

Mental Health/ Substance Abuse



Suma Shah, MD

Associate Professor, Neurology



DukeHealth



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- Outdated data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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- <https://www.siumed.edu/gme/impairment-residents#:~:text=Mental%20health%20issues%20such%20as,risk%20factor%20for%20performance%20impairment>.
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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



Supporting the Non-Renewed Resident

Joshua Kornbluth, MD
Asst Prof of Neurology and Neurosurgery
Tufts Medical Center
Tufts University School of Medicine



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



Who has had to not renew a resident?



Who plans on not renewing a resident this academic year?



Who worries a current resident might get asked to not renew eventually?



Who is so confident in their recruitment process, system support, educators and mentors, physical, behavioral and mental health support, peer support, etc that this will never be a problem???



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

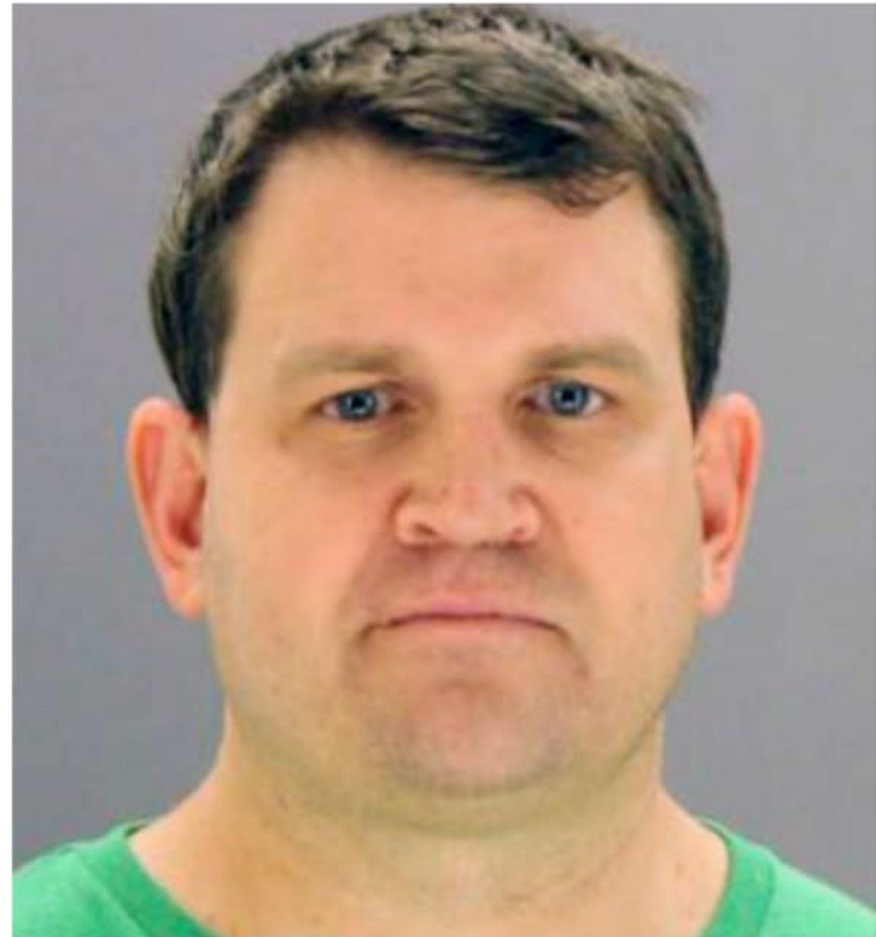


Consequences of Failing to Fail a Resident





Consequences of Failing to Fail a Resident





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?

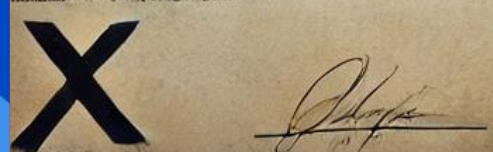
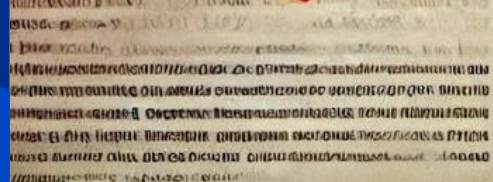
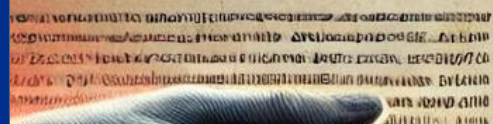
- To ensure that your trainees can provide safe and effective care to patients at all points in their training, develop skills, knowledge, and attitudes required to enter the unsupervised practice of [your specialty here], and establish a foundation for continued professional growth.



