Mental Health/ Substance Abuse

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Outline

- Background/Statistics
- Signs of Impairment
- Role of faculty and program leadership
- Story
- Challenges
- How to address
- Discussion

Overview

- Unique challenges in navigating challenges with psychiatric illness or substance abuse
- Impairment: inability to practice safely
- High prevalence of depression, anxiety, burnout, and substance abuse

Substance Abuse Statistics

- 4.4% of people working in healthcare: heavy alcohol consumption
  - 7% in general population
- 5.5% of medical professionals: illicit substances
- 10% of medical professionals: prescription medications

Mental Health Statistics

- Depression rate amongst medical residents: 29%
  - Nonphysician rate 8%

Potential contributors

- High stress environment
- Long working hours and sleep deprivation
- High expectations and pressure to perform
- Exposure to trauma and suffering
- Internal pressures (high achieving personality, decreased willingness to admit challenges)
  - Isolation
  - Financial stress
  - Lack of work-life balance

Statistics?

- Outdated data
- Incomplete data
  - Underreporting
- Young persons aged 16-35 use the largest proportion of drugs of any age group
- Distinct stressors in clinicians
- *The Sick Physician*, 1973

Potential Impacts

- Patient safety
- Resident’s own health
- Burnout leading to early departure
- Deputation damage and loss of career opportunities

Signs of Impairment

Table 2. Common symptoms of a physician with substance abuse problems

Socially removed	Sexual promiscuity
Decreased performance	Smell of alcohol
Spending more time at work	Heavy drinking at events
Change in diet/appearance	Problems with law enforcement
Inaccessibility/frequent absences	Excessive sweating
Defensiveness/irritability/conflicts with co-workers	Patient complaints
Unusual drug orders	Frequent illness/injury
Domestic distress	Isolates themselves in office
Mood swings (euphoria/depression/anxiety)	Ataxic gait/slurred speech/tremors

- Disclaimer: these are not specific
- Use as a guide to recognize signs/patterns

Signs of Impairment

- **Physical**
  - Alcohol on breath (at work)
  - Poor grooming, poor hygiene, overly tired
  - Increase in physical complaints
  - Decrease in attention span
  - Pupils dilated or constricted
  - Long sleeves in hot weather

- **Social/Behavioral**
  - Intoxicated at work/on-call
  - Reports of stated suicidal ideations by resident
  - Suicide attempt
  - Resident asks for help
  - Withdrawn/isolating
  - Less responsible/unpredictable
  - Irritable/Defensive/argumentative
  - Having conflicts with peers/supervisors/staff
  - Unexplained accidents/ER visits
  - Frequent intoxication at department functions
  - Crying/Mood changes
  - Inappropriate comments, jokes, etc.

Professional Signs of Impairment

- Critical incident
- Self-prescribing (controlled substances)
- Asking peers to prescribe controlled substances for them
- Frequent or Unexplained absences
- Decline in dependability (doesn’t answer pages, etc.)
- Decline in quality of work
- Inappropriate orders
- Complaints from supervisors, patients, staff, peers

Story

Program directors' role

- Do not be the trainee's physician
  - Refrain from making diagnosis
  - ADA laws

- Manage performance
  - Concretely describe performance concerns, provide examples, hold residents to standards

Barriers

- Medical board reporting: licensing worries
- Fear of lost work opportunities
- Professional culture/stigma

Screening and Assessment Tools

- Regular mental health screenings
- Peer and supervisor observation and reporting

Strategies for Prevention and Support

- Institutional policies
  - Establishing mental health resources (e.g., counseling, hotlines).
  - Promoting a culture of openness and support.
  - Ensuring reasonable work hours and time off.
- Individual strategies: self care (sleep, exercise), stress management (mindfulness, relaxation), strong social support networks
- Education and training

Take Away Points

- Important to recognize and address mental health and substance abuse
- Vulnerable time of lives and career

Thank you.
Questions/Discussion

References

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Penn Medicine

AUPN PROGRAM DIRECTOR'S WORKSHOP: THE STRUGGLING RESIDENT

Residents with Legal (Non-Medical) Issues

Saurabh R. Sinha

September 27, 2024

Outline

- Not covering
  - Malpractice issues
  - Non-criminal behavioral issues
  - Actions that violate institutional policies/procedures but are not illegal
- Covering
  - Applicant with a prior conviction
  - Trainee with a criminal allegation
    - Institutional considerations/perspective
    - Trainee considerations/perspective
  - Impact of allegations and convictions on medical career

Acknowledgements

- For helpful discussion and suggestions
  - Dr. Jeffery Berns
  - Sean V. Burke
  - Dr. Catherine Kuhn

“Common” Legal Issues with Trainees

- Drug/alcohol-related charges
  - Possession → Use → Distribution
  - DUI
- Domestic relationship-related charges
- Theft
- Traffic violations

Fundamental Differences between Legal Problems and Other Trainee Issues

- Very likely to involve people/agencies outside of program/institution
  - Legal system
  - Medical board
- Program likely will not have the option of addressing as an internal matter
- Almost always will have implications for career/licensure

Requirements for Physician Licensure (www.fsmb.org)

- Medical education
- Medical training
- Performance on a national licensing examination
- Mental, moral, and physical fitness to safely practice medicine
  - Personal history and background
  - Work history
  - Physical and/or mental conditions
  - Criminal background checks

Applicant with a Prior Conviction

Examples

- Shoplifting
- Multitude of speeding violations
- Disorderly conduct
- DUI(s)

Institutional Considerations

- Institutional policies vary
  - Applicants always asked to disclose convictions, more variability on arrests/allegations
  - Criminal background checks often required for employment (and licensure)
  - Urine drug screens often required
- State medical board policies vary
  - Medical licensure requirements – need to make sure that they could be licensed to practice if hired
  - Rarely disqualifying and may be hard to know if would qualify for licensure until they apply
- Institutional/program standards
  - Does the conviction raise concerns about professionalism/patient care: Severity/seriousness, Pattern of behavior, Explanations offered
  - Hiring standards should be higher for physicians

Program Approach

- Blanket policies inappropriate
  - Potential for rehabilitation
  - Concern for disparate impact on URM
- Set a very high threshold for disqualifying an applicant solely for a history of conviction or arrest
  - Program should have standardized criteria for initial screening of applicants
- If candidate meets other criteria for consideration:
  - If details and explanations not offered, ask for them
  - Discuss with GME/HR
    - If possible, prior to interview
    - Definitely prior to offer/match

Issues Discovered after Hire

- After match/contract process
  - Criminal background check
  - UDS positive
- Similar considerations but harder options
  - Failure to disclose almost always a contract/policy violation
  - Failure to disclose on licensing application to medical board a criminal violation
  - Likely others will also be institutional policy violation

Criminal Allegations against a Trainee: Program/Institutional Considerations

Examples

- Drug diversion allegation
- Shoplifting arrest
- Domestic violence allegation
- Substance abuse allegation
- DUI arrest
- Cases with a twist:
  - Crime occurred on campus
  - Criminal allegation involves another employee

Considerations

- Was there an associated violation of institutional policies or professional ethics?
  - Examples:
    - Failure to report for duty
    - Failure to report charges/allegations (required by some employment contracts)
  - Proceed as appropriate for those violations
- Concern for ability to perform duties/patient care
  - May depend on nature of allegations
  - Employee health evaluation
    - Opportunity to address any underlying medical issues, including substance abuse
    - Assess for mental health needs
- Other immediate concerns:
  - Publicity for institution/program

