Remediation:
A Resident Improvement Plan

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Disclosures

- Dr. Brady – Board of Directors, ACGME
- Slides adapted from Dr. Bill Lobst, (ACGME)
- We do want to acknowledge:
  - University of Colorado Health Sciences Center
  - Emory University School of Medicine
  - Mayo Clinic College of Medicine
  - California Pacific Medical Center

Learning Objectives

- Develop a structured, consistent approach to problem residents
- Design a system for documentation
- Equip with tools to address remediation needs in all competency areas
- Recognize when remediation has failed

Outline

- Describe the magnitude of the problem
- Present a stepwise approach to creating a remediation program
- Discuss relevant legal issues
- Use sample cases to practice constructing a remediation plan

The Problem Resident

Why does it matter?

- Struggles in residency can predict struggles in future practice
- Working with learners is both an honor and a responsibility
- Hidden costs of problem residents
- Problem residents are everywhere

Internal Medicine Residency 2008

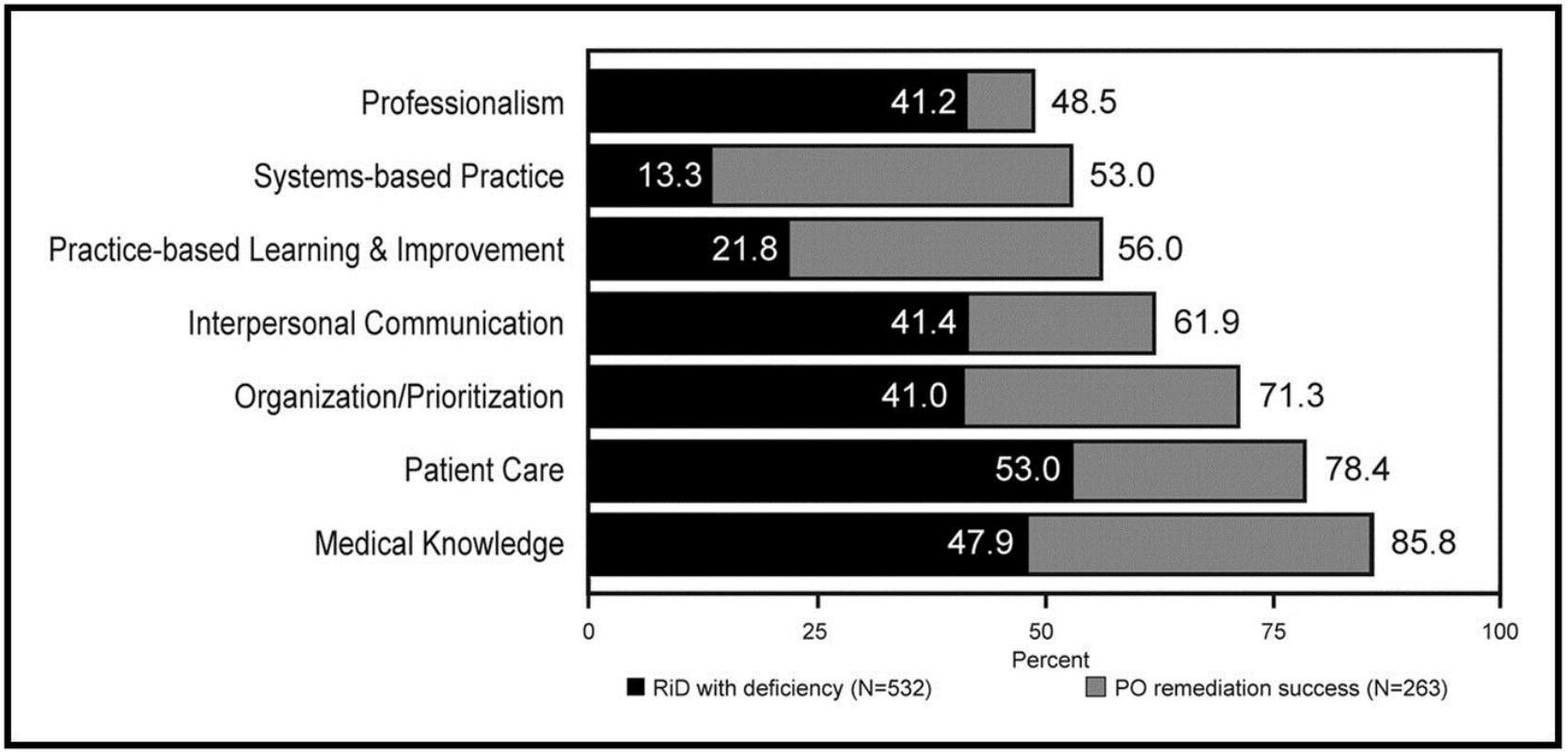
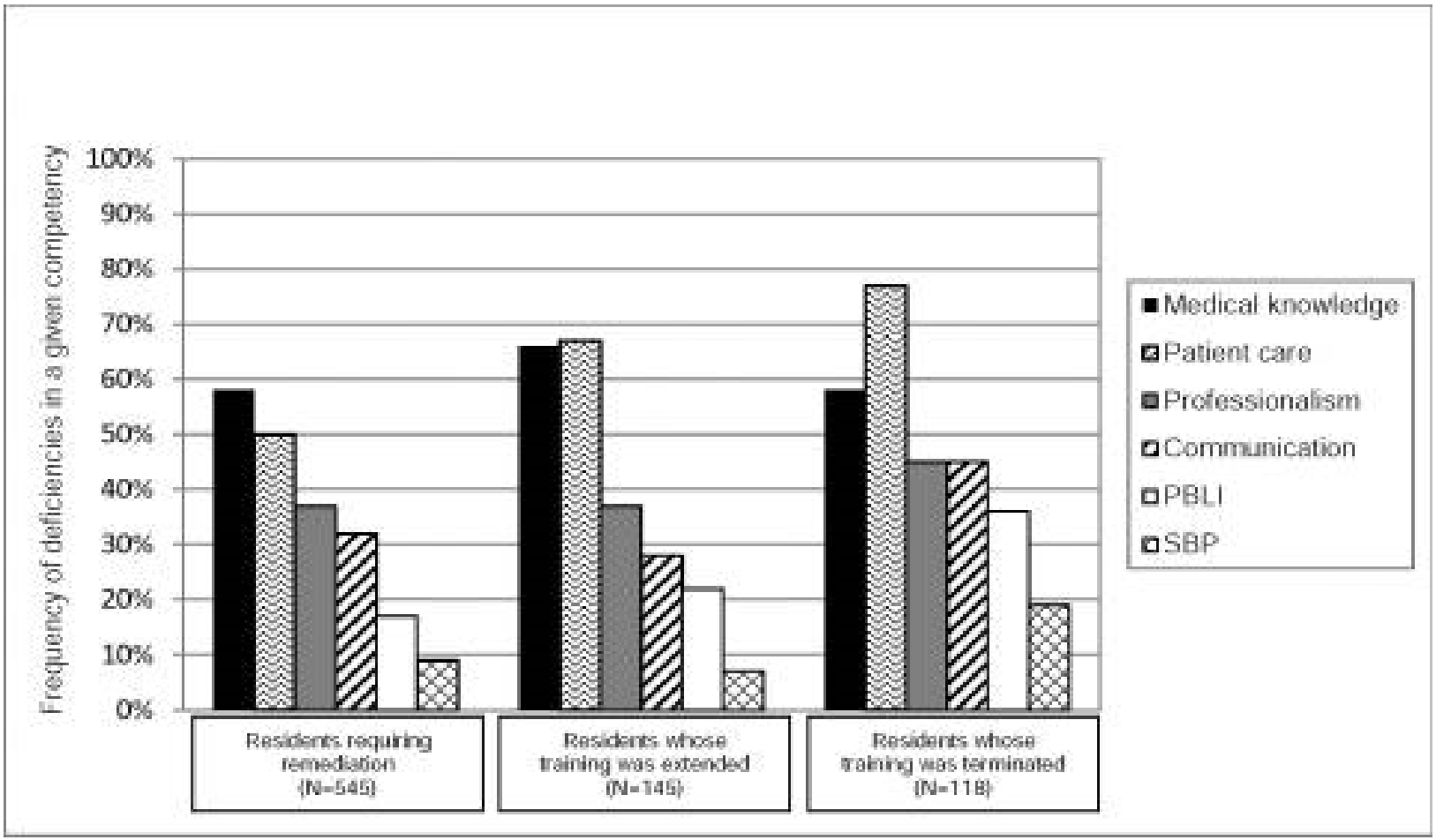


Figure 1. Comparison of reported competency deficiency frequencies in 532 residents with program directors (n= 268) estimated the likelihood of successful remediation. Dupras. Am J Med 2012

Remediation in Pediatric Residency



Riebschleger M. JGME 2013

Approach to Evaluation and Remediation

1 Identify & Define the Problem

2 Engage Resident in Self-reflection

3 Outline the Improvement Plan

4 Implement the Improvement Plan

5 Follow-up and Decision-making

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How do PDs become aware of problem residents?