Accreditation Council for
Graduate Medical Education



CONTRACT



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.

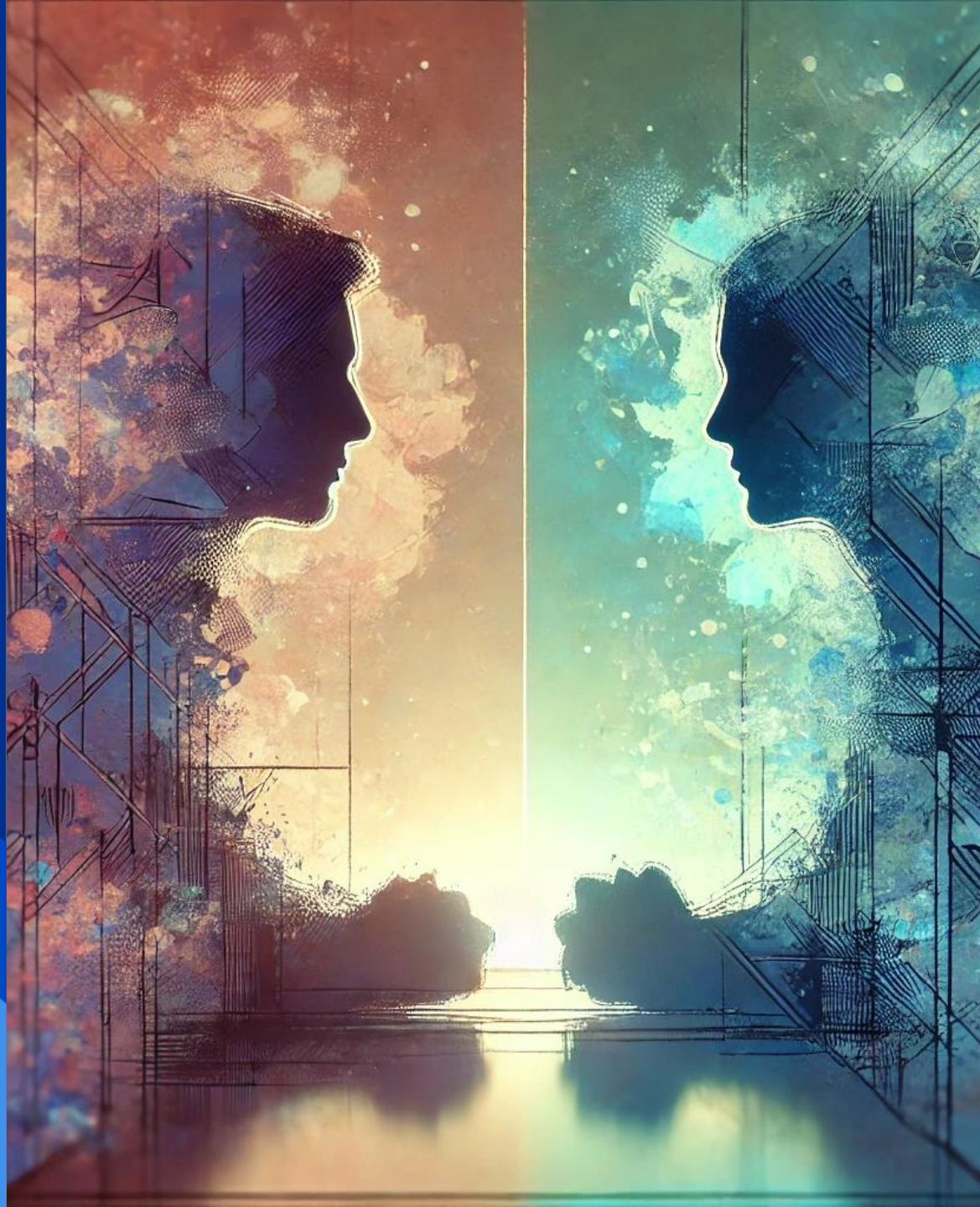
Do not expect hospital to follow their policies or contract.

