Lawson ND, Kalet AL. The Administrative Psychiatric Evaluation. *J Grad Med Educ.* 2016;8(1):14-17.

Supplementary Content. Additional Case Examples.

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Supplemental Case 1

Lakeisha is a postgraduate year 1 resident in obstetrics and gynecology. One day, she accidentally discharges a patient on hydralazine 50 mg PO q6h instead of hydroxyzine 50 mg PO q6h, though the patient calls her before any harm results. The program is not aware that Lakeisha has any medical or psychiatric conditions. May her program request an administrative psychiatric evaluation?

Comments: No, because there is no reason to believe that her performance problems were caused by a psychiatric condition.

Medication errors are common. Gandhi and colleagues[1] found that 7.6% of outpatient prescriptions contain an error; 43% of those errors have potential for patient injury, and 26% are potentially serious or life-threatening. The rates of prescribing errors in residents are reviewed in Honey et al.[2]

Program directors may want to know how much evidence of potential harm is needed to request an administrative psychiatric evaluation. In Lakeisha's case, one error such as this is not sufficient to warrant a request for administrative psychiatric evaluation, but it is difficult to determine a precise threshold of errors or other evidence to substantiate a direct threat to patients.

Instead, programs should evaluate the strength of the link between a resident's risk of harm and his or her suspected mental disorder. For example, social anxiety disorder is not likely to be related to the medication error. By default, programs should treat problematic performance as a performance issue unless there is a clear connection to a psychiatric condition.

Supplemental Case 2

Jing is a postgraduate year 2 internal medicine resident whose diagnosis of generalized anxiety disorder is known to her program. On her most recent rotation performance evaluation, she received an average score of 3 for medical knowledge (on a 1-9 scale), but there have been no incidents to raise concern for patient safety under her care. What is the appropriate course of action for her program to take?

Comments: The hospital cannot require an administrative psychiatric evaluation. There is no reason to believe that her performance problems were caused by her condition.

Instead, this resident may be offered remediation. The opportunity for remediation is an essential part of due process for residents,[3] and it has a very high success rate. Dupras and colleagues[4] found that all ACGME core competency areas save professionalism were successfully remediated in the majority of cases. Zbieranowski et al[5] found that 78% of residents both successfully completed remediation and graduated from their residency programs. Guerrasio et al[6] reported successful outcomes in 90% of cases, and found that only one competency area required a significant increase in faculty face time to assist in the remedial process. Clearly, remediation is a first-line strategy for correcting performance deficiencies.

Strategies to ensure successful remediation have been reviewed in other sources, and readers are encouraged to visit those sources for additional information about this topic.[7,8,9]

Supplemental Case 3

Cathy, the Director of Graduate Medical Education (GME) at a teaching hospital, is approached by a resident who believes he is being required to submit to an unwarranted administrative psychiatric evaluation. Cathy agrees and submits the matter to corporate compliance, which declines to intervene. What else can she do to ensure the equal rights and treatment of the resident?

Comments: Cathy did the right thing when she filed her report. But she cannot rely on institutional or even ACGME policies to provide adequate protections for the residents at her hospital. For example, the ACGME Institutional Requirements state that an institution need only have a policy that deals with harassment complaints.[10] That policy could be to do nothing; the institution is not obliged to abide by the policy; and the policy need not be effective in order to comply with the requirements. Cathy might fear for her job if she is seen as going against the interests of the hospital. But there is still a lot she can do.

Most of all, Cathy must make sure that this resident's program director, the Designated Institutional Official (DIO), corporate compliance officers, deans, and members of the grievance panel are familiar with the Americans with Disabilities Act (ADA) laws and their applications to requests for administrative evaluation. She can accompany this resident on important meetings so that she may be able to give a full account of the proceedings in the event she is subpoenaed. Cathy can make sure that relevant documents are put into this resident's file where he can see them, and she can ensure that important or submitted files reach the members of the grievance committee.

Concerned GME members such as Cathy are crucial to increase awareness of the issues described in this article, which have so far received relatively little attention in graduate medical education. Disability discrimination in medical education is more common than discrimination based on race, religion, or gender,[11] yet a meta-analysis of 177 articles on discrimination in medical education reported no studies on disability discrimination.[12] This is a problem

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that is very infrequently discussed in the medical community, though it will demand the attention and active involvement of everyone to change.

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The analysis presented here is an informal discussion of the issues raised and does not constitute an official position of the US Equal Employment Opportunity Commission. The views and opinions of this article reflect only those of the authors, as cited. The article considers residents to be employees for legal purposes.

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