Remediation of the Struggling GME Learner

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Disclosure

• Jeannette Guerrasio: Book Royalties
  • *Remediation of the Struggling Medical Learner*, 1\textsuperscript{st} and 2\textsuperscript{nd} editions, published by the Association of Hospital Medical Education.
Session: Saturday March 9, 2019

- **Part 1**: Individualized Remediation Plans (7a – 10a)

- **Part 2**: Programmatic Considerations (1:30p – 4:30p)
Part 1

Introduction
Approach to the Resident with a Clinical Reasoning Deficit
Small group exercise
Questions for the speakers

Break

The Use of Simulation to Remediate Difficulties with Professionalism and Interpersonal Skills
Small group exercise
Questions for the speakers

Complete evaluations
Part 2

Very brief introduction
Underlying Mental Health Concerns Among Struggling GME Learners
Questions for the speakers

If you Build it, They Will Come: Developing a Remediation Program at Your Own Institution
Small group exercise
Questions for the speakers

Break

Documentation and Legal Considerations in the Remediation of Graduate Medical Trainees
Small group exercise
Questions for the speakers

Complete evaluations
What We Know

15%
Responsibility

• Low attrition surgery programs
  • 21.0% versus 6.8%; P<.001
Responsibility

• Low attrition surgery programs
  • 21.0% versus 6.8%; P<.001

  were more likely to provide resident remediation
Are we seeing more struggling learners?

• 3 hypotheses

• With NAS, our mode of assessment has changed
• The way we train residents has changed
• Change in medical student assessment is pushing struggling learners through
Recognition of the Learner in Need

• Early identification is critical, but often doesn’t happen

• Deficits are rarely self-reported

• Written evaluations are often not helpful
Barriers to Recognition

• We don’t see it

• We do see it, but...
  • Denial
  • Perceived negative consequences to the learner
  • Struggling learners are time-consuming
  • Lack of comfort with remediation
  • Remediation resources not available
  • Fear of retaliation, legal ramification

• Improved recognition often requires culture change

Model for Remediation

- Competence Assessment
- Diagnosis of Deficiency
- Development of Remediation Strategy
  - Remediation with:
    1. Deliberate Practice
    2. Feedback
    3. Reflection
- Reassessment

Competencies:

• Medical Knowledge
• Patient Care
• Interpersonal Skills and Communication
• Professionalism
• Practice-Based Learning
• Systems-Based Practice

The Outcomes Project. Accreditation Council for Graduate Medical Education. 1999.
Competencies “Plus”:

- Medical Knowledge
- Patient Care
  - Clinical Skills
  - Clinical Reasoning
  - Organization & Time Management
- Interpersonal Skills and Communication
- Professionalism
- Practice-Based Learning
- Systems-Based Practice
Competencies “Plus”:

• Medical Knowledge
• Patient Care
  • Clinical Skills
  • Clinical Reasoning
  • Organization & Time Management
• Interpersonal Skills and Communication
• Professionalism
• Practice-Based Learning
• Systems-Based Practice
• Mental Well Being
Common Chief Complaint: “This intern is disorganized”

• Differential Diagnosis of “disorganized”
  • True problem with organization
    • Global
      • Usually not new, bills are late, desk is messy, no system
    • Specific
      • Unfamiliar with new system, EHR, unprepared for your program
  • Clinical reasoning deficit in an otherwise organized individual
    • Unable to collect data efficiently, cannot triage information
    • Ineffective problem representation
    • Lack illness scripts

• Issue with mental well-being
Additional Information

**Direct Observation**
- Collect a H&P
- Efficiency
- Prioritize tasks
- Responsiveness/Ownership

**Presentations/Rounds**
- Integration of information
- Formulation of ddx, A/P
- Ability to summarize case
- Formulation of questions

**Interview the Learner**
- Reading materials
- Stressors
- Substance abuse
- Learner’s perspective

**Other Sources**
- Chart review
- Arrival/departure time
- 360° evaluations
Remediation Team Approach

• Review the learner’s academic record
• Review *examples* of deficit(s) and confirm deficit(s)
• Look for trends and severity
Remediation of Clinical Reasoning: 
A Metacognitive Journey

Joseph Rencic, MD
Case

• Intern in internal medicine was flagged for discussion by the clinical competency committee. Review of his undergraduate medical record reveals no “red flags.” His standardized test scores were slightly above average. Illustrative quotations from attendings:
  • “His presentations usually include all the relevant information, but also include too many irrelevant details. They are always too long.”
  • “His differential diagnoses always focus on zebras.”
  • “He can’t see the big picture. He knows the trees but not the forest.”
  • “If you ask him a specific question about his patient, he answers correctly most of the time.”
Diagnose the Learner. Where is the Lesion?
Problem Representation

If we misidentify the learner’s problems, we’ll provide the wrong solutions to them.
Problem Representation: Theoretical Constructs

• Dual process theory\(^1\)
  • Cognitive load\(^2\)
• Expert performance theory\(^3\)
• Self-regulated learning theory\(^4\)
• Self-determination theory, including self-efficacy\(^5\)

\(^1\) Pelaccia et al. Med educ online. 2011;16(1):5890.
\(^3\) Ericsson. Acad Med. 2015;90(11):1471-86.
The Case Revisited: Problem Representation

• With your colleagues generate hypotheses about the location of his “lesion.”