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



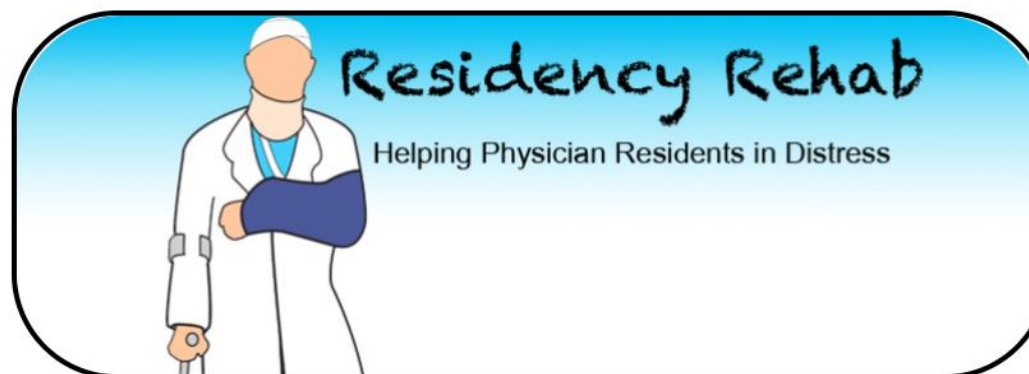
Options after non-renewal

- 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

[Home](#) | [Purpose](#) | [My Story](#) | [Legal Cases](#) | [Black Residents](#) | [What Do I Do Now?](#) | [News Links](#) | [Attorneys](#)

RESIDENCY TERMINATION? RESIDENCY PROBATION?

Pro Bono consulting services





Non Clinical Doctors

NON-CLINICAL JOBS FOR DOCTORS

WHERE TO FIND NON CLINICAL JOBS

USEFUL LINKS

MORE...

