

Remediating Residents: Determining When Enough Is Enough

Remediation of residents is fraught with multiple challenges for program leadership. Program directors (PDs) are responsible for identifying a “problem resident,” developing and implementing a remediation plan, identifying any compounding issues (i.e., mental health issues, chemical dependency), and ensuring remediation outcomes, all while dealing with a lack of validated tools and having to adhere to multiple policies. Additionally, the determination of “the end of the line” (whether a resident has indeed completed or failed remediation) becomes loaded with emotion and PDs have difficulty navigating the dismissal of a resident. We propose the following structure for navigating the minefield of resident remediation and potential dismissal.

Setting the Stage: Structure

Although the discussion of summative feedback and evaluation methods is beyond the scope of this article, they are imperative components of a successful program. An effective remediation process requires a robust and well-documented evaluation process. How much documentation is enough? According to Irby and Milam, “None may be enough, but more is better” (1). Faculty and 360-degree evaluations should document descriptive observations, without interpretation, about performance. Faculty should describe performance and provide examples of where it differed from expectations.

The residency’s evaluation program must be robust so that issues requiring remediation can be accurately and efficiently diagnosed and tracked over time. A clinical competency committee (CCC) serves many purposes within the overall evaluation structure. It is necessary not only for the Next Accreditation System, but also to adjudicate evaluations and identify residents in need of remediation. A CCC improves attestation of competency, sets standards for—and signs off on—all resident decisions for promotion and graduation. The fact that a CCC will share in the responsibility to track progression of competencies/milestones, manage remediation, and determine final outcomes can be a source of comfort for most PDs. Additionally, the discussions at CCC meetings surrounding resident performance can provide minutes that are an asset when action is needed. To this end, excellent documentation of CCC meetings is essential; these minutes can help facilitate due process.

Setting the Stage: Process

In addition to having a CCC in place, a successful remediation process has several critical components that must be standardized and transparent. These components include clear expectations for resident performance with outlined consequences when performance strays. Faculty involved

in remediation must be familiar with programmatic and institutional graduate medical education (GME) policies and need to educate residents on them as well. Preparing program leadership for the remediation process is critical. PDs and assistant PDs must know their institutional policies for filing grievances, academic improvement plans, and appeals process. It is helpful to develop written policies and procedures with your GME office to ensure that your program’s policies are aligned with the institution.

Resident policies must be clearly written with consequences defined if expectations are not met. These policies must be openly explained and provided to housestaff early and often; we suggest discussing the evaluation and remediation process as early as intern orientation. This communication helps set the stage for a culture of frequent direct observation, documentation, and feedback to help improve performance. Programs must also inform residents of deficiencies that are not remediable, such as grossly unprofessional behavior or misconduct. Inform your residents of what is reportable and to whom, and define potential actions if deficiencies are not corrected by the remediation process. Consequences may include dismissal from the program, extension of training, or nonrenewal of contract. Residents should be given access to policies describing potential disciplinary actions including probation and termination. Whatever process you put together with your GME committee, ensure that it is publicized to residents and followed.

Letter of Deficiency

Letters of deficiency should be descriptive and specific. They should state facts: “Dr. A failed to meet expectations of arriving on time and picking up the code pager for 5/7 call days” or “Dr. B was unable to prioritize problems by acuity or severity.” Once deficiencies are explained and examples provided, the letter should provide an action plan for improvement. A remediation action plan or individualized learning plan focuses on the identified, underlying problem. Achieving resident buy-in is critical to the success of remediation; a self-developed plan can be used as the framework for remediation. Residents may be offered the opportunity to choose an advocate or mentor for the period of remediation.

The action plan must be concrete, understandable, and objective. Clear expectations for acceptable performance must be in place, including clarity about whether remediation is required or voluntary (which may be a policy at some institutions) and consequences if expectations are not met. Remediation plans typically employ deliberate practice, feedback, and reflection (2). The timeframe for remediation,

usually three to six months, should be clearly spelled out. The letter and discussion that accompanies it need to define for the resident the measures being used to assess compliance and success within the remediation period. To this end, the letter of deficiency should clearly outline expectations for improvement such as, "In the next three months, Dr. C will have no further deficiencies in dictations..." or "Dr. D will perform at/above expected level on 3 mini-CEX's..." The plan should also include a schedule for meetings with the PD, mentor, and chief residents.

Last, the letter of deficiency should define potential actions if unsatisfactory performance continues. These actions include further time on remediation/delayed promotion, suspension or termination, negative/marginal board annual ratings, or nonrenewal of contract. If necessary, the last option is often an easier route since no termination is involved.

Residents should have a face-to-face meeting with faculty to review the letter and discuss its implications. Residents need to be told upfront what information may be communicated to others. At this time, residents should again be given a copy of the GME academic improvement policy and instructions on how to appeal. Formal hearings are not required for academic issues. Disciplinary actions will involve human resources and hearings may ensue. When possible, it is best for the resident and the program to keep issues based on competency or milestones so that they remain in the academic realm.

Conclusion

A successful remediation program requires careful planning and establishment of both structure (CCC) and processes

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Conclusion

A strongly grounded QI curriculum can add value to both the institution and residency while remaining fluid and fun. We consider the curriculum development process our own QI project as we continually re-evaluate and redesign our program based on feedback. ☉

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(academic improvement, letter of deficiency, dismissal). It is critical that program leadership and remediation faculty are well acquainted with program and institutional academic policies and that these are provided, and explained, to residents early and often. To help educate the resident on deficiencies and to defend your committee's actions if needed, it is critical to document all steps, including resident behavior requiring remediation, feedback/discussion with the resident, remediation plan and reevaluation plan, notification of consequences, action, and appeals. The remediation process should be rewarding; residents can benefit tremendously from faculty taking the time to work individually with them. However, not all remediations end well; if the decision is academic and follows due process, the courts are on your side. ☉

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