Immediate Actions to Take/Consider

- Discuss with GME and Risk Management
- Employee health evaluation
- For anything but the most minor issues: advise trainee to get a personal lawyer
- Immediate change in status (informed by employee health evaluation):
  - None
  - Special elective
  - Suspension
  - Administrative leave
  - Corrective action

Criminal Allegation Reported ONLY to the Program or Institution

- Approach:
  - Contact GME/Risk Management
  - Contact campus police/local police
    - May need permission of accuser, especially if a spouse
  - Consider carefully before discussing with trainee – especially if allegation involves other parties
  - Actions to take while issue being investigated
    - Employee health evaluation
    - Change in status
  - Examples:
    - Substance abuse allegation
    - Partner of trainee contacts institution about allegations of domestic violence

Criminal Allegations against a Trainee: Trainee Considerations

Initial Steps/Considerations for Trainee

- Need an attorney
  - For the criminal matter itself
  - impact of matter on career/license and future licensure
- Ensure that policies/requirements for institution and medical board are followed
  - Failure to follow these policies can be a significant problem by itself
  - Reporting requirements vary
- All states:
  - Self-reporting required
  - Hospitals
  - Peer licensees
- Others:
  - State/local law enforcement agencies
  - Courts
  - Federal agencies
  - State/local professional societies
  - Post-graduate training programs: IL, LA

Physicians/Professionals Health Programs

- Offer confidential assessment, referral to treatment, resources and monitoring for physicians at risk for impairment
  - Substance use disorders
  - Mental health disorders
  - Behavioral disorders
  - Other medical conditions
- Confidential, therapeutic alternative to discipline
- Supported by state medical boards and legislations
  - May include exemptions from mandatory reporting requirements
  - PHP-mandated treatments may require medical leave
- Can be an important part or rehabilitation process (with or without criminal allegations)

Pretrial Diversion Programs

- Eligibility
  - Typical requirements (vary by state)
    - First-time offender
    - Non-violent crimes, mostly for misdemeanors – DUI specifically excluded in some states
- Procedures (and name) varies by jurisdiction
  - May require initial guilty or no-contest plea
  - Plea then put on hold while on probation type of program (depends on nature of crime, may include restitution, community services, rehabilitation)
  - Case is dismissed upon successful completion of program
    - May or may not be removed from record

Consequences of a Criminal Conviction: Impact on Licensure

- Criminal accusation or conviction by itself does not exclude ability to obtain licensure
  - Evidence of rehabilitation holds significant weight in most situations
- Applicants for licensure and Licensees must disclose/report convictions
  - Required by all medical boards
  - Failure to report can be a criminal offense
  - Convictions will show up on background check; arrests may – will certainly show up on Google
  - “disclose and explain” is best policy

Summary

- Criminal allegations and convictions involving trainees are uncommon
- Carry extra weight for a physician
  - Held to higher standard
  - Impact on career/licensure
- Important for institution to determine if
  - Institutional policies were violated
  - If it is “disqualifying”
  - Potential impact on reputation of program/institution
- Make sure to involve/consult with
  - GME office
  - Human resources
  - Risk management/institutional counsel
  - Employee/occupational health
- Develop plan for immediate action and long-term plan
  - Status of trainee in program
  - Status of trainee after program


Penn Medicine

Tufts Medicine
Tufts Medical Center

Supporting the Non-Renewed Resident

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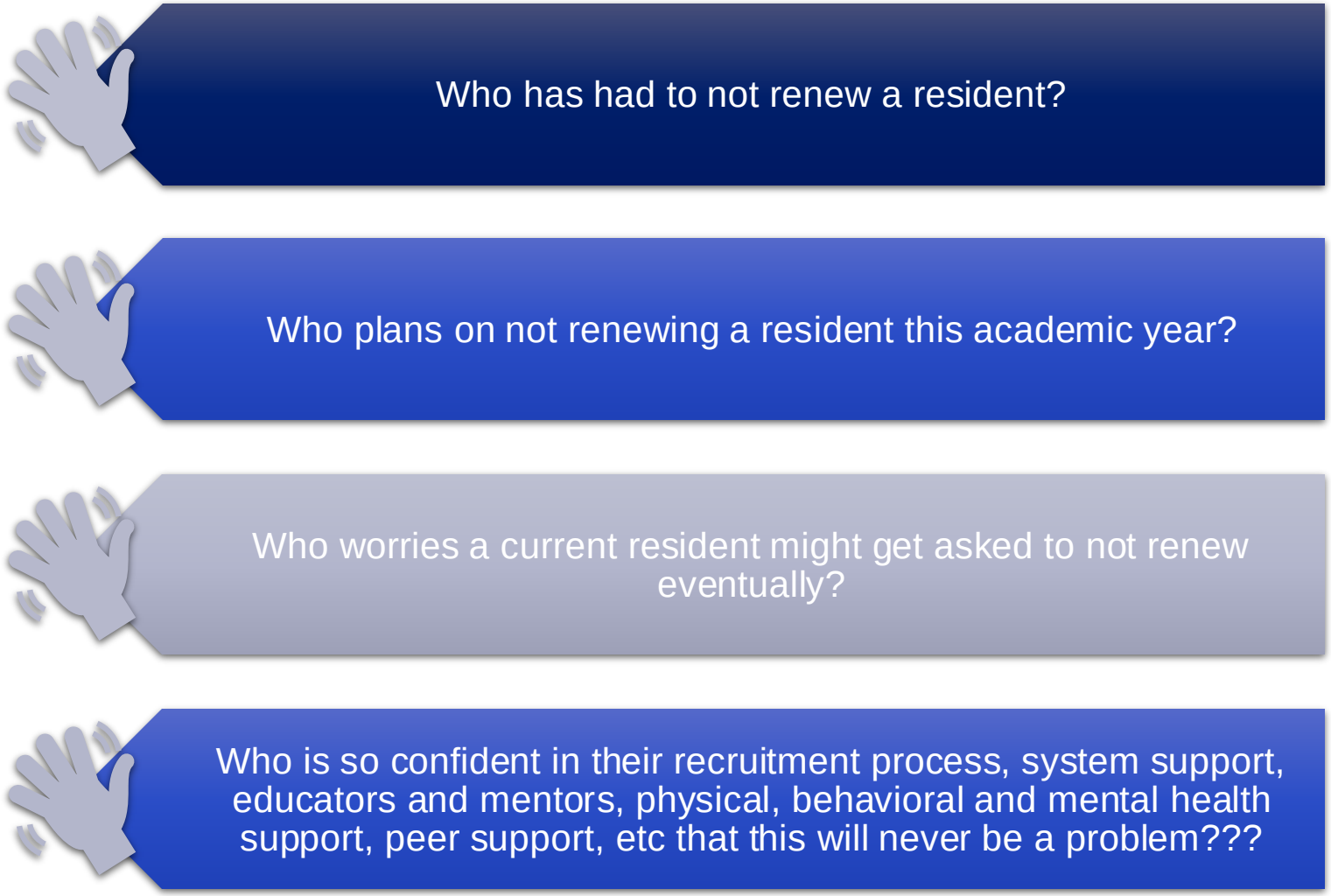
The primary health system of Tufts University School of Medicine

