MUSC
Medical University of South Carolina

Hollings Cancer Center
An NCI-Designated Cancer Center

Remediation Essentials:

Steps, Stumbles, and Successes

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I do not have any relationships to report with ACCME defined ineligible companies.

I will be/will not be discussing unlabeled/investigational uses of medical devices or pharmaceuticals during this presentation.

Objectives

- Recognize and define resident struggles
- Detail remediation based on competencies/milestones
- Common pitfalls addressing issues
- Learn importance of early involvement of your GME
- Learn about constructive ways to discuss issues with residents

Resident struggles are common

- Residents can struggle in many different ways
  - Spectrum is wide: knowledge, technical skills, interpersonal skills, psychiatric illness, substance abuse
- 5-15% across specialties
  - Seem rare in small programs like urology but can affect entire program
  - Most identified by end of PGY2; 90% still graduate
  - Observation: Likely underreported due to shy PD

Roback 1989, ABIM 1992, Reamy 2006, Christensen 2016
Han, Badalato et al 2024 JSE—urology PD survey

SAU urology PD survey 2023

- 49% response rate; ~2/3 reported remediating ≥1 during past 5 yr
    - Professionalism and Interpersonal and Communication Skills most common concerns
        - Technical skill least common
    - Barriers: inadequate documentation of feedback, early recognition
    - >50% responded that their GME has remediation program but another 20% didn't know
        - About half reported that GME is routinely involved in creating/overseeing remediation at their location
    - Most notified their GME
    - PDs document conversations about performance 50-60% of the time
    - Non-promotion or non-renewal uncommon
    - For both non-remediating and remediating PD: ~1/4 wouldn't trust a graduate to care for a loved one

David Han et al 2024 JSE—urology PD survey

Why P and ICS are important

- ACGME worked with PARS to assess connection between milestones 6 mo prior to graduation with patient complaints in the Patient Advocacy Reporting System (PARS) during the 2 years following graduation
  - Professionalism and Interpersonal and Communication Skills milestones predicted patient complaints in PARS—and PARS has shown that higher rates of complaints predict medicolegal action
    - Using this information can be helpful in conversations with resident remediating P and ICS
    - My experience: Can help surgically talented and highly intelligent residents find insight…

Misop Han, JAMA Network Open 2023

Why your CCC matters: Milestones

- Competencies and milestones provide the structure used for remediation plans
- The better the data from evaluations, the better the problem is defined, the better the plan can be designed

Recognition and definition of resident struggles: The role of the CCC

- Subjective impressions needed to inform CCC – faculty opinion, reports from sources outside department, nurses, program coordinator
    - Hallway flyby conversations don't help much if not documented
    - Pitfall: Lack of documentation. Keep a log of every conversation and email received
    - IMO hallway conversations are also a teaching opportunity for faculty in delivering real time feedback
- Data inputs – CCC needs multisource information to collate and make assessment at the milestone level – 360, esp peer, nurses, faculty, self
    - Easy data: ISE score
    - Harder to identify: Interpersonal and Communications Skills (patients, consulting services, chiefs)

Recognition

- Pitfall: Ignore early signals at your peril—have the conversation
- Intern organization, late to rounds, ISE
    - Going back farther, often these are predictable: standardized testing, med school performance
- Formative feedback = conversations in real time (debrief after clinic/rounds/OR, video review, review of any direct observation)
    - Feeds into summative feedback at end of rotation and sets the stage for later conversations with PD
    - Coaching opportunity for you and your faculty – faculty development for formative feedback

CCC has identified an issue. Now what?

- First decision as PD: handle yourself or involve GME
    - Answer depends on the issue (medical vs ISE)
    - Pitfall – not informing GME
        - They have resources beyond what you may have
        - They too have a stake in your trainee and program status
    - Pitfall – inaction early in residency, avoiding the hassle factor
        - Leads to late residency woes

Semi-annual meeting

- This is a crucial conversation
    - Prepare yourself: This is the real work of a PD
        - Have your remediation plan prepared
    - Ask about the person first, then explore their awareness of an issue using CCC data
    - Mental or physical issue if identified definitely requires GME and often others (EAP)
- Start the conversation by stating your shared goal of developing a capable and competent urologist
    - Sets foundation for discussing the issue, minimizes natural defensiveness

Elements of a good remediation plan

- Written and given to trainee and contains
  - Specific objectives based on milestones, not vague
  - Timeline
  - Outcomes if objectives met or not met
- PD must understand institutional process
  - Include institutional resources in plan, e.g. employee assistance program

Sample remediation document: https://medicine.utah.edu/documents/gme-template2formal-remediation-letter

SMART(ER) structure of remediation plan

- S: Specific
- M: Measurable
- A: Achievable
- R: Relevant
- T: Time bound
- E: Engaging
- R: Reassessed periodically

Additional elements of a good remediation plan

- Review entire document with trainee
    - Many plans require PD and trainee signatures
- Presence of another can help if contentiousness is expected, or witness is desired
    - PC, GME staff
- Important: PD availability to meet during remediation time frame to discuss progress. IMO standing meetings
- Important: Resident's mentor or APD involvement, supportive role less formal than PD interactions

Failed remediation: Now what?

- Understand due process at your institution
- Involvement may include ombudsman, DIO, GME committees/council, legal offices etc
- Letter of “probation”
- Letter to resident file (exists post residency)
- Non-promotion: repeat a rotation or an entire year
- Non-renewal at end of year
- Dismissal
- These potential outcomes need to be in the initial remediation plan

Options when remediation is unsuccessful

- Depending on context a soft landing can be brokered with another training program
- GME are aware of potential legal implications
- Lawsuits generally favor institutions if due process was followed
- Remember:
  - 80-90% of remediation plans result in progression to next level
  - Rarely is a resident non-renewed

Conclusions

- P and ICS hurt patients and careers—important to address deficiencies
- Teach/ask/beg faculty to give formative feedback and honest summative feedback on rotation evaluations
- PDs: explore concerns early - when stakes are low - to develop relationship early with residents; this helps with crucial conversations when stakes are higher
- Document concerns small and large and use faculty development sessions to teach formative feedback so remediation letters are not bombshells
- Construct highly specific remediation plans based on CCC milestone ratings
- Involve your GME office, APD and resident mentor
- Inform department chair of your plan and bring the evidence and your plan
- Embrace the struggle

Questions

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Some stumbles

- Faculty: “This new chief resident can’t operate!”
    - This is a problem! Since when??
    - A bigger problem: Zero prior evaluations or CCC with this concern
    - Timeline too short to turn the ship around…but competence can progress with faculty efforts
- Faculty: “This resident has no idea how to do my clinic!!”
    - PD: “Did you tell them how to do your clinic?”
    - Faculty: ”No! He should know! And you’re the PD so you should know!”
    - PD: “Let’s try this: How about you try telling them how to do your clinic? Definitely a problem if they can’t handle it after that.”
    - Faculty: “Should I?”