04 March 2017

Dear Trauma Surgeons,

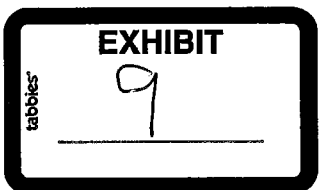
Thank you for taking the time this past week to give me feedback on my recent rotation with you. Although I do concede that my knowledge base has been my weak point in the past, since I learned of the resource of the learning analyst, this is improving. I have been taking advantage of the tools she has shared with me since working with her, starting this past November. My learning has become more effective as a result. I would also point out that in none of my formal evaluations did any attending give me anything less than a 4/6 (basic mastery) for medical knowledge.

However, I would like to officially disagree with several points made in the trauma service consensus evaluation letter given to me on Thursday. Of note, in four months of the trauma rotation most of these significant criticisms were not brought to my attention in order for me to address them. Only this past Thursday, after completing my rotation, have most of these concerns been discussed with me – too late for me to take corrective action during my trauma rotation.

Regarding the statement that my surgical skills are average to below average, from the attendings that provide me autonomy in the operating room (ie – not scrubbing into the case, allowing me to operate without prompts, or allowing me the role of primary surgeon), my operative evaluations have been positive and on par with my peers. These verbal evaluations have come from Drs. Pieper (he also sent the email evaluation), Naughton, and Boecker. My only New Innovations SLU Trauma evaluations are as below:

8/23/2016: 8/9 in evaluations related to surgical skill – Dr. Boecker
9/16/2016: "...Good technical skills." 6/6 in all evaluation fields. - Dr. Boecker.
9/10/2016: 4/6 in technical skill – Dr. Mahoney
11/3/2016: 5/6 for technical skill – Dr. Mahoney
11/3/2016: 5/6 in technical skill – Dr. Boecker
2/3/2017: 5/6 in technical skill – Dr. Tenquist
2/22/2017: 5/6 in technical skill – Dr Boecker
3/1/2017: "On technical surgical skills, Dr. Rice has a very strong interest in learning and is aggressive about pursuing cases and procedures. At this point, I would say she is average in her technical performance. She is able to handle cases that a fourth year resident should be able to perform, but I would not yet hand over a complex technical procedure to her." - Dr. Pieper via email including to Dr. Freeman

You assert that I possibly place the trauma patient at risk if I am not re-directed. Please provide an example. On the contrary, there have been multiple occasions in which I have managed critically-ill patients for hours, even after the attending has left the trauma bay. On 3/1/2017, Dr. Pieper wrote, "Dr.



Rice has a good understanding of surgical/critical care management for trauma patients. I would say she is above average in this area compared to her peers." I have had no poor patient outcomes or negative feedback on which to base this letter. On "systems based practice" which encompasses the promotion of patient safety and participating in standardized treatment plans and algorithms, I scored 4/6 or 5/6 in this evaluation category by all who evaluated me – Drs. Tenquist, Boecker and Mahoney.

In regards to the criticism of having difficulty with trauma patient disease processes, in the meeting today, Dr. Rand gave the example of debating the use of IV contrast for acute versus chronic renal failure patients. While, in this example, I knew that the patient was on dialysis, I was not sure if the patient had any remaining kidney function or if her dialysis schedule would need to be altered after administration of contrast. Not yet knowing the new patient's history, meeting her in the trauma bay, I felt that this was worth discussing. If there was concern about my knowledge base in this area, we could have discussed the topic at that time rather than have the uncertainty end up as an issue of final evaluation.

The letter states that I have difficulty fully synthesizing a comprehensive plan for the patient. As I discussed today, my days on trauma service typically went smoothly as I evaluated the trauma patient then called you with my findings and plan. In general, my plans were accepted and care moved forward. In support of this, Dr. Pieper wrote in his evaluation on 3/1/2017 that I have quickly improved in this area and have good reasoning behind my plans.

