatives—that is, they must actually be available to the person choosing—or else the concept contradicts itself: "choose, but you do not have any alternatives." Kerry was placed in just such a position when told he could continue his outpatient case only if he also completed the chart review.

When he retracted his earlier approval, the training director ignored two major responsibilities of his position: 1) to promote the goals of the training program (one of which must certainly be the development of well-trained, experienced clinicians), and 2) to protect the training environment from incursions by competing demands. His reversal also violates the duty of fidelity (the obligation to honor prior commitments). Unless there are compelling reasons for changing one's mind, we each owe "faithful follow-through" to others who rely on the truth and validity of our statements and decisions.

Appealing to well-accepted standards of conduct is another way to achieve clarity about various duties owed to residents in the program. We would argue that APA's Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry can provide ethical guidance here, in that many of the principles developed to govern the psychiatrist-patient relationship can be applied equally well to interactions between faculty and residents. Extrapolating and applying Section 1, Annotation 1 to the faculty-resident relationship, we read: "A psychiatrist [faculty member] shall not gratify his or her own needs by exploiting the patient [resident]. The psychiatrist [faculty member] shall be ever vigilant about the impact that his or her conduct has on the boundaries of the doctor-patient relationship [faculty-resident relationship], and thus upon the well-being of the patient [resident and goals of the training program]." (4). Faculty members abiding by this principle will not demand a resident's participation to fulfill their needs at the cost of the resident's educational goals or the goals of the training program.

Confidentiality

Susan had just begun her outpatient work with a patient who started therapy sessions by complimenting Susan on her appearance and on her office. Susan began her work with the patient by exploring these remarks, but in the sixth session, the patient started comparing Susan's physical attributes to her own, going into elaborate sexual detail. Susan became uncomfortable in this session and was unable to work through the patient's transference toward her. She discussed this problem with her supervisor, and they explored her inability to deal with the patient's remarks therapeutically as well as her countertransference issues. Susan talked about her reactions to sexual advances from patients of the same sex, including those based on her religious and cultural beliefs.

The next day, one of Susan's colleagues asked about this patient, expressing sympathy and remarking about Susan's counter transference. When Susan asked how her colleague had obtained this information, she was informed that her supervisor had mentioned it during a discussion of clinical scenarios with two of Susan's colleagues. Susan asked her supervisor why he had shared this information with people outside of the supervisory dyad and was told that he used her case and their discussion to counsel another resident who was experiencing a similar problem.

Analysis. Susan's situation is based on a relatively common phenomenon. Residents frequently discuss their emotional and affective responses to the process of therapy during supervision, and faculty members may want to use this information as a teaching tool. However, confidentiality is a core value of psychiatry, one that is imparted to residents from the start of their training. Should the concept also apply to information exchanged during supervisory sessions? What is the message to residents if their sensitive information is not similarly protected?

One approach to this question is to consider the meaning and purpose of the concept of confidentiality. Traditionally, two different answers have been given to this question: 1) to establish a climate in which another person is encouraged to share sensitive information for a previously agreed-upon purpose (e.g., effective treatment); and 2) to recognize the fact that the person sharing the information has a right to control access to that information (5).

Do either of these conditions apply to information obtained from a supervisory session? That a resident will almost always be in a position to decide what to tell his or her supervisor about therapy sessions seems apparent. It seems equally clear that a supervisor will be in a better position to guide the resident's development if he or she receives an unedited account of what occurred during the sessions. Keeping information gained from supervisory sessions confidential contributes to an environment in which residents are encouraged to expose weaknesses and to receive constructive criticism. The test question here is: "Does the behavior in question promote or damage previously agreed-upon goals?"

Assuming that both resident and faculty member understand that supervision will be effective to the extent that the resident honestly and completely discloses his or her uncertainties, questions, and feelings about the experience, it seems clear that faculty disclosure of residents' personal information without consent has the potential to damage training in general, and supervision in particular. Disclosing this information also undermines the supervisor's standing as a role model (e.g., as a psychiatrist who takes confidentiality seriously).