Problem Identification

Most common event:

- Direct observation in clinical setting
- Critical incident/complaint
- Poor performance (morning report/ITE)
- Neglecting patient care responsibilities

Most common individuals:

- Chief residents
- Attending thru *verbal* comments
- Other residents
- Written comments from attendings less frequent, self and patients *rare*

Yao and Wright, 2000

Problem Investigation

- Preliminary data gathering
- Contributing Factors
- Look for Patterns
- List the Observable Deficiencies

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VANDERBILT UNIVERSITY

INTERNAL MEDICINE TRAINING PROGRAM

Resident Self-Assessment/Reflection

Name (Print)_____ PGY_____ Date_____

The Internal Medicine Training Program is committed to resident development of ongoing self-assessment and self- reflection skills. Each resident needs to complete the following self-assessment form prior to each 6-month formal meeting with program leadership.

PATIENT CARE competencies (gather essential/accurate information about pts; make informed decisions about diagnostic/therapeutic interventions based on pt information/preferences, up-to-date scientific evidence/clinical judgment; develop/carry out patient management plans; counsel/educate patients and families; perform competently all medical/invasive procedures essential for the area of practice.)

How I am doing ? (circle) Feel Uncomfortable Feel Comfortable Feel Very Comfortable
Need Improvement (circle) A lot Some Little to none

Area(s) in which I feel strong_____

_____

Area(s) I need to keep improving _____

_____

Specific objectives for next 6 months and strategies to achieve objectives
1._____

2._____

MEDICAL KNOWLEDGE competencies (demonstrate an investigatory/analytic thinking approach to clinical situations; know and apply the basic and clinically supportive sciences which are appropriate)

How I am doing ? (circle) Feel Uncomfortable Feel Comfortable Feel Very Comfortable
Need Improvement (circle) A lot Some Little to none

Area(s) in which I feel strong_____

_____

Area(s) I need to keep improving_____

_____

Specific objectives for next 6 months and strategies to achieve objectives
1._____

2._____

Practice based learning competencies (analyze practice experience/perform practice-based improvement activities; locate, appraise, and assimilate evidence from scientific studies related to pts' health problems; apply knowledge of study designs/statistical methods to the appraisal of clinical studies and other information on diagnostic/therapeutic effectiveness; use information technology to manage/access medical information.)

How I am doing ? (circle) Feel Uncomfortable Feel Comfortable Feel Very Comfortable
Need Improvement (circle) A lot Some Little to none

Area(s) in which I feel strong_____

_____

Area(s) I need to keep improving_____

_____

Specific objectives for next 6 months and strategies to achieve objectives
1._____

2._____

Secondary Causes

- Deprivation
- Distraction
- Depression
- Dependence
- Disordered Personality
- Disease

Reality of Secondary Causes

- Does not excuse poor performance
- May necessitate LOA/Fitness for Duty eval
- Evaluation by non-teaching physician (employee health)

Your role is as an educator, not a treating physician. You should not diagnose/treat your learners