Disclosures

1. None

All images generated with DALL-E with my own prompts unless otherwise indicated

Audience Participation



Outline

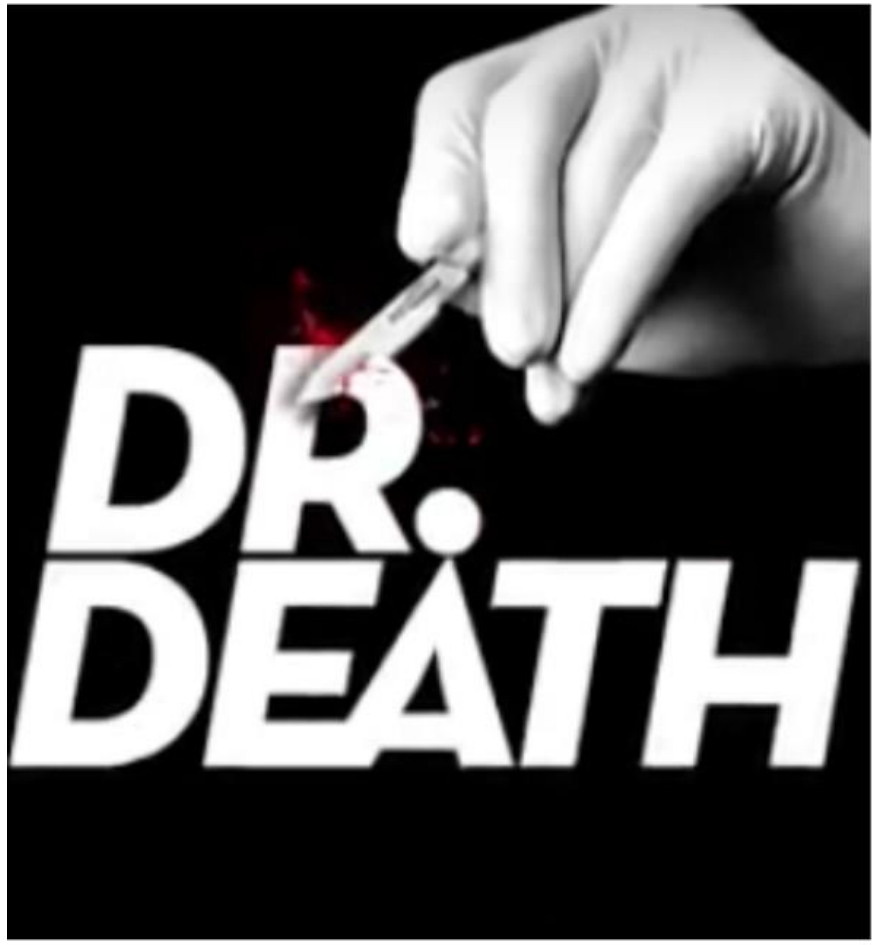
- A resident's failure doesn't have to be your failure
- Reminding you that you're not alone
- Reminding you to rely on your GME office, chief/chair/mentor/friend
- Reminding you that as PD, the decision isn't yours alone – GME/Dept policies, CCC, but responsibility is

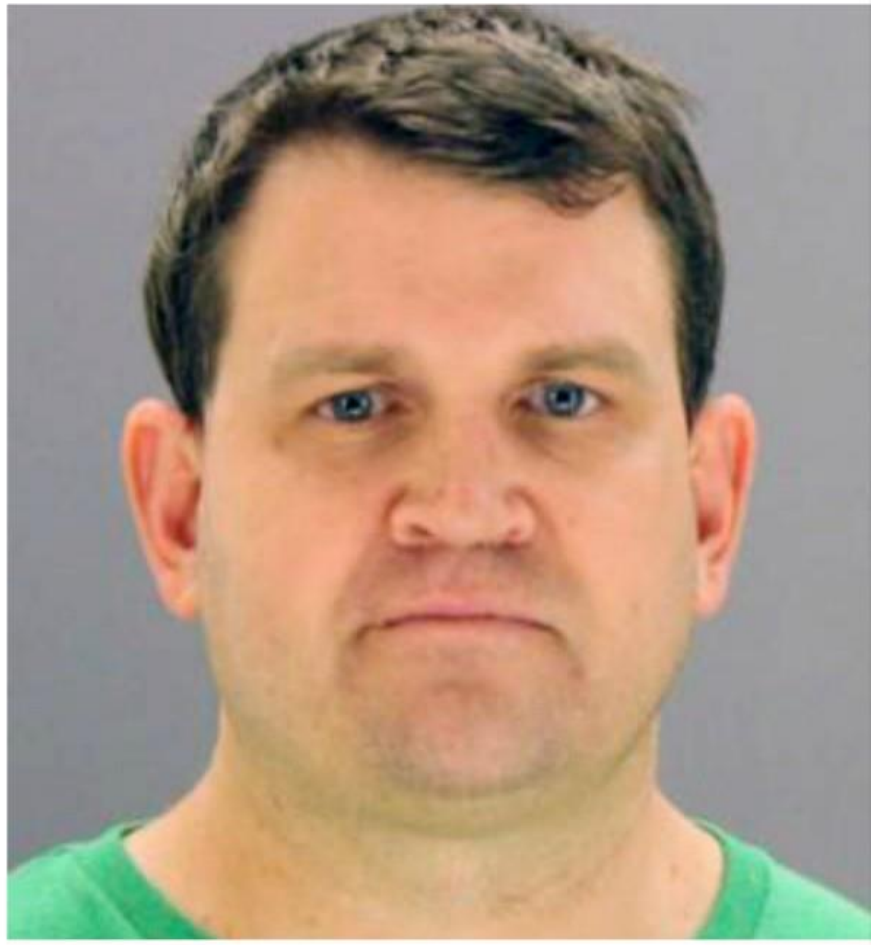
- Practical Issues – preparing for non-renewal, completing it, debrief
- Post-Non-Renewal options for residents
- Case studies

Consequences of Failing to Fail a Resident

https://en.wikipedia.org/wiki/Michael_Swango#/media/File:Michaelswango.jpg

Consequences of Failing to Fail a Resident





PERSPECTIVES

The Hidden Costs of Failing to Fail Residents

Nicole K. Roberts, PhD
Reed G. Williams, PhD

Consequences of Failing to Fail a Resident

"From our experience and investigations, residency program directors are more likely to keep a learner with insurmountable performance problems in a program and allow that person to move on to the next step in training or practice than they are to dismiss a resident whose performance problems were not successfully addressed"

"Even more difficult to quantify, but also more alarming, is the message the program sends to other residents, coworkers, and the general public when an underperforming resident is tolerated. "

What is your job as a Program Director?

- To ensure that your trainees can provide safe and effective care to patients at all points in their training, develop skills, knowledge, and attitudes required to enter the unsupervised practice of [your specialty here], and establish a foundation for continued professional growth.

Accreditation Council for Graduate Medical Education

Pro tip!

You can BOTH not renew a resident's contract and still mentor them through the process

Trainees as employees

Residents and Fellows are in a unique position as hospital employees and learners

Trainees are entitled to due process, and this due process can protect you and your program in the event of non-renewal

Reasons for non-renewal

1. Performance Issues: clinical skills, knowledge, and professionalism.
2. Conduct Issues: Instances of unprofessional behavior or misconduct, which may compromise patient safety or the integrity of the medical program
3. Incompatibility with Program Requirements: Sometimes, residents may not align well with the program's culture or expectations, leading to conflicts with faculty or peers, resulting in non-renewal
4. Personal or Health Issues: Personal challenges, including health problems, can affect a resident's ability to complete the program successfully. These issues might lead to extended leaves or withdrawals, which can impact contract renewal
5. Institutional or Policy Compliance: Non-compliance with institutional policies or accreditation requirements. (USMLE Steps!)

