



Remediation of the “Problem” Resident

Harendra Arora, MD
Professor and Residency Program Director,
Department of Anesthesiology,
University of North Carolina School of Medicine

Disclosures

- I have no conflicts of interest or financial disclosures
- I am not an expert in remediation of “problem” residents

Learning Objectives

- Define “problem” resident.
- Identify “problem” residents in need of remediation
- Design a remediation plan that is specific to the learner’s areas of difficulty
- Identify resources to assist in remediation of a “problem” resident

Problem Resident: Academic and/or Misconduct

- “one who fails to meet the standard of performance in one or more ACGME competency.”
- We all have them
- We know when we see one
- “Problem” can present in different “forms”

“Problem” can present in different forms

Academic

- Patient care (PC)
- Knowledgebase (MK)
- Application of knowledge (PC, MK)
- Ability to improve (PBLI)
- Poor documentation (PC, P, SBP)

Conduct (or misconduct)

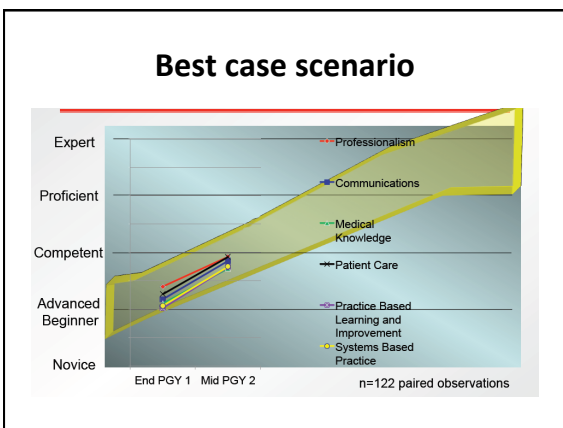
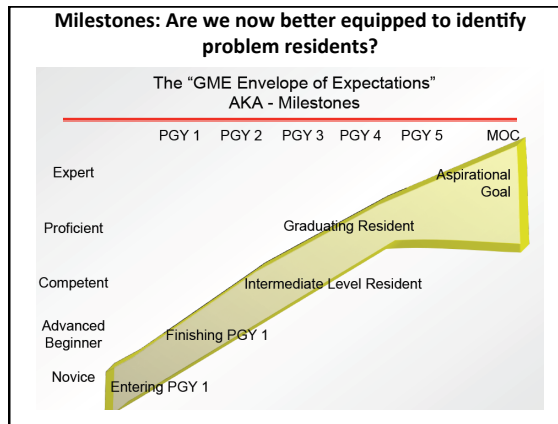
- Behavior (P)
- Violation or disregard of rules (P)
- Lying, theft, harm (P, PC)
- Poor communication skills (ICS)

Problem in dealing with “Problem” Resident

- Documentation by faculty often lacking
 - Unwilling to complete evaluations
 - Evaluations may not represent actual performance
 - Vocalize concerns but unwilling to document
- We are not trained in remediation of problem learners
- Problem presents in different shapes and forms

Residents: Students and Employees

Employees	Students
<ul style="list-style-type: none"> • No discrimination • Follow written policies • Comply with employment contracts • Provide notice 	<ul style="list-style-type: none"> • Feedback / assessments • Adequate opportunity for improvement / correction • Due process • Provide notice



Goal of NAS

The actions of the ACGME must fulfill the social contract, and must cause sponsors to maintain an educational environment that assures:

- the safety and quality of care of the patients under the care of residents today
- the safety and quality of care of the patients under the care of our graduates in their future practice
- the provision of a humanistic educational environment where residents are taught to manifest professionalism and effacement of self interest to meet the needs of their patients

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How to identify "problem" resident?

- Develop a comprehensive multisource evaluation infrastructure
 - Direct observation by faculty
 - Peer review from fellow residents
 - 360°s from patients, RN's, others
 - Conferences, Journal clubs, Case-based assessments, OSCEs, SIM
 - Timeliness of documentation (duty hour logs, case logs, etc)
 - Performance on ITE, Basic ABA exam

Identify "Problem" Resident

- Rule of thumb: Get faculty to
 - Document
 - Document
 - Document

Resident assessment fallacies

- Subjective assessment
- Inter-rater variability
- Resident or assessor having a "bad" day
- **Compensation fallacy:** Erroneously labeling residents as "good" who have some strong characteristics (professionalism) that "cancel out" their unsatisfactory characteristics (patient care/judgment)
- **Halo effect:** some residents are truly outstanding in one or two areas, and deficiencies in other areas are overlooked

Problems with Post-rotation Evaluations

- Grade inflation
- Attending physicians' lack of willingness to document poor performance
- Lack of knowledge about how to document performance concerns
- Comments section often does not correlate with the numeric ratings

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Daily Real-time Feedback

- Written and Verbal
- Concern / Praise cards
- Add a box for confidential comments that only PDs can see