Intellectual Property

Pam met with the chief of the research division to discuss an idea she had for a research project. The chief encouraged Pam to pursue her idea by initiating a literature search. After collecting a number of relevant articles, she met with the chief, who took the articles to review and told Pam that he would contact her in a few weeks. Two weeks later, having not heard from the chief, Pam again met with

him to discuss additional data she had found; she also told him she would like to initiate the project after she completed her exams. Within 2 weeks, Pam discovered a senior resident distributing a survey to residents for a new study being conducted by the research division. To her dismay, she realized that the survey was based on the research idea she had proposed to the chief of research. As a second-year resident, Pam did not feel comfortable in confronting the chief of research: she feared that calling attention to the situation might affect her training negatively, since the chief of research played a role in evaluating residents.

Analysis. Theft of intellectual property is not limited to the resident-faculty relationship in psychiatry but can occur in the context of any intellectual endeavor. What makes this incident especially egregious is the vulnerable position of the resident: she must decide whether to report a case of scientific misconduct that involves one of her supervisors. This situation would have been prevented if the faculty member had considered his duty to place the goals of the resident's training ahead of his own projects. Beginning the research project without the resident's consent and collaboration is theft of intellectual property. Furthermore, the chief seems to assume that because of her subordinate position, Pam will not object to his actions. From an ethical point of view, he has neglected her intrinsic value and treated her purely as a tool for achieving his personal goals.

Role Reversal

Dr. Michael was a new faculty member who worked with residents in both clinical and academic settings. Soon after he was appointed, residents began to have concerns about his inability to discuss differences in clinical impressions and treatment plans. At such times, he would often attack their knowledge and professionalism and had increasingly begun to make personal comments about the residents' language, appearance, and dress, often explaining to them that it was his obligation to be honest with them. He was also overheard on multiple occasions commenting about residents' personal and professional deficiencies to other staff and students.

The resident group met with the director of the service involved and other faculty to discuss their experiences with Dr. Michael. The director informed them that they should be patient with Dr. Michael and attributed his behavior to his lack of experience.

Three months later, finding no change in Dr. Michael's behavior, the residents requested another meeting. During this meeting, the director acknowledged that Dr. Michael had problems in his interactions with residents but explained that the residents needed to work at accommodating Dr. Michael's behavior and at developing coping skills to deal with the stressful environment created by their conflicts with him. To justify his view, the director also added that there were residents with whom faculty members did not get along, but they coped, and the same was expected from the residents.

Analysis. Appointment to faculty status confers a number of responsibilities, among the most fundamental of which is the duty to serve as a competent mentor to students and residents in the program. When a faculty member is unable to meet this obligation, for whatever reason, the program has a responsibility to remedy the situation, either by counseling him/her regarding the process and goals of supervision or removing the faculty member's supervisory responsibility. However, we are not suggesting that every conflict should result in the elimination of the supervisory role with residents. Rather, we believe that to expect residents to assume a mentoring relationship with the faculty member is not an adequate solution to the problem. Doing so in effect reverses the roles of faculty and resident, thus inviting subsequent role confusion about evaluation and other faculty responsibilities. More importantly, developing clarity about these role-based responsibilities will help prevent situations in which residents are harmed by unethical faculty behavior.

Frank Communication

Tim had received excellent evaluations from the consultation-liaison rotation he had just completed. However, during his next clinical rotation, complaints about his interpersonal skills and clinical performance emerged. In discussing Tim's performance, the director of training informed him that he had also received complaints from his prior rotations. Tim was puzzled, because he had received all "Excellent" evaluations from those rotations. Furthermore, despite the fact that he had repeatedly requested feedback about his performance, no difficulties had been identified in his evaluations.

The source of the complaints from the current rotation came from the chief of that service, which led other staff to express negative views about Tim's competence. When Tim attempted to engage faculty members in a dialogue about his deficiencies, he was told that whatever was discussed in faculty meetings was confidential. Instead of discovering what he could do to improve his performance,

Tim was asked to sign a remediation plan and was put on 6 months' probation.