JOBS FOR PHYSICIANS WITHOUT RESIDENCY

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



UNIQUE SIDE GIGS FOR PHYSICIANS WITHOUT A COMPLETED RESIDENCY

Medical
consulting

Pharmaceutical
company
positions

Clinical
research
positions

Healthcare
administration
roles

Clinical
informatics
jobs

Medical
editor, writer,
or media
consultant

Health tech
startup
founder or
venture
capitalist

Tutoring,
teaching, or
medical
educator

Health policy,
public health,
or politician

Health coach,
patient care
navigator, or
patient
advocate

Practice
management
or billing &
coding jobs

Medical device
development
or
representative

Learn more at
www.physiciansidegigs.com/physicians-without-a-completed-residency

PHYSICIAN
SIDE GIGS



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

Spencer K. Hutto, MD

Assistant Professor of Neurology

Associate Program Director, Neurology Residency

Director, Emory Neurosarcoidosis Clinic

Emory University School of Medicine

 @HuttoSpencer



EMORY
UNIVERSITY
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MEDICINE

Department of
Neurology

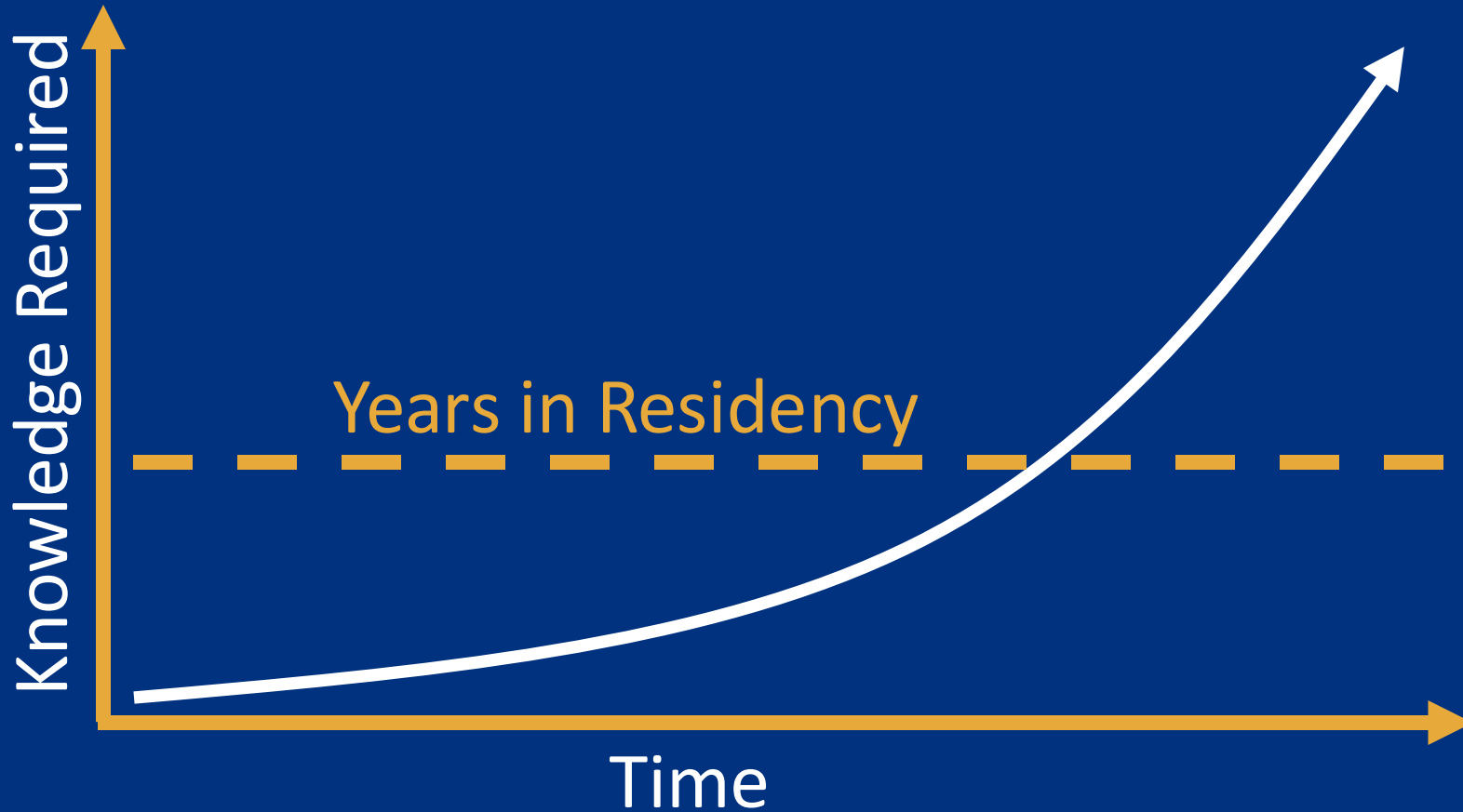


AUPN
Association of University Professors of Neurology

Objectives

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

Being Competent



The Struggling Spectrum



A Common Challenge/Expectation

3.5%

Point prevalence in