Preparing for non-renewal

- Document.
- Everything.
- This includes:
  - 1:1 meetings
  - SAR and CCC Minutes
- Hallway conversations with colleagues that are unofficial feedback → followed with an email summarizing key points
- Every critical conversation with your trainee should also be followed with an email to them summarizing key points
- Maintain confidentiality as best as you can
- Prepare for an appeal
- If residents are unionized, ALSO educate yourself on the Union's stances on this

Preparing for non-renewal

- Prepare the department
- Prepare the trainees

Expect the trainee is preparing themselves

r/Residency • 1 yr. ago
samekiicdiif

Tips to Refute Disciplinary Action in Residency

SERIOUS

The hospital is likely building a file on you just in case if you are reading this post. This is the point where someone said you are a problem or your PD thinks you are or someone in GME.

I used to believe the stories that you had to do something really bad to receive disciplinary action or termination. This is not even remotely true.

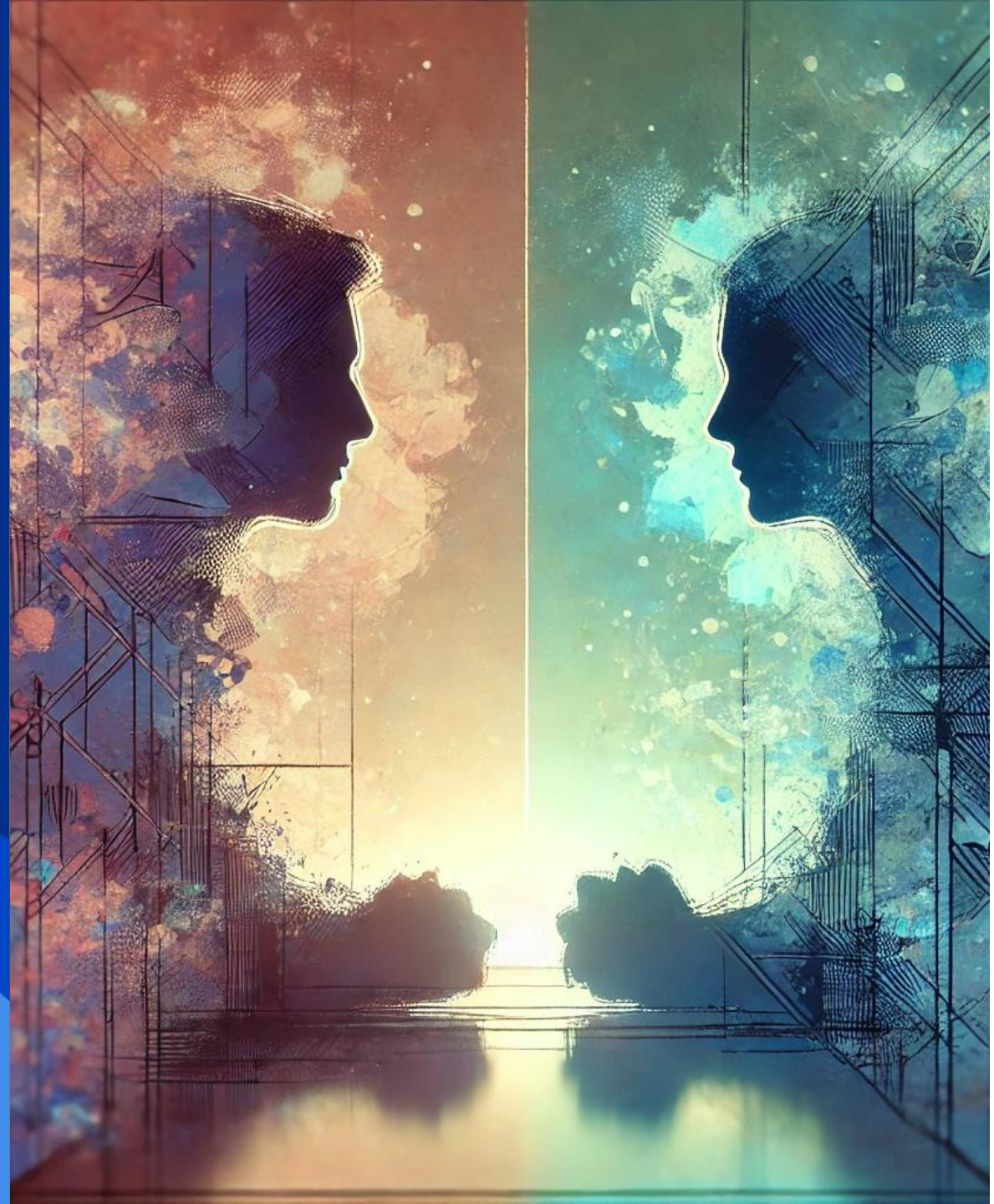
Do not expect hospital to follow their policies or contract.

Pearls:

1. In the hospital's eyes you are guilty just by allegation. The burden of proof will be on you to try to disprove the kitchen sink of allegations they throw at you. Their mantra is document, document, document. They usually will have two people in meetings to document what they want to allege. The PD may at this moment be sending emails to the hospital lawyers alleging you missed meetings, were late, etc. this is the "papering."
2. I would highly advise all residents to keep copies of essential documents like signed employment contracts, grievance procedures, and disciplinary procedures. Save these as a PDF in a folder from the intranet as these change year to year. Keep copies of all documents you sign during orientation or onboarding.
3. Remember, the minute anything happens you will lose access to your email, duty hours, case logs, EMR. Print out and save all the emails. Label them with dates and subject too. Looking back on documents is a nightmare without organization.
4. Next you need to get everything in writing. Send meeting notes after everything single faculty feedback session, even the negative ones. Otherwise they can frame it even worse. At meetings,also email meeting minutes directly afterwards.
5. I would not trust your coresidents or basically anyone employed by your employer. When push comes to shove, you will get shoved under the bus to protect their 300K loans, earning potential, and family. Some of them will even do so voluntarily and get a kick out of it. They will be rewarded with chief resident positions, graduation rewards, LOR, etc. surprisingly few attendings will stick up for you despite the research, excellent cases, performance etc. I have seen coresidents screenshot group chats and send it in. Your coordinator will email your missed meeting, tardy paperwork, etc. Trust no one.
6. Psychiatric notes in the hospital system are not kept confidential. I highly advise going elsewhere.
7. Anyone on a formal remediation should consult an attorney. The Hospital lawyers already have. It is never too early to consult an employment attorney. I found healthcare lawyers know nothing. Anyone who claims they specialize in residents is lying until proven otherwise. It's a money grab. Expect few to understand residency. Probation is usually a formality. At this point, you should be getting your documentation in order. Expect termination or non renewal. Try to

The GME office is your friend here

Engage Risk Management or General Counsel as necessary



Dismissal/non-renewal Process

- Your GME office should have a policy to guide you.
- DO NOT have this meeting alone. Have a 3rd party with you.
- Make it clear to the resident what they will get credit for
- Make clear what you will and will not say as a reference or when completing verifications, and what your obligations are to the hospital and them when completing requests from outside agencies
- They should be provided a physical copy of grievance/appeals and due process guides
- When is dismissal occurring?