Legal Issues to Consider

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CCC Resident Improvement Plan: RESIDENT B					
What is the deficiency	**Competency**	**Action Plan**	**Measures**	**Determination of Success**	**Timeline for Reevaluation**
1. Difficulty in consistently establishing an effective therapeutic relationship with patients and caregivers.	PC, Prof, ICS	1. Curriculum: emotional intelligence and ICS skills. 2. The Resident will meet with Improvement Coach every-other-week for 2 months to work through curriculum and complete assignments given by Improvement Coach.	1. Direct observations; OSCEs (evaluated by Improvement Coach) 2. Direct observations in clinic (performed by Dr. Peterson) 3. Inpatient evaluations	Milestone Evaluations of 3.0 with rare 2.5 in the areas of PC, Prof, and ICS	Revised to 5/1/15
2. Ineffective communication in interprofessional teams.	ICS, SBP	Peer Coach(es) will evaluate Resident on rounds as well as working with teams in order to provide real-time feedback Peer Coach(es) will provide information back to Improvement Coach so that structured reflection on this feedback can occur during every-other-weekly meetings	1. Direct observations by Peer Coach(es) who will complete Milestones Evaluation 2. Inpatient evaluations	Milestone Evaluations of 3.0 with rare 2.5 in the areas of ICS, SBP	Revised to 5/1/15
4. Resistance to feedback from others.	PBLI, Prof	1. Reflection exercises arranged by Improvement Coach centered on acceptance of feedback as a component of Emotional Intelligence	Every-other-week meetings and assessment of readiness to change as evaluated by Improvement Coach	Improvement in PBLI and Prof assessment done by Improvement Coach at weekly meetings	Revised to 5/1/15
6. Perceived lack of confidence and difficulty in supervising interns and students.	PC	1. This will be covered in the ICS and Emotional Intelligence curriculum delivered by the Improvement Coach	1. Direct observations by Peer Coach(es) who will complete Milestones Evaluation 2. Inpatient evaluations	Milestone Evaluations of 3.0 with rare 2.5 in the areas of PC and SBP1	Revised to 5/1/15

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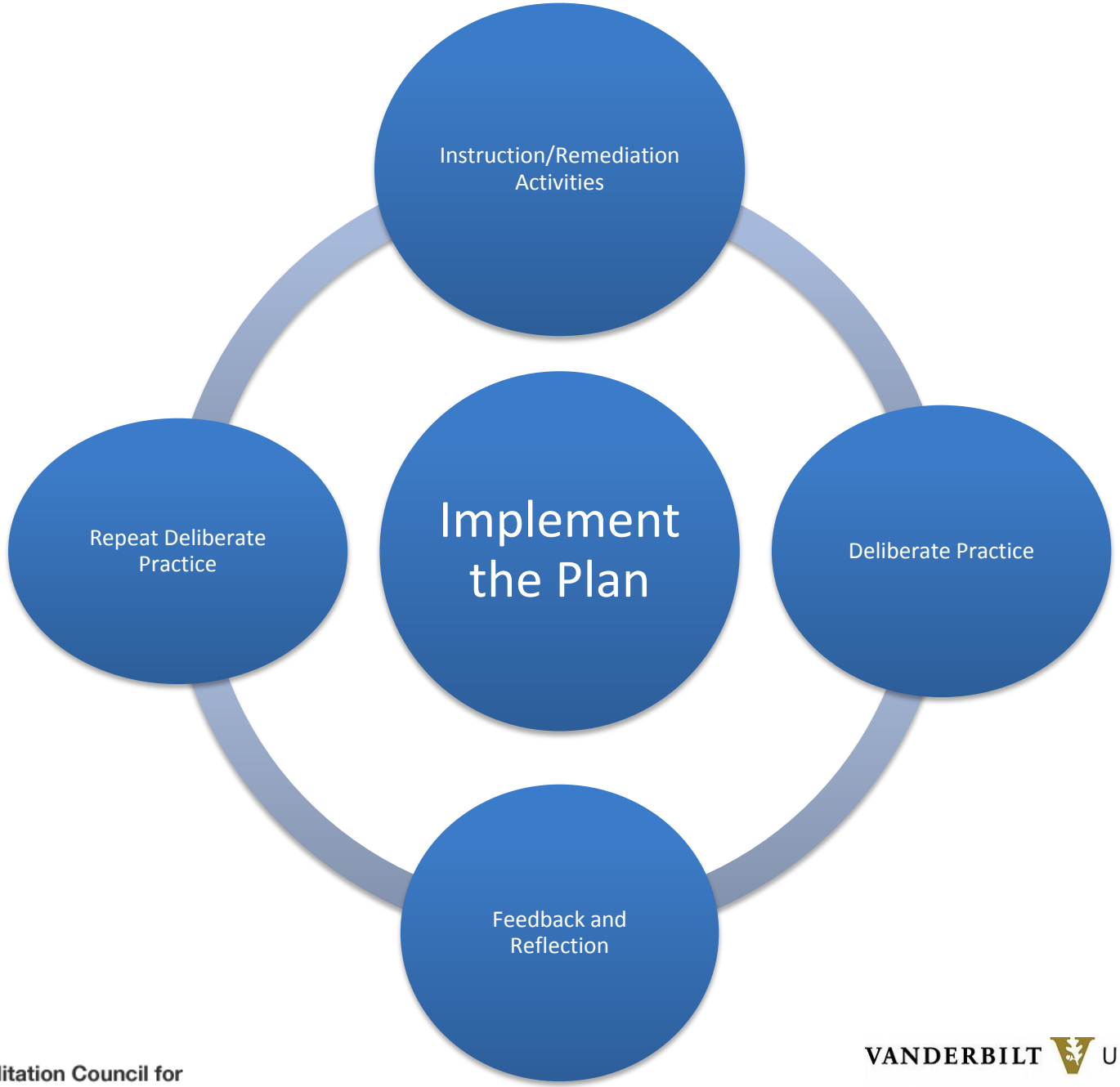
Implement the Plan

