REMEDIATION CASE STUDY – With Commentary

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| *A new resident matched into your program. She had an impressive application including very high USMLE scores and glowing letters of recommendation. On the interview she was noted to be a little shy but otherwise had a good interview.* | While all programs try to *suss* out issues during the interview, this is very difficult to do. On another note, more and more residents with diagnosed learning differences are now in medical school. The medical schools provide support for these learners, where in previous years they might have been “weeded out.” And none of this will be revealed to you at the interview. Often you find out about learning issues only after they start to struggle as a resident.  |
| *3 months into residency, she is noted to be slower than her peers. She appears to become extremely anxious every time she has to care for a sick patient. She becomes pale and tremulous and speaks very softly. You wonder if she has an undiagnosed psychiatric illness.* | At this point, the faculty and the PD should be looking at the new residents in order to identify issues as early as possible for the purpose of *supportive* educational intervention. This early intervention often prevents remediation farther down the road. If you feel there might be an undiagnosed psychiatric illness, it’s time for a referral to your resident well-being committee. DON’T GO IT ALONE—USE YOUR RESOURCES. |
| *Upon closer investigation, you find that the resident is quite knowledgeable. In conference she answers all questions correctly, and she does extremely well on departmental exams. However, when she sees a patient, she seems to have difficulty applying her knowledge to the bedside. She has difficulty coming up with a comprehensive differential diagnosis and encounters difficulty in performing procedures.* | Starting to sound like a clinical reasoning issue if they have the correct answers but can’t apply the knowledge in patient care. Time for an “educational interview” to find out what might be contributing to the issue(s). The procedural difficulties could be tied to the anxiety this resident is experiencing or it could be a separate issue. It will take a period of “close observation” before you will have a better idea of what is going on. Using tools like the “Observation & Feedback Form” will provide you with objective data to move forward. NOTE: You should be setting up an improvement plan at this point of closer observation. See the box below for more detail on what constitutes an “improvement plan.” |
| *You have an initial conversation with the resident to get a sense of how she thinks things are going. Her perspective is that she is doing okay. She feels like she should read more and that will increase her confidence. You offer her any further assistance and tell her you will continue to monitor her progress.* | Part of this initial conversation should be a request for her to have a discussion with someone in the institution who has experience in interviewing residents for learning issues (Note: This is NOT a formal evaluation. This is NOT learning testing.) Could be done by your PhD educator if you have one. Or it can be done by someone in the program (faculty with experience) but they should develop an interview framework so that there is consistency in interviews. The interviewer should not be the PD as it ideally should be someone who is objective and not one of the resident’s evaluators or someone who determines their promotion/retention. If you are telling her you are going to “monitor her performance”, this would be the time to set up an “improvement plan.” It does not need to be a remediation plan at this point. Key Point: The more specifically you can identify what you are monitoring and how you are monitoring it, the more transparent the process will be for all. |
| *Over the next 2-3 months, you get a lot of “off-the-record” comments from attending about this resident. “She is too slow.” “She functions on the level of a medical student.” “Something is wrong with that resident.” However, her written evaluations from her attendings are all excellent and there is no written confirmation of the “off-the-record” comments you are hearing.* | Hopefully, by now you are getting “on the observation forms” comments, in addition to those off-the-record comments. This is one of the greatest reasons to implement early “educational support plans.”The issue of faculty and their evaluations is something that has to be addressed at the program level. It has to become part of the culture that we give honest and timely feedback during mid-rotation feedback; feedback Fridays; end of rotations and on written evaluations. What appears on a written evaluation should never be a surprise to the resident. Remember, Program Directors rely on these written evaluations when monitoring their resident progress.  |
| *You have another conversation with the resident who still feels like she is doing well. She again states she needs to read more and that will boost her confidence.* | Sometimes residents lack the self-awareness to see their own deficiencies or learning gaps. This lack of self-awareness can make them very hard to remediate. The first barrier is to increase the resident’s self-awareness. Having a VERY defined set of issues with their corresponding competencies (see sample improvement plan) with specific documentation will be very necessary with this type of resident. See the PowerPoint for more ideas on the learner with self-awareness difficulties. |
| *On the in-service exam, the resident scores the highest in the entire program. You begin to feel better about the resident’s progress.* | Don’t be fooled. Some residents can score very high but still not be able to integrate the knowledge into patient care that is safe. Just as we make no decision about a resident’s promotion/retention based on a low inservice score, we should make no high-stakes decision or decide a resident is just fine based solely on their inservice exam.  |
| *Over the next few weeks, the resident begins to deteriorate. She begins coming late to shifts and seems unfocused. The attendings are now coming to your office telling you the resident is not competent. Her written valuations now start to reflect a slightly lower evaluation than her peers.**You decide it is time to place the resident on a remediation plan.* | Since this resident was referred to the resident well-being committee months ago, these new behaviors should be reported to them. They will most likely start to suspect substance abuse. But it could also be accumulated sleep deprivation. Many of these behaviors are indicative of the resident staying up late to study combined with worry about their situation which leads to poor sleep quality. Since you intervened early, and the improvement plan didn’t fix the issues, it’s time for a remediation plan with even more scrutiny and specifics regarding documentation for each area of deficiency. At this point, because this resident seems to have issues with self-awareness, you will have more success if you choose the most important issues and address those first. All remediation plans should be about 3-6 months in length. Key Point: It should be made very clear to the resident what the options are once the remediation period is over (i.e., continued remediation, taken off remediation, probation) |
| *Information about Probation* | There are times when a resident might go straight to probation and skip the improvement & remediation stages. Refer to your institutional policies for egregious actions that would dictate this. Whenever a resident goes on remediation, let your GME/DIO know so that they have a “heads up” in case it becomes probation down the road. In most institutions, the probation process is administered in conjunction with the GME office and may require a legal review. |