Supporting the dismissed resident

Mental health resources

- Offer counseling services
- Provide information on employee assistance programs

Career counseling

- Offer guidance on alternative career paths
- Provide resources for job searching if appropriate

Transition planning

- Assist with planning next steps (e.g., transferring to another program)
- Offer letters of recommendation for suitable positions

Supporting the rest of your program

Maintaining morale

- Address concerns transparently while respecting confidentiality
- Reinforce program values and standards

Addressing concerns of other residents

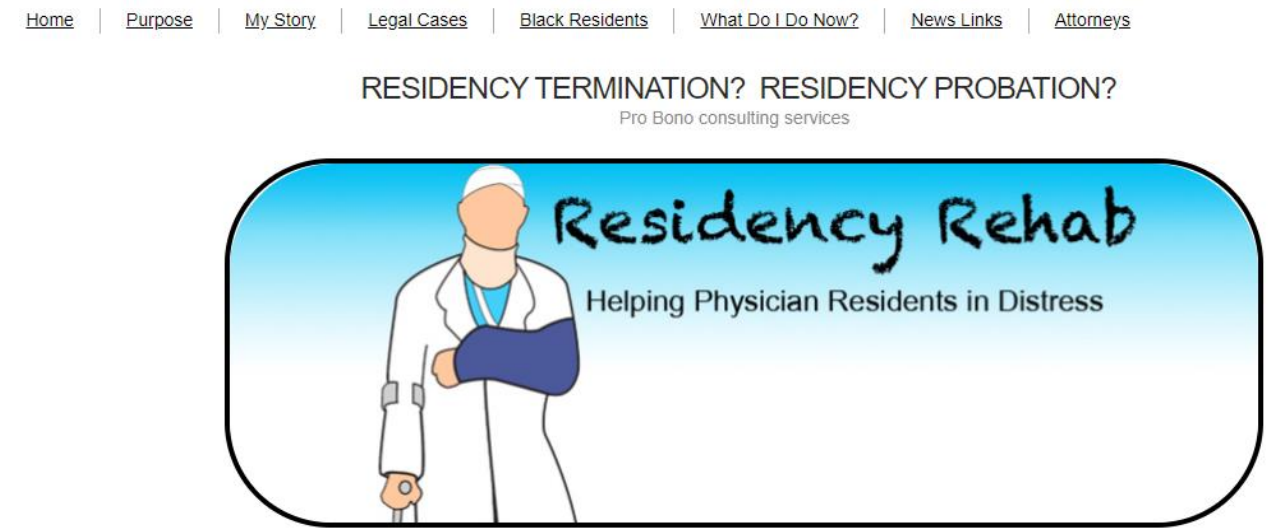
- Provide appropriate information to mitigate rumors
- Reassure other residents about their own standing

Faculty debriefing

- Discuss the situation with faculty to ensure consistent messaging
- Use as a learning opportunity for future resident development

Options after non-renewal

- Especially if early on, re-enter the Match the following year.
- TY years can be very helpful
- https://www.ama-assn.org/medical-students/preparing-residency/non-acgme-open-residency-fellowship-positions
- https://www.residentswap.org/
- If they are on a work visa, non-renewal may have very different options and consequences. Talk to your GME office and someone versed in international law



Non Clinical Doctors

NON-CLINICAL JOBS FOR DOCTORS WHERE TO FIND NON CLINICAL JOBS USEFUL LINKS MORE...

There are jobs for physicians without residency and board certification

It is challenging to find a job if you are a physician without residency, and the process takes persistence, resourcefulness and hard work.

Most traditional jobs for physicians require a medical license. If you cannot get a medical license, there are options.

Some of the limitations for physicians who are looking for

What to do post-dismissal

Prepare for questions

The dismissal may or may not be what the rest of the residents expected.

Work may shift onto the other residents. Can you minimize this?

Can you fill an open spot?

How will you message when asked why you have an open spot?

Case Studies

Case Study 1: Non-Renewal Based on Failure to Pass Step 3 by the End of PGY3 Year

Case Study 2: Non-Renewal Due to Failure to Remediate Performance Issues

Case Study 3: Non-Renewal Due to Professionalism Issues

Case Study 1: Background and Resident Progress

Resident Background:

- PGY3 Neurology Resident: Struggled with standardized testing but consistently met clinical milestones.
- Institutional Policy: All residents must pass USMLE Step 3 by the end of the PGY3 year to continue into PGY4.

Timeline:

- Resident took Step 3 once during PGY2 and once during PGY3.
- Despite tutoring and study resources, the resident did not pass on the second attempt.

Institutional Support:

- Early identification of testing difficulties led to personalized tutoring and a dedicated study schedule.
- Regular check-ins with the resident to discuss preparation, anxiety, and strategies.

Case Study 1: Decision for Non-Renewal

Policy Enforcement:

- ACGME and Institutional Guidelines: Progression to PGY4 without Step 3 passing score is not permitted.
- Despite the resident's solid clinical performance, the policy applies equally to all residents.

Communication:

- The resident was informed of the policy at the start of the program and consistently reminded throughout.
- In the final review, resident was told the contract would not be renewed unless they passed Step 3 before the end of the academic year.

Case Study 1: Outcome and Lessons Learned

Outcome:

- The resident was non-renewed and supported through career counseling, exploring non-clinical roles in research.

Support After Non-Renewal:

- Offered exam prep resources and mentorship for future exam attempts.
- Referred to alternative careers in research, healthcare policy. Ultimately spent a year doing research, retested and Passed and was matriculated into another program.

Lessons for the Program:

- Regular check-ins and additional educational resources helped support the resident, but institutional policies must be upheld.

Case Study 2: Background and Performance Struggles

- **Resident Background**:
  - **PGY2 Neurology Resident**: Noted to have significant performance issues during the first year, including difficulty with patient care management, delayed decision-making, and incomplete documentation.
- **Remediation Efforts**:
  - A **6-month remediation plan** was implemented, including mentorship, additional supervision, and specific goals in clinical skills and time management.
  - Resident had regular meetings with the program director and faculty mentor to track progress.
- **Performance Review**:
  - Despite additional support and time, there was no significant improvement in key areas such as managing complex cases or meeting documentation deadlines.

Case Study 2: Decision for Non-Renewal

•**Remediation Outcomes**:

- After the remediation period, the resident was re-evaluated by the Clinical Competency Committee (CCC).
- The resident continued to fall short in crucial Core Competencies, including Patient Care, Medical Knowledge, and Interpersonal and Communication Skills.

•**Communication**:

- Transparent communication was maintained throughout the process, with clear feedback provided after every evaluation.
- The final meeting explained the decision to non-renew due to continued underperformance despite remediation efforts.

Case Study 2: Outcome and Lessons Learned

- **Outcome**:
  - The resident was non-renewed but encouraged to explore other avenues, such as research or administrative roles where their skill set could be better suited.
- **Support After Non-Renewal**:
  - Career counseling and connections to professionals in non-clinical medical careers were provided.
  - Emotional support through the wellness office was offered to help cope with the disappointment.
- **Lessons for the Program**:
  - The importance of early identification and clear communication in remediation was reinforced. However, sometimes non-renewal is the necessary outcome when residents are unable to meet minimum performance standards.

Case Study 3: Background and Professionalism Concerns

•**Resident Background**:
•**PGY3 Neurology Resident**: Displayed several professionalism concerns throughout the year, including:
    •Disrespectful behavior towards nursing staff.
    •Consistently late to rounds and clinic.
    •Failure to complete required evaluations on time.
•**Early Intervention**:
- The resident was placed on a professionalism improvement plan with set expectations regarding punctuality, behavior, and timely completion of administrative tasks.
- Meetings with a faculty mentor were held regularly to discuss progress.

