The “Hateful Resident”

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In a 1978 article entitled “Taking Care of the Hateful Patient” James Groves¹ identified 4 types of patients who induce “hateful” feelings in medical providers. The 4 types overlap considerably with personality disorders (TABLE). Groves’ seminal article identified a common, yet hidden fact of patient care—that certain patients evoke strongly negative feelings in their providers. This insight runs counter to the ideal that providers should “love” all of their patients. Having hateful feelings toward difficult patients is normal and can provide useful diagnostic information. Awareness and acceptance of these feelings can lead to better outcomes, both for providers and the patients they serve. The relevance of Groves’ initial article to contemporary medical practice is demonstrated by the fact that multiple articles based on his model, many evidence-based, have been, and continue to be, written since its initial publication.²

In our experience, Groves’ insights are applicable to residency education. Physicians are a cross-section of the general population and may exhibit many of the same challenging behavioral patterns in their interactions with others. “Hateful residents” can be characterized into the same 4 categories that Groves uses to describe “hateful patients” and they evoke similar negative emotions (TABLE). Such hateful residents may take up an inordinate amount of educators’ time, frustrate efforts by these educators to assist them, and resist efforts to be remediated.³ Consequently, upon graduation these residents are challenged with finding faculty who will write positive letters of recommendation for them.⁴ Hateful residents exhibit inadequate professionalism and/or interpersonal communication, yet traditional evaluation methods used in residency education often fail to identify these deficiencies clearly and early in their training.⁵

Our goal in writing this article is to use Groves’ typology to help residency educators identify specific categories of hateful residents early on in their training, make appropriate assessments, and implement useful

strategies for remediation. Educators hoping to manage stress levels generated from the difficult issues posed by these residents will do well to consult with, and gain emotional support from, other colleagues or by presenting such cases in Balint groups or other personal and professional development groups.⁶ With difficult residents, as with difficult patients, one does not want to “fly solo.”

The Dependent Clinger

Overview

Residents who are *dependent clingers* often begin residency with glowing statements about the program. Early on, they may solicit a “special” relationship with a faculty member. A faculty member thus “chosen” may be enticed by having an appreciative physician-in-training under his or her wing and give special attention to this resident. Groves might refer to this as the “honeymoon phase.” Over time, residents who are dependent clingers become increasingly critical of the program. Such residents will escalate their complaints to their advisor or other superior and may call or e-mail them at home or at inappropriate times. At this point, educators may feel that they are in “over their heads” and become increasingly avoidant toward this type of resident. The resulting tension in the relationship may be hard to tolerate over the remainder of the residency. Such residents may have a dependent personality disorder or borderline personality disorder.

Emotional Cues

Avoidance, feeling overwhelmed or “sucked in,” feeling manipulated by praise.

Tips

- Early recognition: Repetitive after-hour pages and calls to an advisor’s or program director’s home are signs of possible budding dependency. Educators who feel overwhelmed by the emotional needs of a resident and who engage in subsequent avoidance of that resident may know that they are dealing with a dependent clinger.
- Boundary settings: Educators are encouraged to know and state their boundaries. Residents should be encouraged to follow protocol regarding complaints (ie, follow the chain of command and leave e-mail or voice mail messages at work).

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- **Detriangulate:** Residents should be encouraged to go directly to the appropriate parties with complaints, dealing with their complaints directly rather than going through a mediator.
- **Social support:** Residents having difficulty adjusting socially to training should be encouraged to find appropriate sources of emotional support (ie, family, counseling, support groups).
- **Self-care:** Explore the possibility of burnout or depression. If these factors are identified, encourage the resident to seek the assistance of a counselor, mentor, or physician, if appropriate.

The Entitled Demander

Overview

Residents who are *entitled demanders* expect and feel entitled to special treatment from their residency program. Such residents seem to feel “entitled” to setting their own rules (ie, deciding when they must go on vacation, or what call schedule they will agree to) and cannot understand why the residency program cannot accommodate their needs. When triggered, these residents may threaten their residency educators with reporting them to the head of the program(s) or offering a bad review on the Accreditation Council for Graduate Medical Education’s Resident Survey. Educators may find it difficult to manage their negative feelings toward such residents and might engage in a futile “counterattack.” Such residents may have a narcissistic personality disorder and, for many educators, may pose the most difficult challenge of all 4 types of hateful residents.

Emotional Cues

Anger, disbelief, disgust, desire to counterattack, avoidance.