internal medicine
programs

81%

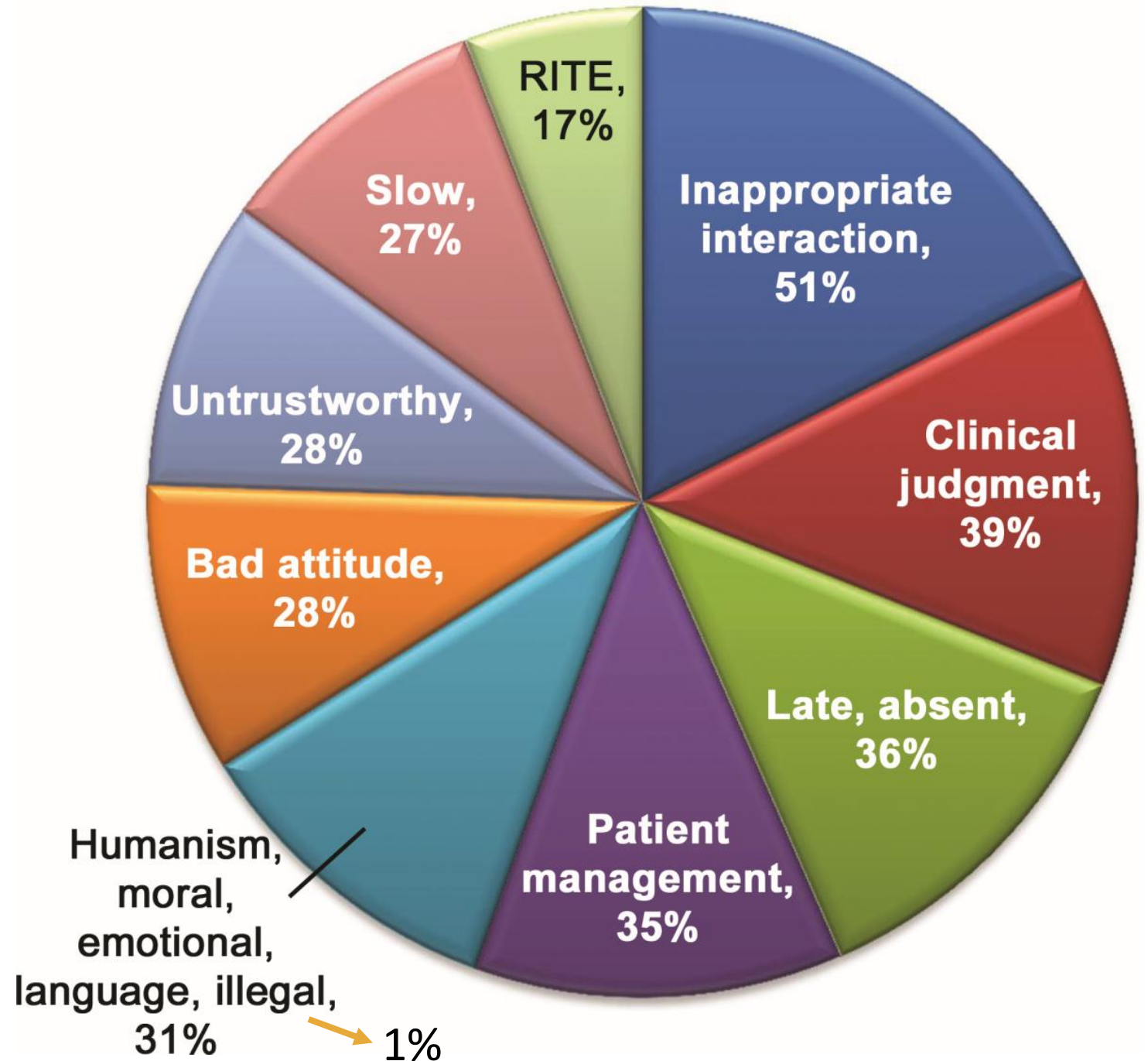
Neurology PDs
reporting at least one
struggling resident

81%

Struggling residents
identified in their
first neurology year

Types of Deficiencies

Cognitive
Behavioral
Multiple competencies



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



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

Indicators

- Clinical competency committee
 - Faculty evaluations
 - Residency In-service Training Exam (RITE)
 - Early contact with frontline faculty and mentors
 - Conference presentations or morning report
 - Simulations
 - Objective standardized clinical examinations (OSCEs)
 - Intern year
- Traditional mechanisms
- Will often find you,
consider seeking out
- Modern
methodologies
-
- The diagram illustrates the categorization of various indicators into two groups. A large orange bracket on the right side of the list groups the first three items (Clinical competency committee, Faculty evaluations, and RITE) under the heading 'Traditional mechanisms'. Another large orange bracket on the right side groups the last three items (Simulations, OSCEs, and Intern year) under the heading 'Modern methodologies'. An orange arrow points from the fourth item, 'Early contact with frontline faculty and mentors', to the text 'Will often find you, consider seeking out'.