Case Study 3: Decision for Non-Renewal

- **Continued Professionalism Issues**:
  - Despite early interventions, the resident's unprofessional behavior persisted.
  - Multiple complaints from peers and staff led to further reviews, showing little to no change in attitude and behavior.
- **Final Decision**:
  - The Clinical Competency Committee and program leadership decided that, due to repeated professionalism lapses, the resident's contract would not be renewed for PGY4.
- **Communication**:
  - The resident was informed of the decision in a final meeting, and clear documentation of the professionalism violations was presented.

Case Study 3: Outcome and Lessons Learned

- **Outcome**:
  - Resident was non-renewed and offered mentorship and counseling for future career directions, possibly outside of clinical practice.
- **Support After Non-Renewal**:
  - Offered additional resources for coaching on improving professional behavior and navigating difficult work environments.
  - Career counseling focused on potential roles in health administration or research that didn't involve direct patient care.
- **Lessons for the Program**:
  - Reinforced the importance of clear behavioral expectations and timely intervention. This case highlighted the need for a structured approach to managing professionalism concerns.

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Clinical Performance Remediation in the Struggling Resident

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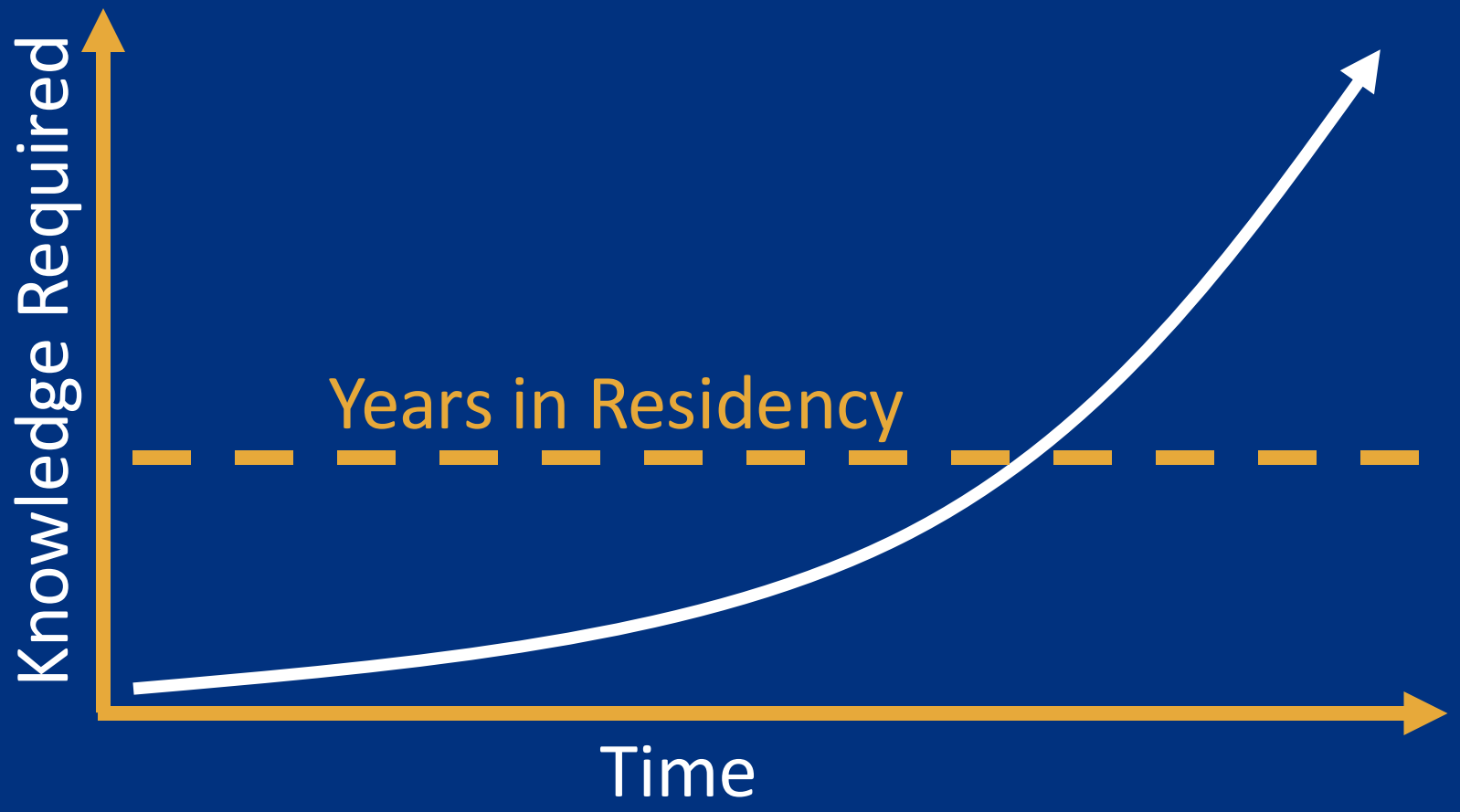
Objectives

- Epidemiology
- Early identification
- Remediation structure and plan
- Obstacles
- Self-reflection

Being Competent



Derderian and Kenkel. J Craniofacial Surg 2016.

The Struggling Spectrum

Derderian and Kenkel. J Craniofacial Surg 2016.

