Academic Remediation: Why Early Identification and Intervention Matters

Carol M. Rumack, MD, Jeannette Guerrasio, MD, Alicia Christensen, JD, MS, Eva M. Aagaard, MD

At our institution, we have developed a remediation team of strong, focused experts who help us with struggling learners in making the diagnosis and then coaching on their milestone deficits. It is key for all program directors to recognize struggling residents because early recognition and intervention gives the resident the best chance of success.

Key Words: Department of Radiology; internal medicine; Graduate Medical Education.

INTRODUCTION

In 2016, we reported data collected from 2002 to 2012 about the characteristics, deficits, and outcomes of 102 residents placed on probation from all 142 of our Graduate Medical Education programs, out of a total of 3091 residents during that time (1). Since then, we have developed a unique campus-wide remediation program to provide the needed expertise, resources, and support to allow our residents to find career success. Program goals include early identification of struggling learners, reduction of the number of learners on probation, and increase of the number of learners deemed competent to complete their programs despite initial difficulty.

Identifying Red Flags in Resident Applications

If an applicant is not well prepared to start in your program, the next years of training may be very frustrating to you, your faculty, the resident, and their peers, and may distract your time from other residents who are better prepared. Whereas our data suggest that some information about applicants placed them at higher risk, each institution and program should determine which learners are least likely to thrive in their specific environments. Although learner characteristics play a role in this, the resources and priorities of the program are equally important. The goal should be "goodness of fit."

An example of these deficits is applicants with borderline, low, or even failing United States Medical Licensing Examination scores. Such learners may be at an increased risk of failing United States Medical Licensing Examination Step 3 as well as their in-training and board certification examinations. Yet many have excellent or even outstanding skills in other competency domains that are major assets to patient care. In reviewing these applicants, program directors (PDs) can search for evidence of growth; development of strategies to improve; and known, fixed challenges that may have inhibited testing performance. In addition, programs and institutions should determine whether they are able to or can develop the resources necessary to support a learner who may struggle with test taking. Examples might be ongoing board preparatory courses, dedicated study time, tutors, and test-taking specialists.

Residents transferring programs or changing specialties are other important groups to attend to. Be sure to speak directly with the previous PD to understand how the resident functioned in that program while recognizing the PD's bias if transferring is described as a weakness. In our experience, it is not sufficient to simply have a written summary final letter, which is required by the Accreditation Council for Graduate Medical Education (ACGME). The letter may be very neutral if there were problems and the resident was terminated or encouraged to withdraw. Concerns should also arise if letters of recommendation appear to be from faculty members who do not know the resident well as they will likely make very vague recommendations rather than specific comments about the resident's work ethic, competence in that discipline, and level of clinical experience.

If a resident applicant is older than the usual applicant, it would be helpful to understand why he or she is late in applying, particularly if there is a gap between finishing medical school and starting residency. Does the resident explain the gap with other excellent educational experiences? Is the resident outside of the match because he or she switched from another specialty and has explained why this was best for his or her skills? Or is this a second career and the resident might

Acad Radiol 2017; 24:730–733

From the Department of Radiology (C.M.R.); Department of Internal Medicine (J.G.); Graduate Medical Education (A.C.); Department of Internal Medicine (E.M.A.). Received September 15, 2016; revised December 19, 2016; accepted December 22, 2016. **Address correspondence to:** C.M.R. e-mail: carol.rumack@ucdenver.edu

http://dx.doi.org/10.1016/j.acra.2016.12.022

be much more mature than the average applicant? Factors that affected a resident's ability to complete medical school earlier may persist and impact residency training.

Identifying Early Indicators of Struggling Performance Is Critical to Success

Unfortunately, end of rotation evaluations by faculty are rarely helpful in identifying poor learner performance (2). In fact, in a study of internal medicine residents, program directors found that e-mails, hallway conversations, and phone calls from faculty members or chief residents are the more common means of identifying struggling residents (3). The multisource evaluations from the program coordinator, nurses, technologists, and medical students may report as much or more about struggling residents than supervising and fellow physicians. They know the resident's ability to perform as a clinical team member and have ample opportunity to observe the resident's interpersonal and communication skills. Direct observation by faculty of clinical skills, including ability to identify radiological findings, to form a differential diagnosis, and to recommend next steps in imaging, is also very valuable. These reports can provide direct evidence of the skills observed and not observed. Ultimately, such direct observations are critical to facilitating diagnosis of learner struggles.

Often, people stop the PD or the chief resident in the hallway to explain a problem but do not write it down on a monthly evaluation. As PD, you may wonder whether you can use these hallway consults as solid data to act on with a letter of warning or remedial learning plan. You can if you document when, where, and from whom you heard concerns with specific examples. The most effective method is for the PD to document the problem by writing back to that person in an e-mail to confirm what he or she heard. E-mails should be saved in the resident's file for the Clinical Competency Committee (CCC) to review. During training, even one concerning episode is worth saving in case there is a recurrence of that problem. At the end of the residency, these e-mails can be deleted if there are no further issues to resolve. CCC review of each resident allows for the resident's entire record to be reviewed, for the severity and frequency of concerns to be determined, and to ensure that the institution's policies are followed and residents are treated with parity.

MAKING A DIAGNOSIS

You need to consider all six competencies in making your diagnosis of the problem, as residents frequently struggle in more than one domain (4–6).

MEDICAL KNOWLEDGE

Data that track medical knowledge are always available from in-service examinations and now from Radiology Core Examinations that can be used with comparison to national benchmarks. By setting a specific lowest acceptable examination score, you establish a standard to be expected of all residents. If you wait until one resident fails badly before you establish a standard cut score, the resident may be concerned that he or she is not being treated fairly.

PATIENT CARE

Patient care can be divided into three parts. First, clinical skills evaluation by faculty through direct observation of procedures and patient reports are most valuable. For example, interventional radiology faculty attendings can record what level of supervision is required for specific procedures. For a first-year resident to require direct supervision is expected. If a third-year resident requires direct supervision but no other resident at that level of training requires direct supervision, this finding should be very concerning. Other red flags may be patient complaints, staff concerns, or sentinel events.

Clinical reasoning requires direct observation and chart review. This can be determined during case discussion in conference and in the resident's radiology reports. Does the resident make critical and pertinent observations, develop a thorough differential diagnostic list, and have a management plan based on expressed clinical judgment?

Organization and time management are also part of clinical patient care. What is the residents' report time turnaround? Do they take hours to produce reports that other residents perform quickly? Are they completing the same number of reports as expected for their level of training?

INTERPERSONAL AND COMMUNICATION SKILLS

Although faculty evaluations can identify a deficit in resident interpersonal and communication skills, the most valuable evaluators will be technologists, nurses, clerks, consultants, or patients during procedures. These multisource evaluations particularly from radiology team members can compare the resident's effectiveness at communication to other radiology residents.

PROFESSIONALISM

Unprofessional behavior is generally not identified by faculty. Rather, residents are more likely to perform poorly in stressful situations in the presence of technologists, medical students, or chief residents. Program coordinators are often excellent sources of information regarding the professionalism of residents, especially as it pertains to administrative task completion. Things like timely completion of evaluations and paperwork can be important harbingers of later unprofessional behavior (7).

Mental well-being has been reported increasingly as a concern among residents in the United States. Rather than making a specific diagnosis by faculty or the PD, when unexplained behavior occurs, which is out of the ordinary for the resident, or does not fit the situation, such as falling asleep during reading radiology examinations, psychiatric evaluation should be