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

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

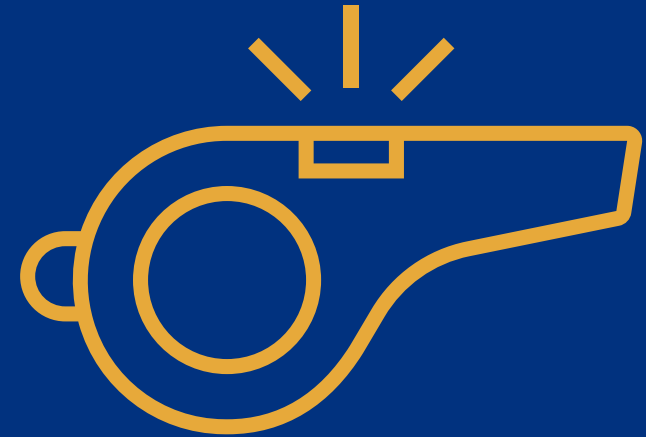
- 1) Distraction
- 2) Deprivation of sleep
- 3) Depression
- 4) Drugs and alcohol
- 5) Disease
- 6) Disability of learning
- 7) Disorder of personality

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



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

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

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

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

Successful Remediation

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

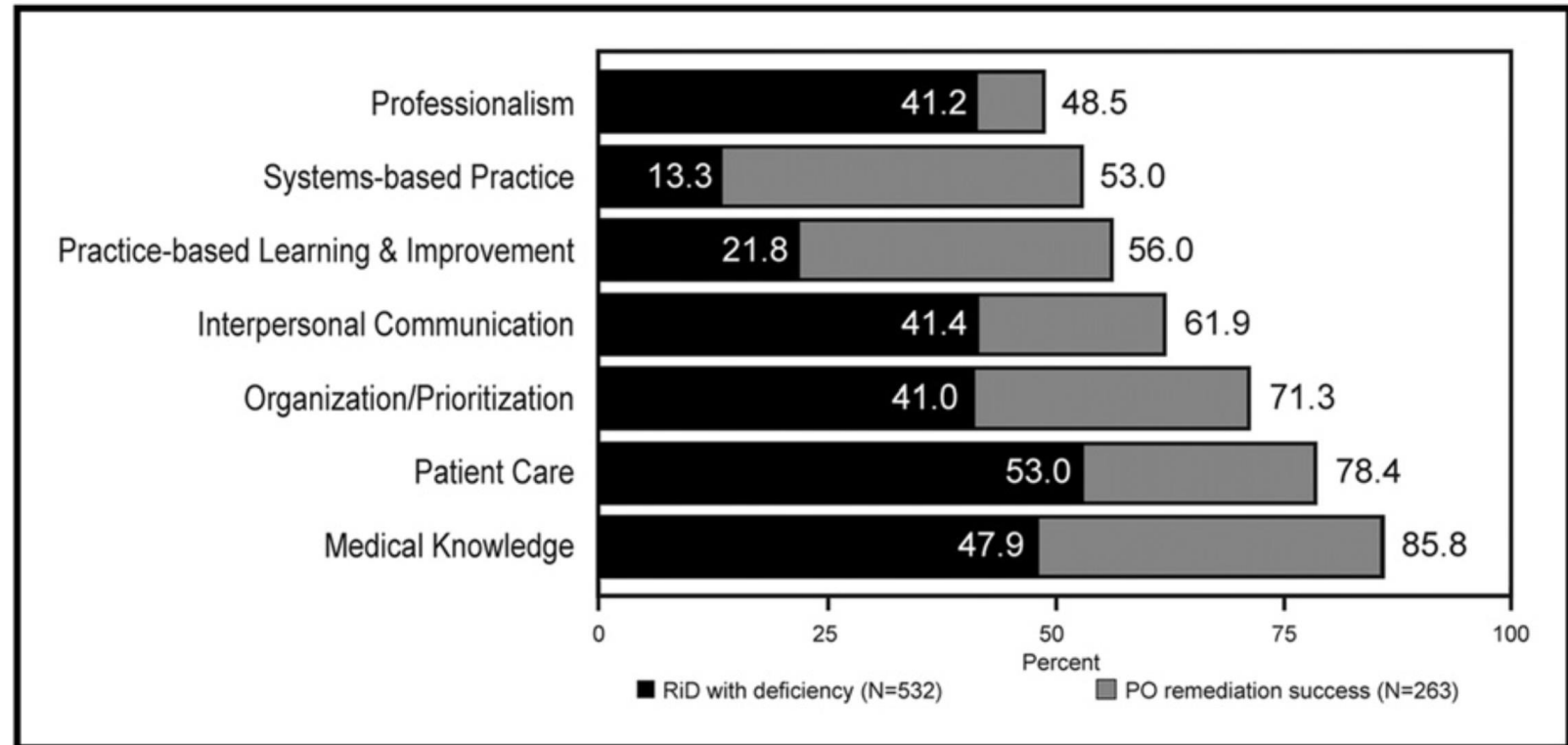
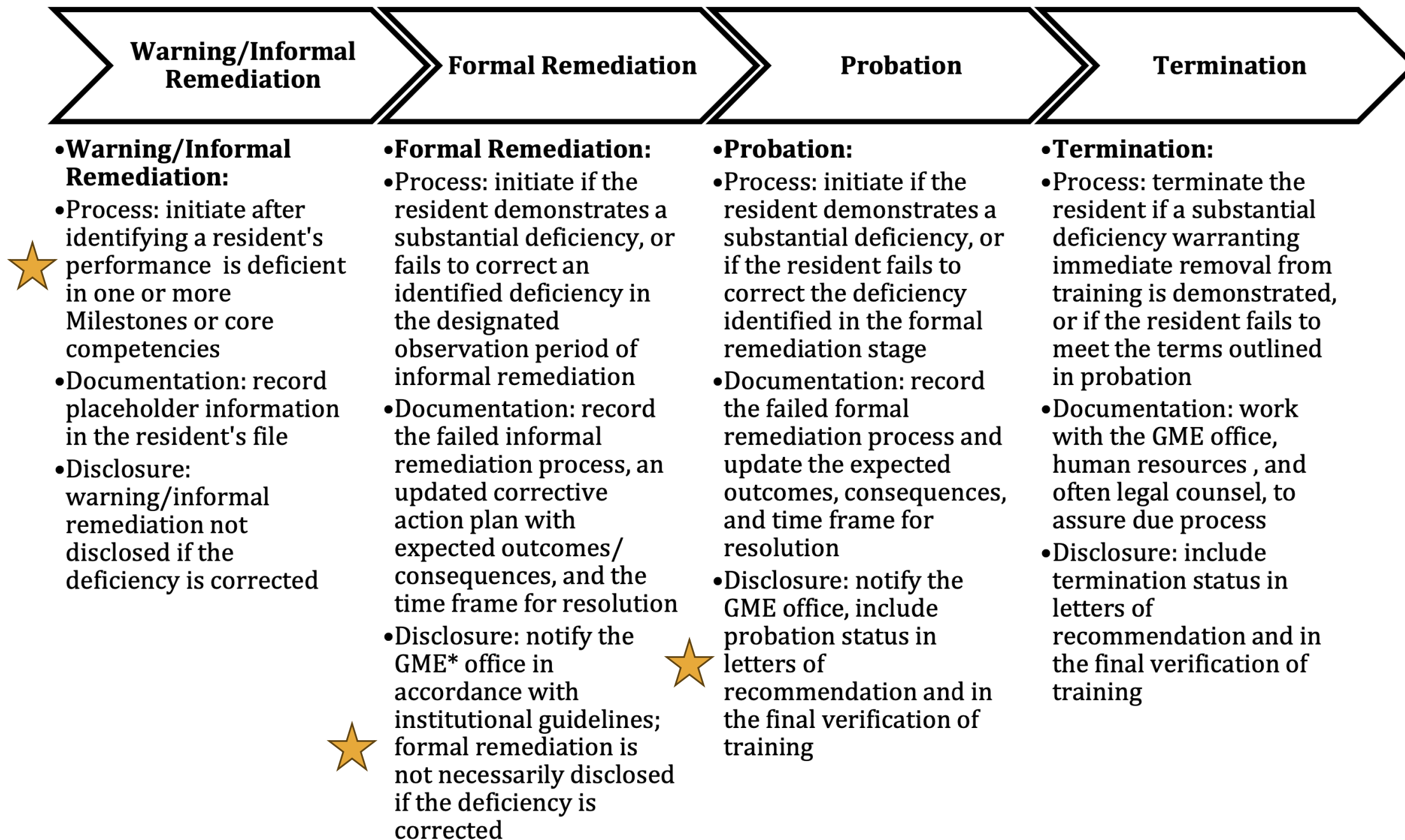


Figure 1 Comparison of reported competency deficiency frequencies in 532 residents with program directors (n = 268) estimated the likelihood of successful remediation.



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

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

Shepherd

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.”



Thank You!

Questions? shutto@emory.edu



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