A Common Challenge/Expectation

3.5%

Point prevalence in internal medicine programs

81%

Neurology PDs reporting at least one struggling resident

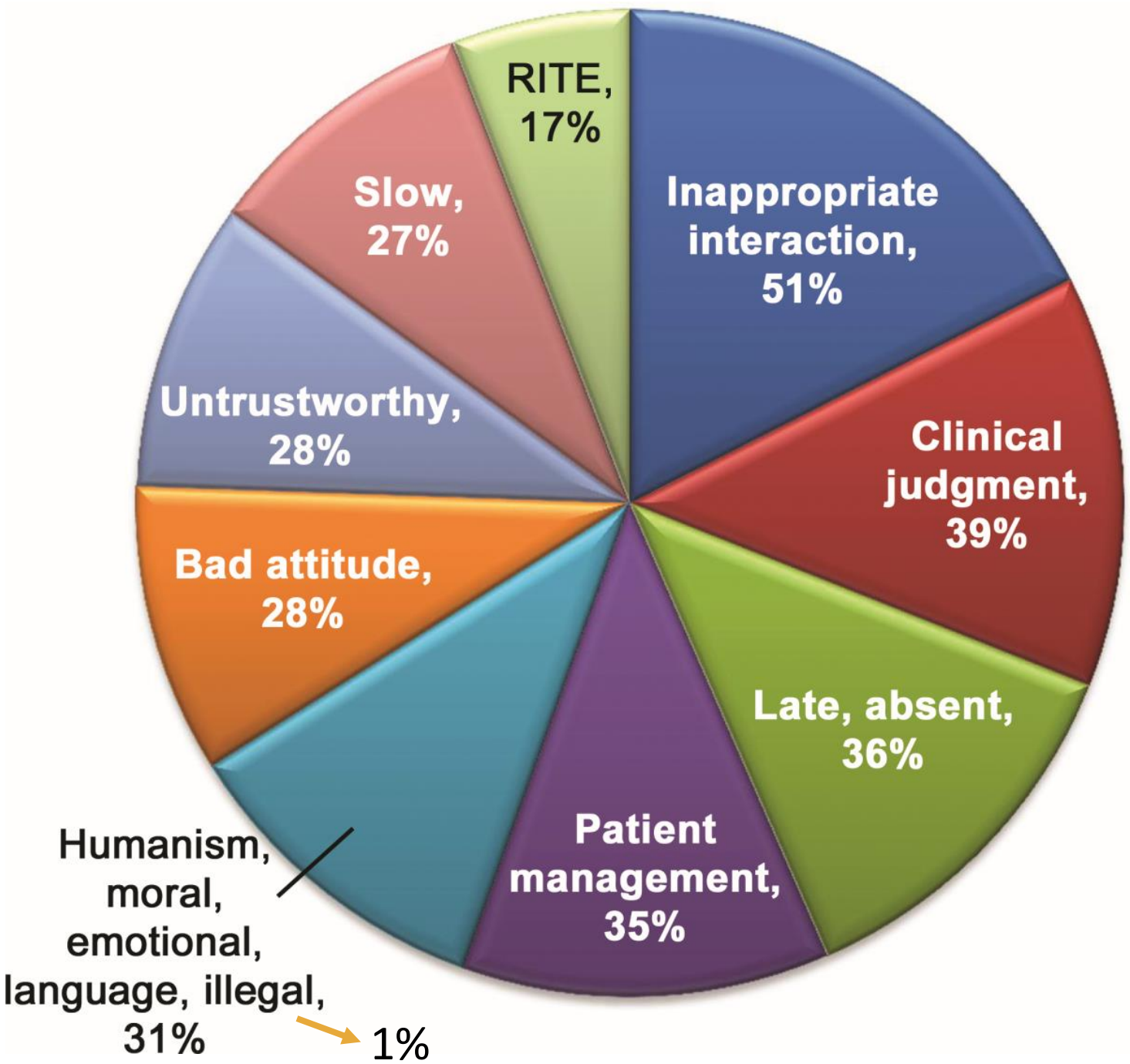
81%

Struggling residents identified in their first neurology year

Dupras et al. Am J Med 2012.
Tabby, Majeed, Schwartzman. Neurology 2011.

Types of Deficiencies

Cognitive
Behavioral
Multiple competencies

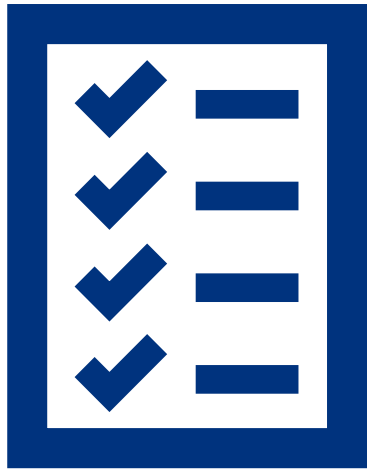


Tabby, Majeed, Schwartzman. Neurology 2011.
Dupras et al. Am J med 2012.
Derderian and Kenkel. J Craniofacial Surg 2016.

Clinical & Academic Performance

Clinical Judgment

Patient Management



Medical Knowledge

Systematic Approach

Set expectations
Identify struggler
Provide feedback to the struggler
Develop a remediation plan
Implement the remediation plan
Assess whether the remediation plan has been achieved
Remain vigilant about the trainee's performance even after remediation is achieved

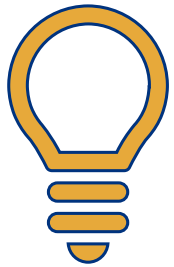
Kurzweil & Galetta. Semin Neurol 2018.

Identification

Earlier is Better

The longer the problem, the more significant the issue

Reduces negative impacts to patient care



Improved problem recognition and reflection

Decreases negative effects to healthcare teams

Pirie et al. BMC Med Ed 2020.
Tabby, Majeed, Schwartzman. Neurology 2011.
Kurzweil & Galetta. Semin Neurol 2018.
Derderian and Kenkel. J Craniofacial Surg 2016.

Indicators

- Clinical competency committee
- Faculty evaluations
- Residency In-service Training Exam (RITE)

Traditional mechanisms

- Early contact with frontline faculty and mentors

→ Will often find you, consider seeking out

- Conference presentations or morning report
- Simulations
- Objective standardized clinical examinations (OSCEs)

Modern methodologies

- Intern year

Pirie et al. BMC Med Ed 2020.

TABLE 2. Guerrasio's Expanded ACGME Core Competencies Plus

ACGME Competencies	ACGME Competencies "Plus"
1. Medical knowledge	1. Medical knowledge
2. Patient care	2. Clinical skills
3. Interpersonal skills	3. Clinical reasoning and judgment
4. Professionalism	4. Time management and organization
5. Practice-based learning and improvement	5. Interpersonal skills
6. Systems-based practice	6. Communication
	7. Professionalism
	8. Practice-based learning and improvement
	9. Systems-based practice
	10. Mental well-being

***Average of 1.6 deficits/remediated learner

Derderian and Kenkel. J Craniofacial Surg 2016.
Guerrasio et al. Acad Med 2014.
Guerrasio J. Remediation of the Struggling Medical Learner 2013.

Prerequisites for Remediation

- ✓Non-judgmental setting
- ✓Resident insight
- ✓Rooted in objective facts
  - ✓Documented specific examples
  - ✓Fair evaluation & due process
- ✓Mentor, remediation coach, or other trusted person
- ✓Transparency

Underlying Issues

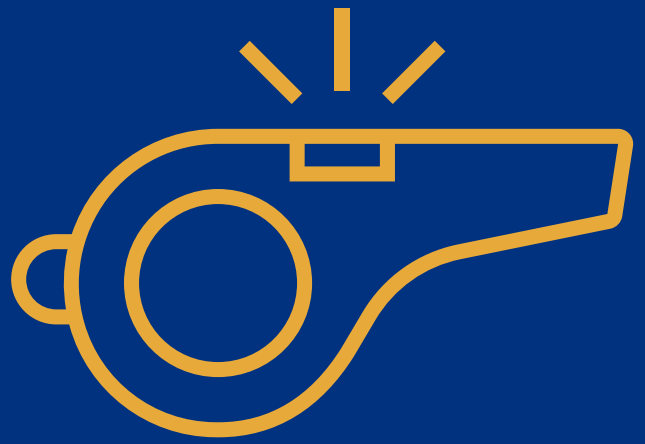
1) Distraction
2) Deprivation of sleep
3) Depression
4) Drugs and alcohol
5) Disease
6) Disability of learning
7) Disorder of personality

30% of those remediating will have depression, anxiety, and/or a personality disorder

Dupras et al. Am J med 2012.
Kurzweil & Galetta. Semin Neurol 2018.
Tabby, Majeed, Schwartzman. Neurology 2011.
Lucey & Boote. Practical Guide to Evaluation of Clinical Competence 2008.

Remediation Coach

- Unbiased and interested
- Skillful at the trainee's deficit
- Available with adequate time
- Needs to be trained/prepped
- Valuable source of input in determining remediation success



Plan Features

- ❑ Define specific deficiencies: link to milestones
- ❑ Action plan with clear steps and resources available
- ❑ How progress will be measured
- ❑ Timeline for re-evaluation(s)
- ❑ Steps to be taken if remediation unsatisfactory
- ❑ Documentation, including a signed agreement

Kurzweil & Galetta. Semin Neurol 2018.