- Get Resident buy-in
- Delineate consequences of failure
- Assign mentor/advocate
- Document everything
- Protect resident confidentiality


Instruction/Remediation Activities
Deliberate Practice
Feedback and Reflection
Repeat Deliberate Practice
Implement the Plan

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Two Cases

1 Patient Care Concerns

2 Interpersonal Skills/Professionalism Concerns

Case 1: Patient Care Concerns

You, the program director, have received multiple emails from colleagues raising concerns about Intern A. Although it is late in her first year, she has been noted to be disorganized and overly verbose in her oral presentations. Although she is good at gathering information, she is having trouble synthesizing complex data. She is unable to articulate a differential diagnosis for her new patients and consistently defers to her upper levels to develop a plan of care. She has not been able to perform any of the basic procedures in her specialty. Your APD also notes that she has been consistently violating duty hours. She seems to be working hard but takes longer than her peers to get her work done. Review of her evaluations show that she receives high praise for ability to connect with patients and their families, her work ethic, and her genuine care and concern for her colleagues.

Case 1: Patient Care Concerns

- Medical Knowledge Deficiencies
  - Evaluate learner subtype
    - Lack of script recognition, Lack of script specificity
    - Premature closure
    - Lack of confidence
    - Incorrect causal attribution
    - Inappropriate adaptive inferences
  - Structured reading plan, accountability
- Clinical Reasoning, Clinical Skills
- Time Management

Case 1: Patient Care Concerns

- Medical Knowledge Deficiencies
- Clinical Reasoning, Clinical Skills
  - Direct Observation
  - Identify difficulties with problem representation, illness scripts, cognitive bias; physical skills
  - Recommendation: Buy-A-Qualifier, SNAPPS, Highlighter Exercise, Metacognition, Simulation
- Time Management

Case 1: Patient Care Concerns

- Medical Knowledge Deficiencies
- Clinical Reasoning, Clinical Skills
- Time Management
  - Peer mentoring
  - Teach practical skills, prioritization

Case 2: Interpersonal Skills/Professionalism Concerns

You, the program director, have received multiple complaints from your residents, fellow attendings, as well as staff regarding Resident B. He has been noted to be argumentative and difficult to work with. He tends to focus on small details rather than stepping back to look at the big picture and perseverates on topics to the point that efficiency is lost and patient care is compromised. He is unwilling to accept feedback. Both colleagues and staff describe him as aloof and cool, and concerns have been raised that he is unable to effectively demonstrate empathy to patients. He becomes easily frustrated with his patients and has demonstrated inflexibility. He is very hard working, often staying late to "read up" on his patients. His in-training exam score is one of the highest in his class and and evaluators consistently comment on his broad knowledge base and systematic evidence-based approach to patient care.

Case 2: Interpersonal Skills/Professionalism Concerns

- Evaluate external factors
- Videotaped patient interactions
- Observed H&Ps
- Cultural mentor
- Professionalism curriculum
  - Metacognition
  - Mindfulness
  - EI
  - Resiliency
  - Difficult Conversations

Pearls

- Structured, consistent approach
- Document
- Focus on PATTERN, not individual instances
- Focus on BEHAVIOR, not the person
- Require significant improvements

Legal Issues to Consider

"The fear is worse than reality"

Myth vs Reality

- Myth – I can avoid getting sued as long as I stick to my institutional and ACGME policies and procedures.
- Reality – I am likely to win any case as long as I stick to my institutional and ACGME policies and procedures.
- The key is focusing on the performance, not the person.