Regarding the accusation of difficulty in prioritizing as chief, as well as missing rounds and plans for other patients while talking for over an hour with one family, there is only one example of this of which I am aware. This particular family had a history of being very difficult (litigious and was planning to sue the neurosurgeon) and had already been talked to at length by Dr. Rand, then by me, then the next day by Dr. Draper (who, as a result, missed giving a lecture to the trauma service), then by me and Dr. Tenquist together, then by me again the following day for about an hour. In the end, the family voiced gratitude for my explanations and time. Not only was I able to prioritize my other duties, for the whole month of January I successfully juggled the role of chief of trauma ICU in the absence of the fellow, in addition to being chief of the floor service, trauma activations, and operations. This required extensive delegation to other residents, medical students and nurse practitioners to keep the service running smoothly. It was challenging, but there were no major problems or bad patient outcomes. Additionally, it is often that the trauma chief is unavailable for rounds due to duties in the trauma bay, OR, ICU or other patient care situations. This was not unique to me. Being able to speak with patients and families is an important aspect of a chief's duties. In particular, Dr. Pieper commented on 3/1/2017, "Mandy is excellent in communication with patients and their families. She can speak with them in a compassionate manner, and she can explain their condition as well as treatment plan/surgical procedures in a way patients can understand."

Regarding the criticisms of rigidity and inability to adapt, I noted that Dr. Mahoney had commented on this topic several times during my first and second months as a fourth year. More recently, however, Dr. Boecker recognized that I was growing in this area and was "learning to adapt." Additionally, in the meeting today, Dr. Naughton read over the trauma consensus letter, which appeared to be his first time to see it, as he verbally dissented from the statement of my being rigid.

In regards to the comment that as stress increases, my personality changes and I become unable to process feedback, I am not sure of the origin of this, unless this is in reference to a few episodes with Dr. Freeman. I recall times, specifically during one of his call weekends, when there were difficult interactions between us. I did become frustrated in the trauma bay when Dr. Freeman was excessively critiquing many minor details of several procedures to the point that multiple people in the trauma bay discussed how frustrating it was after the fact. One physician purposefully distracted him in order to remove him from the room and thus diffuse the tension. In addition, the following day he acted apologetic and we both made jokes about how frustrating it was. To be sure, I have witnessed most attendings' personality change under stress.

Regarding the critique that I want to please all, which could interfere with my leadership ability, I do understand my tendency towards avoiding confrontation with many attendings. I admit to finding some of them more difficult than others, and I do try to avoid discomfort with them when possible. Specifically speaking to interfering with the running of the service, please provide examples of the service suffering as a result of my desire to work smoothly with others, to network, to collaborate and cooperate instead of dictate, when unnecessary. On the contrary, my exquisite ability to communicate and network with other services has led to continual, unsolicited positive feedback from staff, residents and attendings from the departments of radiology, ED, medicine, anesthesia and other surgical services over these four months as trauma chief. As an example, I received a text on 2/19/2017 from the administrative ER chief resident, "I always like when you're on, and I've learned a lot from you over the days. Thought you should know that we all really appreciate when you are on. Very easy to work with." In addition, Dr. Pieper wrote on 3/1/2017, "Dr. Rice is an excellent teacher to her junior residents and students, both on procedures and medical/surgical diagnoses and treatments." I would also refer you to the medical students' evaluations of me on Oasis which are positive for my ability to teach and lead the service. One student even stated that she changed her path from medicine to surgery after her experience with me on trauma. Again, the many roles that I filled in the month of January while the trauma fellow was off service speak to my ability to coordinate and lead.

A recurring theme in our meeting Thursday was a problem with my "niceness," which Dr. Freeman then stated may be interfering with the attendings' ability to assess me and my progression. This critique is vague and needs clarification. I don't believe that my personality has resulted in a problem or poor patient outcome and in fact I believe there is overwhelming evidence to the contrary.

In summary, I believe that the statements in your letter, the concern for my progression to fifth year, and the call for remediation with formal counseling sessions are generally unfounded. Furthermore, the very late voicing of many of your concerns, after the completion of four months on trauma service, robs me of my ability to have been able to address them during our time together and to have made improvements. The submission of your letter to my residency file greatly threatens my progression to fifth year. This comes at an especially critical time as I need to be gathering letters of recommendation and starting applications for trauma/surgical critical care fellowship.

I urge you to formally rescind your consensus trauma evaluation letter.

Sincerely,

Mandy Rice, DO