Case 1

You are precepting in an acute concerns walk-in clinic in your program-based Primary Care Practice in mid-May.

Mary is one of the interns who just started this Outpatient Pediatrics rotation on Monday. She is presenting a 3-year-old patient who was seen in the ED yesterday evening for a rash and diagnosed with Henoch-Schonlein Purpura (HSP). She is following up in the Clinic as instructed, with new complaints of abdominal pain and decreased oral intake.

Mary describes that the patient has not had fever or emesis. She notes that the rash remains unchanged from that which was described in the ED last night. She does not report anything about oral intake or abdominal pain. She says that the patient's heart and lung exams are normal, and again describes the rash. She does not mention an abdominal exam or anything about hydration status (mucous membranes, skin turgor, etc.).

She does not offer an assessment, but goes right into her plan, which is to treat the pain with Tylenol and to encourage fluids at home.

Case 1 Further history

Mary's continuity clinic is in a private office in the outlying community, and this is her first experience at the Primary Care Center and on an outpatient Peds rotation. She has not yet seen a patient with HSP as a resident, and didn't learn much about it as a medical student. Additionally, the clinic is quite busy today, and her co-intern had to leave for his own weekly outlying continuity clinic, so Mary and the senior resident have been busily seeing patients all afternoon. Mary didn't have a chance to read about HSP prior to precepting with you, nor did she have the opportunity to ask the senior resident about this illness.

Case 2

You are at the end of your first of two weeks on inpatient service with one of the interns Veronica. This is your first time working with Veronica, but you have been looking forward to working with her, as she seems to be generally well liked by the housestaff and many of your colleagues.

As the week has progressed, you begin to notice some possible deficiencies in Veronica's work. When the fellow has asked questions of her directly, she often responds, "I don't know," or, "I didn't ask that," to many of the questions. She often injects some self-deprecating humor to lighten the mood. Yesterday, when you checked in on the status of the Infectious Disease consult on one of her patients, she apologized because she hadn't called them yet. She had been working on her progress notes most of the afternoon, though she joked about prioritizing her online shopping. This morning after rounds, the senior resident approached you to voice similar concerns. "It seems that she just doesn't really care," said the resident.

Case 2 Further History

Veronica comes from a family of physicians. In fact, her father, a thoracic surgeon, is an associate dean at your medical school. She attended an Ivy League school for undergrad and attended your affiliated medical school "because it was free!" She enjoys being in your city and your program, and she has lots of friends and family locally. She does not endorse any social stressors. She has never received any substantial constructive feedback.

While historically very confident in her academic skills, she has doubted herself through much of intern year. The work is so much harder than she anticipated. She feels that her knowledge base is far below her peers, and she is afraid that this hinders her work. She often puts off doing work—like calling a consult—because she is unsure how to approach it and this makes her feel stupid. She has found that others—like her seniors—will do her work for her if she puts it off and apologizes with humor. She is learning by observing what seniors are doing, but she admits that she is not learning as fast as she probably should.

Case 3

Drew is a second year Pediatric Emergency Medicine fellow. He is an enthusiastic teacher in the ED, always engaging residents and students for teaching points during shifts. He also loves the technical and procedural elements of Emergency Medicine, and demonstrates competency for most procedures.

During the shift, Drew calls you as the attending and states "We have a really sick kid in room 2, I'm going to intubate." Upon your arrival, the patient is a complex medical patient well known to the staff in the ED and some of the residents working in the ED. He is ill, but overall he is close to his baseline per those that have cared for him on the floor and is currently stable. You ask the fellow to assess the clinical situation and delineate his management strategies. As he is preparing equipment for an advanced airway, he responds, "Altered mental status, I need to intubate." You press him a little further and ask what is on his differential and what other things he might consider for his management. He responds; "He has altered mental status. If you weren't here, I would intubate."

Case 3 Further History

After the patient is stabilized, you as the attending review with Drew the pertinent aspect of the case including differentials and alternative management strategies for the situation. You offer your thoughts on the case, specific aspects in his patient care that he could improve upon, and are clear regarding various styles in management strategies. He again states, "This is what I would have done if you weren't here." Later in the shift he comes back to you and reports that he has polled the other attendings in the ED and they all agree with his management of the patient.