Tips

- **Immediate follow-up:** Educators need to meet immediately with the resident post violation along with as many affected parties as possible.
- **Documentation:** Document in writing all feedback about resident in question.
- **Boundaries and consistency:** Review the rules and expectations with the resident and reinforce to the resident that the rules apply to everyone without exception. Document this conversation in writing.
- **Emotion management:** Contain the desire to counterattack and “put the resident in his or her place.”
- **Probation:** If the entitled behavior is repeated, immediately warn the resident verbally that further breaches will result in probation and document this conversation in the resident’s file. Also ensure the resident understands what the implications of

probation would be (in regard to job references, credentialing and licensure, etc). Another faculty member should be present for this conversation. We have found that documenting the conversation in a letter sent to the resident’s home is very effective. Proceed to probation and, ultimately, termination if necessary.

The Manipulative Help Rejecter

Overview

Residents who are *manipulative help rejecters* may repeatedly complain about the residency or their personal lives but dismiss concrete suggestions to improve things out of hand. These residents need to share pessimism but wish to stay stuck. Their complaints seem sincere and as such can easily evoke sympathy. As might be expected, however, their repeated refusal to take responsibility for their problems can wreak havoc on resident morale and make residency educators feel frustrated, inadequate, and hopeless. It is these feelings that can provide a clue that the residency may have a manipulative help rejecter on its hands.

Emotional Cues

Anger, inadequacy, avoidance, pessimism.

Tips

- **Do not offer advice:** Solicit the residents’ input about what they have already tried for their problem and what their ideas are for fixing it.
- **Share pessimism:** Let the residents know that there may not be a quick fix to their problem. If the problem revolves around the program or clinic, let them know that while their input will be considered, “the program is what it is.”
- **Find a venue for their input:** Invite residents who are manipulative help rejecters to be part of curriculum planning so that their input can be heard. However, under no circumstances should they be put on the recruitment committee.
- **Solicit support:** Faculty members need to support each other in normalizing their feelings of inadequacy evoked by this type of resident.

The Addict (*Note: For sake of clarity, we have retitled Groves’ fourth category of the self-destructive denier as the addict*)

Overview

All residencies sooner or later deal with the addicted resident. Addressing alcoholism and other addictions in residency is essential to protecting patients’ lives and saving the careers of such learners. However, efforts to intervene with addicts in residency are usually met with anger, denial,

TABLE OVERVIEW OF CATEGORIES

	Dependent Clinger	Entitled Demander	Manipulative Help Rejecter	Addict
Characteristics	Bottomless need; splitting	Intimidation; entitlement	Yes...but	Unconscious suicide
Feelings evoked in providers	Aversion	Fear; counterattack	Guilt; inadequacy	Hopelessness; anger
DSM-5 diagnosis	Borderline and/or dependent personality disorder	Narcissistic personality disorder	Somatic symptom disorder; illness anxiety disorder	Antisocial personality disorder; substance-related and addictive disorders
Tips	Early recognition; clear boundaries	Redirect entitlement	Share pessimism; elicit solutions	Compassion; referral; consultation

Abbreviation: DSM-5, Diagnostic and Statistical Manual of Mental Disorders (5th edition).

and defensiveness. Many useful articles have been written about dealing with impaired residents.^{7–10}

Emotional Cues

Hopelessness, inadequacy, fear of attack, wishing that the problem would just “go away.”

Tips

- **Collaboration:** Educators concerned about addiction in a resident should work closely with their state’s impaired physician program. The chair or residency director should work closely with the resident’s advisor and the program’s behavioral scientist or another mental health professional.
- **Early index of suspicion:** Complaints about problem drinking and/or observations of excessive drinking or drug use should be taken seriously.
- **Nonjudgment:** Impaired residents should be approached firmly but compassionately.
- **Referral:** Residents suspected of substance abuse should be referred to a specialist for evaluation. If possible, referral to an in-house Employee Assistance Program and/or your statewide impaired physician program is highly recommended.
- **Confidentiality:** All discussions/interventions concerning possible resident substance abuse need to be confidential. If necessary, impaired physicians may need to take time off for inpatient treatment. Upon return, their schedules may need to be modified to the program to allow them sufficient time to attend outpatient treatment.
- **Education:** All incoming interns should be educated about the prevalence of substance abuse among physicians and guidelines for what to do when a

fellow resident is suspected of having a substance abuse problem.

Summary

This article applies a descriptive, patient care model of the hateful patient to residency education. It is our belief that having a descriptive model for hateful residents, including the unpleasant emotional reactions evoked by such learners, will help educators better manage their own negative feelings about these residents and implement effective early intervention strategies.

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