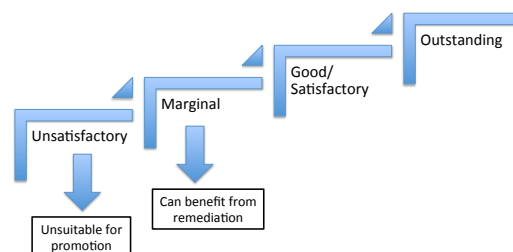
Competence problems that should be documented:

- Lack of or poor judgment
- Inadequate clinical skills/patient care
- Deficient technical or procedural skills
- Ineffective communication skills
- Inability to acquire and integrate professional standards into one's repertoire of professional behavior
- Lack of personal insight or self-awareness
- Inability to control personal stress or emotional reactions that interfere with professional functioning (conduct or emotional problem)

Red Flags

- Tardiness,
- Poor documentation (includes case logs, duty hour logs, conference attendance, etc)
- A disproportionate amount of attention by training personnel is required
- Grumbling from peers
- The trainee's behavior does not change even after feedback, remediation efforts, and / or time

Resident Performance



6 Worrisome D's

- Depression
- Deprivation (sleep, food)
- Distraction (finances, family/SO, illness)
- Disability (neurocognitive, physical)
- Disordered personality (ADHD, borderline)
- Drugs (alcohol, narcotics)

Designing Appropriate Remediation

- Clinical competence Committee plays a critical role
 - Identifies deficiencies in context of core competencies and milestones
 - Reviews block rotations
 - Identifies task-oriented demonstration of skills
 - Individualized educational plan

CCC: Individualized Educational Plan

- Arranges mentor/coach preferably, outside of CCC (core faculty, master clinicians)
- Sets timeline with goals
- States ramifications of failure to achieve goals
- Arranges follow-up to assess progress

Context issues to be considered:

- Support systems
- Adjustment issues to new setting both personally and professionally
- Changes in status (finances)
- Impact of significant life events
- Personal risk factors (substance abuse, ADD, other psychiatric disorders, etc.)
- Could just be "burnout"

Implementing the Individualized Educational Plan (IEP)

- CCC recommendations forwarded to PD
- Ultimate decision to execute IEP rests with the Program Director
- Remediation may or may not include probation
- Involve GME (DIO) and legal office in case IEP will possibly lead to non-promotion, nonrenewal of contract, no credit, extension of training, suspension, withdrawal from program, termination

Letter of Deficiency

- Clear and explicit description of deficiency
 - Competency / milestone-based
- Detailed, well-written remediation plan with clear expectations during remediation phase
 - Timeline
 - Requirements
- Explicit statement of consequences in case of failure
 - Probation, termination, non-renewal

When delivering letter of deficiency...

- Have a witness in the room
- Bring charts, evaluations, milestones data, etc
- Be explicit about no audio or video recording of the meeting
- Document meeting minutes including specific mention of resident's reaction / understanding of the deficiencies
- Provide grievance policy when issuing a warning, probation or termination letter (including due process)

Ensure a paper trail

- Maintain detailed minutes of the CCC meeting
- Save all emails to and from the "problem" resident
- Upload all formal academic counseling into the residency evaluation system
- Document all meetings with the problem resident (including positive ones)

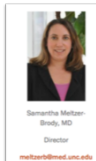
Review of the Decision

- Meeting with another PD / DIO
- Reviewer
 - Meets with the resident; reviews file; meets with other faculty if needed
- A Second Review:
 - Hospital CMO or another official (institution-specific)
 - Meeting with the resident; review of initial report / findings
 - Renders a final decision

Examples of "Problem" Residents

Taking Care of Our Own

Physicians are people too; the UNC "Taking Care of Our Own" Initiative



- Funded through the Sanders Clinical Scholars Program
- Helps struggling house-staff and faculty
- Appropriate professional referral for individuals needing mental or physical help
- Program also provides "burnout / wellness" education
- Confidential

Determine whether the corrective action plan has been successful

- Successful completion of all remediation steps
 - Satisfactory evaluations
 - Achieves anticipated milestones for promotion
- Remove from remediation
- Continue to monitor progress
- If maintains upwards trajectory, no further action

Determine whether corrective action has been successful

- If corrective action plan, unsuccessful
 - Follow through on the plan as was laid out
 - Follow the timeline
 - Document, Document Document
- Involve GME (DIO), legal office, Chair, CCC
- If still no sign of improvement, termination may be inevitable
- Consider offering voluntary withdrawal by the resident from the program as opposed to dismissal

Court Reversal

Irby & Milam, Acad Med, 1989

“The courts will not reverse decision to dismiss a student or to not reappoint a resident where the decision is based upon the faculty members’ professional judgment and a review of the entire record”

For Effective Remediation

A Complimentary Approach that brings together:

- Institutional buy-in
 - DIO, legal office
 - Everyone understands protocol / process
- Interpersonal
 - Frequent constructive feedback
 - Assess / Provide support system
- Psychosocial
 - Ensure understanding (process, desired outcomes)
 - Assess emotions
 - Assess cognitive styles
 - Seek expert assistance (psychiatric / psychological)

Thank you