Behavioral Remediation Strategies

Time/Prioritization

- Directory of resources
- Time management training workshops
- Exercises in setting priority
- Weekly agenda

Professionalism

- Articles on ethics and professionalism
- Professionalism coaching
- Conflict resolution courses
- Self evaluation tools
- Regular check-ins
- Stress reduction, emotional intelligence, anger reduction

Yan et al. Am J Surg 2022.

Cognitive Remediation Strategies

Medical Knowledge

Evaluate time spent studying (effort) and what resources used (efficiency)

Reading assignments/study plan

Review questions

Review course

RITE resources

Clinical Reasoning

Increased supervision of patient encounters and procedures

Chart reviews

OSCEs/standardized patients

Time for reflection

Clinical reasoning exercises

Both: repeating rotations, simulations

Yan et al. Am J Surg 2022.

Implementation

- Advocate, not adversary
- Clarity on roles and expectations
- Timeline review
- Regular assessments and self-reflection
- Adherence
- Outcome determination with clinical competency committee and mentor/coach
- Vigilance

Kurzweil & Galetta. Semin Neurol 2018.

Successful Remediation

- Average of 20 hours face-time with faculty
- Risk of probation reduced by 3.1% per hour of face-time with faculty

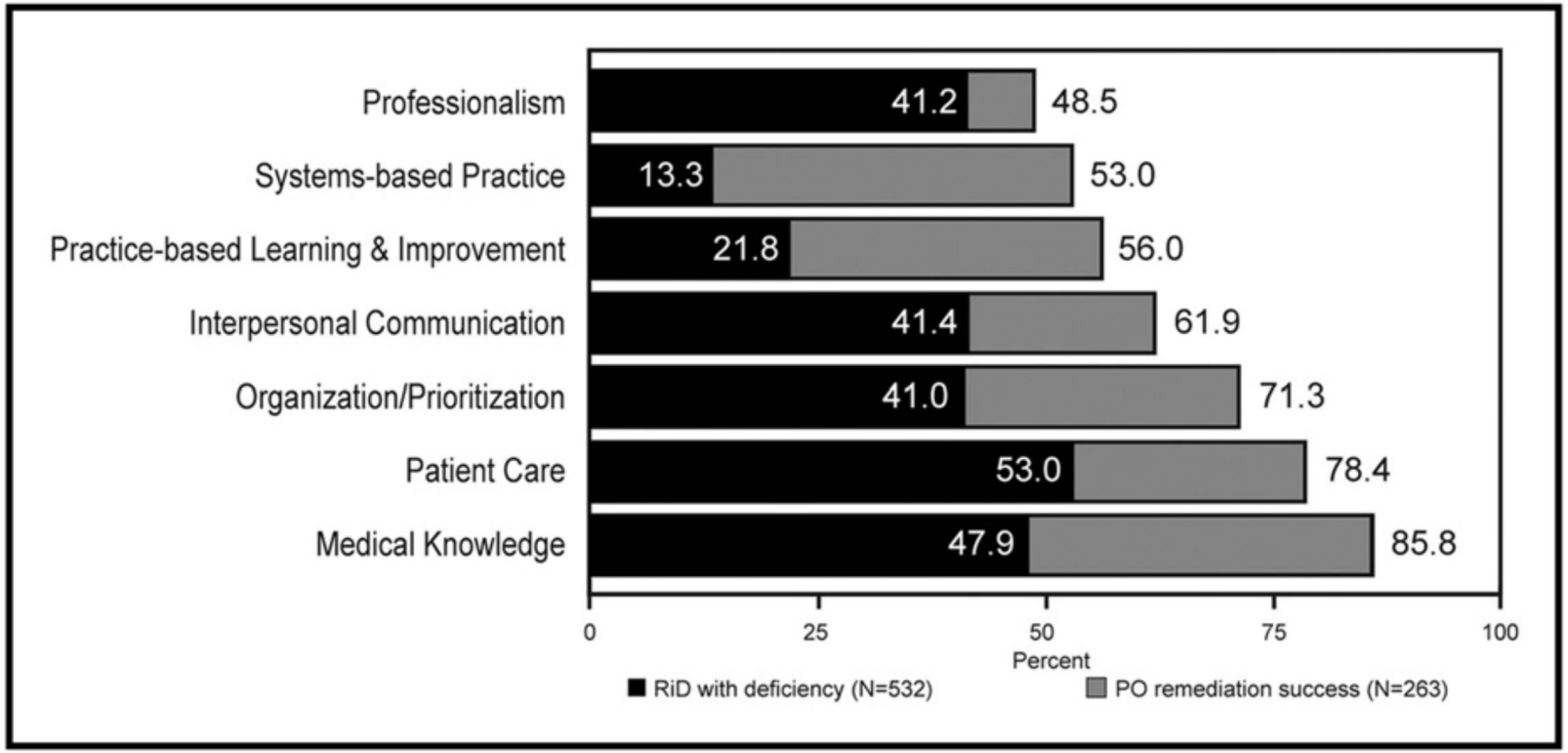


Figure 1 Comparison of reported competency deficiency frequencies in 532 residents with program directors (n = 268) estimated the likelihood of successful remediation.

Dupras et al. Am J med 2012.
Guerrasio et al. Acad Med 2014.

- **Warning/Informal Remediation:**
- Process: initiate after identifying a resident's performance is deficient in one or more Milestones or core competencies
- Documentation: record placeholder information in the resident's file
- Disclosure: warning/informal remediation not disclosed if the deficiency is corrected

- **Formal Remediation:**
- Process: initiate if the resident demonstrates a substantial deficiency, or fails to correct an identified deficiency in the designated observation period of informal remediation
- Documentation: record the failed informal remediation process, an updated corrective action plan with expected outcomes/ consequences, and the time frame for resolution
- Disclosure: notify the GME* office in accordance with institutional guidelines; formal remediation is not necessarily disclosed if the deficiency is corrected

- **Probation:**
- Process: initiate if the resident demonstrates a substantial deficiency, or if the resident fails to correct the deficiency identified in the formal remediation stage
- Documentation: record the failed formal remediation process and update the expected outcomes, consequences, and time frame for resolution
- Disclosure: notify the GME office, include probation status in letters of recommendation and in the final verification of training

- **Termination:**
- Process: terminate the resident if a substantial deficiency warranting immediate removal from training is demonstrated, or if the resident fails to meet the terms outlined in probation
- Documentation: work with the GME office, human resources , and often legal counsel, to assure due process
- Disclosure: include termination status in letters of recommendation and in the final verification of training

Smith et al. West J Emerg Med. 2017.

Obstacles to Remediation

Identification

"Failure to Fail"

Feedback culture

Covering for deficits

Remediation

Negative perceptions

Lack of training

Widespread dissemination of the deficit to faculty

Over the same time period that 28% of residents required remediation, only 0.7% of evaluations indicated a deficiency was present

Schwind et al. Acad Med 2004.
Derderian and Kenkel. J Craniofacial Surg 2016.

PD Reflection

- Are the same resident issues pervasive in your program?
- Could a change in educational programming, mentorship, or residency structure reduce issue occurrence?

Final Words of Advice

Shephard

Use of remediation associated with lower attrition rate

Gatekeeper

High attrition programs more likely to agree with: “I feel that it is my responsibility as a program director to redirect residents who should not be surgeons.”

Schwed et al. JAMA Surg 2017.

Thank You!

Questions? shutto@emory.edu

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