Analysis. Evaluation implies measurement against a standard. Assuming that standards have been clearly developed and adequately communicated to residents, the test of reliable evaluation is intersubjectivity: would other equally knowledgeable evaluators agree that the observed performance failed to meet the standard? Embedded in this concept is the requirement that judgments be objective, based on observation and experience, and communicated in a direct and timely fashion. Evaluation also has a multidirectional component: information is conveyed to the resident to enable him/her to improve his or her performance, but it is also conveyed to others so they can decide whether and to what extent they should rely on the resident's expertise. Evaluative judgments that are subjective, based on rumor and hearsay, or not relayed to the resident in a timely or complete manner would fail to meet the intersubjectivity test and would also contradict the purpose of evaluation: to provide accurate information about a resident's performance. Timely interventions should be made when deficiencies appear.

Discussion

In the context of a training program, ethical lapses such as the ones described above are problematic for two reasons. Clearly, the first is the personal and professional harm that comes to residents who find themselves interacting with an unethical faculty member. But the second reason why ethical lapses should be addressed promptly and decisively is that they have the potential to damage the overall training environment itself. For example, if a training director fails to support a resident who is being exploited by a faculty member, what is the implicit message to other residents and faculty members in that department? If a faculty member can disregard a resident's legitimate interests in this way, what protection is there for other residents who might find themselves in a similar position? Alternately, if a resident's educational needs can be sacrificed and subordinated to other needs, such as the service needs of the hospital or a faculty member's need for assistance, how long will it be before the integrity of the training program and the clinical competency of its graduates are also at risk?

We believe that situations in which faculty members act unethically in their dealings with residents are often the result of lack of foresight, as when an individual faculty member fails to consider the ramifications of his or her behavior or a training program fails to develop clear guidelines that define what is expected in the faculty-resident relationship. Using resources readily available, such as various APA position papers and the ACGME's policy manual and web site, departments or training programs can develop an "Appropriate Treatment of Residents" document to serve as an explicit statement of expectations of faculty in a training program. This document serves two purposes: 1) as a statement of the terms of the contract between faculty members and residents, and 2) as the basis for education of both parties about what is expected in the training program. Once the terms of the faculty-resident relationship are fully explained and accepted by all participants, unintentional or inadvertent ethical problems will be prevented, and residents will be in a position to report faculty behaviors that do not conform to these agreed-upon expectations.

Recommendations

1. Ethics education should be a central component of resident training. We recommend that training programs develop or adopt a document on "Appropriate Treatment of Residents" that explicitly outlines ethical responsibilities in the faculty-resident relationship. This document could be used as a guide to clarify faculty members' ethical responsibilities toward residents.

2. Questions that measure the extent of faculty adherence to these standards should be included on evaluations completed by residents for each rotation.

3. Clear procedures should be developed for handling ethical lapses reported by residents. To the extent possible, these procedures should emphasize collegiality and collective problem solving, as opposed to divisiveness and polarization. We suggest that residents work within the established hierarchical structure. An important resource for residents concerned about training program issues is the Accreditation Council for Graduate Medical Education (ACGME) at www.acgme.org.

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References

1. Igartua K: The impact of impaired supervisors on residents. Acad Psychiatry 2000; 24:188–194
2. Igartua, op cit
3. Kant I: Foundations of the Metaphysics of Morals (Lewis White Beck, Trans.). Indianapolis and New York, The Bobbs-Merrill Company, 1959 (original work published 1785)
4. American Psychiatric Association: The Principles of Medical Ethics, With Annotations Especially Applicable to Psychiatry http://www.psych.org/psych_pract/ethics/medicalethics2001_42001.cfm
5. Brody H: The physician/patient relationship, in Medical Ethics. Edited by Veatch R. Boston, John & Bartlett Publishers, 1989, pp 65–91
6. APA, op cit