Case 4

You are the attending on service in early February. You have been feeling tired all week, having stayed up late the Sunday night before this week on service started to watch the Super Bowl after your favorite team's truly miraculous run to make the playoffs and sweep their way through the playoffs. You thought it was not the best idea, but—since they won!—you are glad you did it. However, you haven't had a chance to catch up on sleep, as you've been staying late at work to finish your notes and then staying up late when you get home to finish a manuscript that is due next week.

Susan is your acting intern. The senior resident has reported to you that Susan seems disorganized and has difficulty following through on her patient care responsibilities in a timely manner. He is also concerned that Susan has a weak fund of knowledge. You have noticed that she does indeed appear disorganized and distracted, but you had not noticed any issues with her medical knowledge, and she seems to get along well with other members of the health care team.

Case 4 Further History

Susan is married and has a 2 year-old son who attends day care near her home. Her husband works full time. She has a 45-minute commute to work and finds it hard to be at day care on time to pick up her son at the end of the day. Furthermore, her son has been ill, requiring her husband to miss work, and she has been up late at night caring for him. She is having difficulty balancing her personal and professional responsibilities and is stressed that she is not doing a good job either at home or at work. Susan feels rushed and tired, and she finds it hard to organize her day. She has never experienced this before and is embarrassed that the team has noticed.

Your observation of Susan admitting an infant with failure to thrive reveals the following:

Susan has a good rapport with the mother but takes a scattered history. She writes her admission note before entering any admission orders, resulting in a delay of any orders being carried out. Her presentation during rounds is not well organized, and her differential for the failure to thrive is rudimentary.

Case 5

Rick is a first year Heme-Onc fellow at a large academic center where he also did his residency training. During residency his performance was excellent and his evaluations throughout were consistently exemplary. Throughout the first year of fellowship, the pediatric residents have approached you as their residency program director regarding Rick. They report that he is very short with them on the phone when they call with questions on admissions to the Heme–Onc team or regarding management of the patients on the team. The residents report that he does not keep them updated with plans on the patients, and the parents and families are constantly asking nurses to page the residents because they are frustrated. During rounds, he is over-critical of the residents' presentations without doing much teaching, provides no feedback, and essentially "barks orders" at them throughout rounds. He has also been known to pull residents from protected educational sessions to place orders for patients on the Heme-Onc team.

Case 5 Further History:

Rick was an outgoing and friendly resident that was well liked by his co-residents and faculty. He is excellent with patients and families and always "got the job done" on all his rotations, but especially Heme-Onc. Comments in his residency evaluations consistently point out his friendly attitude, jovial personality, and outgoing demeanor in his approach to residency. Milestone data from resident evaluations reflect that he has good medical knowledge but that he scores lower than average in his resident class. There is very little in the way of specific comments regarding his leadership or teaching skills throughout residency.

When asked how things are going he reports that "the call nights are brutal, the pager literally goes off every 10 minutes." He states that he is trying to run a super busy service and isn't sure that he is really "getting" Heme-Onc. He hasn't been sleeping well on his non-call nights worrying that he might have made the wrong choice. The faculty in the Heme–Onc division have noticed that he is not as "smiley" and happy as he was as a resident and have been double-checking all of his plans very carefully due to several near-misses in medications and management since starting fellowship.

Case 6

Anna is a second year Neurology Fellow at a large academic center. She previously was a chief resident from a smaller, very well respected pediatric residency. The current residents in the program really like Anna as she is kind and always listens to their clinical concerns. She is extremely well regarded by the patients and families in the neurology department for her kind demeanor and warm bedside manner. You as the fellowship program director have received several emails and multiple evaluations commenting on her taking an extremely long time to return pages and performing bedside consultations. You have also been made aware that she seems to order many more laboratory tests/radiographs, asks for more data before making a management plan, and admits far more patients than her fellow colleagues. She also is known to be at the hospital doing clinical work late into the night, even when she is not on call, occasionally causing her to have duty hour violations.

Case 6 Further History:

Anna did her residency training at a small program. It was a program that allowed her to carry a small patient load on many rotations and do substantial reading about her patients. As the fellowship director, you met with her to discuss her performance. She loves her patients, the fellowship, and living in your city. She reports that the acuity and the complexities of the patients she cared for during residency were different from the ones during her neurology fellowship. She reports that she has a basic knowledge of pediatric neurology but had never been given very much autonomy as a resident. She feels that no one has really taught her how to be a fellow and about the transition into leading the team or running a complex neurology service.