US Supreme Court

- "The courts are particularly ill-equipped to evaluate academic performance."

- Courts don't interfere with professional judgments if:
  - decisions fair and equitable
  - due process followed

Litigation in Medical Education

- 329 cases in ten year span (1993-2002); 171 involved residents
- 63% (108/171) were brought by residents
  - *40% named faculty members as co-defendants*
- 80% of claims directly challenged institutional actions (rejection, demotion, dismissal)

Trouble in Academia: Ten Years of Litigation in Medical Education Minicucci, R and Lewis, B

Litigation in Medical Education

- >50% alleged discrimination
- 13% Lack of due process claimed
  - Failure to have/adhere to established policies for reviewing, promoting, disciplining and terminating
- 13% Breach of employment contract claims
- 6% straight challenges to an institution's decision to dismiss.

>90% of the time institutional defendants "won"

Trouble in Academia: Ten Years of Litigation in Medical Education Minicucci, R and Lewis, B

"Employer"

- Definition – someone who is both an employee and a learner
- Not a student – not FERPA protected

- Residents are primarily employees
- *At the same time*, they are equally learners

Legal issues

- Academic issues of a learner
  - Knowledge-based
  - Lack of core competency
  - Lack of specialty training
  - Lack of introspection
- Misconduct issues of an employee
  - Dishonesty
  - Medical record forgery
  - Harassment
  - Disruptive behavior
  - Theft
  - Violence

Legal principles

- Judicial deference to the professional judgment in reviewing the entire record of the resident's performance
- Judicial support of reasoned academic decision making
- Judicial nonintervention

Cases

- **University of Missouri v. Horowitz** (1978)
  - Due process requirements for students
- **Marmion v. Mercy Hospital** (1983)
  - Non-cognitive issues and adverse effect
- **Kraft v. White Psychiatric Foundation** (1985)
  - Negative clinical evaluations and defamation

Missouri v. (Charlotte) Horowitz

- Performance - mixed
  - Excellent 1st 2 years
  - Clinical: Poor bedside manner, personal hygiene, inability to accept criticism
- Action – dismissal (student not present)
  - Multiple warnings
  - Multiple observers
- Suit
  - Due process violated
  - Religious discrimination
  - Decision based on “non-cognitive” factors, not performance

Supreme Court Decision

- Notice of problem and opportunity to cure
- Student received ample warning
- Decision at a regular faculty meeting called for the purpose (appropriate due process for students)
- Formal hearing/appeal not required
- Noncognitive factors are grounds for dismissal

Due Process for Academic Issues

- May dismiss/not promote if resident given:
  - Notice and opportunity to remediate
    - What is your policy in this area?
  - Hearing and time to prepare
    - What does your program/institution do?
  - Decisions that are careful and reasoned
    - Clinical competency committee

Policies & Procedures

- More complicated = harder to comply
- Policies *frequently* create a higher standard than required by law
- What you write = to what you must adhere
- Best to define **both** the policy **and** the process
  - Availability of evaluations
  - Availability of policies/procedures
  - Consistency in application

Marmion v. Mercy Hospital & Medical Center

- Resident terminated:
  - Failure to communicate
  - Refusal to consult with attending physicians
  - Refusal to follow hospital protocols
  - Disobedience and disrespect
- Faculty: future patients might suffer
- ***Court decision***: not necessary to show adverse effect in order to terminate (or suspend clinical activities)

Kraft v. William Alanson White Psychiatric Foundation

- Trainee denied certificate of completion - unsatisfactory clinical evaluations
- Alleged - defamatory statements by faculty
- Court found:
  - Negative evaluations were not defamatory
    - Relevant to evaluation with limited publication
  - Faculty protected by absolute privilege
  - Evaluation intrinsic to education
    - Implied agreement for evaluation

Legal Issues: General Guidelines

- Utilize your DIO & general counsel
- Know institutional procedures / policies
- Early problem recognition
- Make decisions by committee
- Communication and Documentation
  - Concerns
  - Expectations
  - Consequences
  - Remediation
- **Consistency is key!**

Communicating re: Adverse Actions

- Obtain permission to release
  - *Release to disclose ≠ release of liability*
- Educate about responsibility to disclose
- Answer questions asked
- Answer honestly and accurately
- State facts
  - *"Failed to meet standards of …"*
- Describe mitigating circumstances
  - *"occurred during personal stress"*

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