• Key features
  • “His presentations usually include all the relevant information, but also include too many irrelevant details. They are always too long.”
  • “His differential diagnoses always focus on zebras.”
  • “He can’t see the big picture. He knows the trees but not the forest.”
  • “If you ask him a specific question about his patient, he answers correctly most of the time.”
Data Collection

• What data do you need to collect to confirm your hypotheses?

• How will you collect it?
Data Collection: Key Elements

• Clinical performance
  • Evaluations
    • Talk to attendings and residents personally
  • Direct observation
    • Simulation exercises
    • Standardized patient encounters
    • Real patient encounters

• Preclinical performance
  • Grades
  • Step scores
Simulation Exercises: A Protocol

• **Step 1**: Learn a framework for differential diagnosis using anatomy, pathophysiology, and an organ system-based approach.

• **Step 2**: Practice creating differential diagnosis lists based on four semantic qualifiers: age, gender, race/ethnicity, and chief complaint.
  - List A = comprehensive list of diagnoses
  - List B = most likely four to five diagnoses based on prevalence
  - List C = “can’t miss” diagnoses

• **Step 3**: Write out key historical questions that increase or decrease the probability of the diagnoses on lists B and C.

• Steps 1–4 are repeated with multiple case scenarios until mastery for a given specialty is achieved, usually 10–20 cycles.
Simulation Exercises: A Protocol

• **Step 5**: Create differential diagnoses using framework with a variety of paper cases that provide history and physical examination findings.
  - The learner is given multiple copies of each case, then writes each diagnosis from lists B and C on a separate copy. The learner highlights the information that supports or refutes the diagnosis, and crosses out distracting information.

• **Step 6**: Using the same case as in step 5, create a table of symptoms and signs, rating their relative value in increasing or decreasing the probability of the disease.

• Steps 5 and 6 are also repeated with multiple case scenarios until the remediation specialist determines that this skill is mastered.
Simulation Exercises: A Protocol

• Step 7: Summarize these cases using semantic qualifiers in both written and oral format using epidemiology, onset, site, course, severity, and context to represent the patient’s problem(s).

• Step 8: Create a prioritized diagnostic work-up for each of the diagnoses, considering the following categories: monitor the patient, order lab(s), order test(s), and/or prescribe a therapeutic trial of medication.

• Step 9: Reflect on the case by comparing with previous cases and experiences. Develop questions that can increase learning from the case.

• Step 10: Create a prioritized treatment plan for each of the leading diagnoses, considering the categories above.
Role Modeling Exercise

- 36 yo woman with no significant PMH presents with worsening dyspnea on exertion (DOE). It started 3 days ago with some mild DOE during her usual 3 mile run. During that day she developed a mild non-productive cough. The next day she had worsening DOE, subjective fevers, and could only complete 1 mile of her run. Her non-productive cough increased in frequency. Today she could not complete her run due to her dyspnea, a feeling of generalized fatigue, and R-sided chest pain when coughing or taking deep breaths so she came to the office.
- PMH/PSH: none
- SH: ½ PPD smoker for 16 year, no ETOH
- FH: 2 healthy parents
- Meds: ortho tricyclen 1 tablet daily

Physical examination
- VS: 38.1, 92/58, 112, 12, 94% room air
- General: no significant distress
- HEENT: dry mucous membranes
- Neck: normal JVP, no thyromegaly
- Pulm: bronchophony and egophony in RLL
- CV: tachycardic, RRR, S1, S2 normal; no m/r/g
References


The Use of Simulation to Remediate Difficulties with Professionalism & Interpersonal Skills

Jeannette Guerrasio, MD
Professor of Medicine
Director, UME & GME Remediation
University of Colorado, SOM
Disclosure

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Objectives

- Identify techniques for using simulation to remediate poor professional behaviors and interpersonal skills
- Consider how examples provided can be modified and implemented at your institution
Session Format

• Brief didactic introduction
• Small group case-based discussions
• Report out to larger group
Simulation for Remediation

• 2011, a AAMC survey concluded:

  • Medical simulation is being used to teach and assess students, residents, and practicing physicians in nearly all of the ACGME core competencies

  • Only 44% of medical schools and 19% of teaching hospitals reported using simulation for the remediation of professionalism
Remediation Strategy

Deliberate Practice → Feedback → Reflection in Action
Underperforming Learners

WEAKNESSES

• Trouble identifying feedback
• Can’t actualize feedback
• Large blind spots
• Don’t learn from the hidden curriculum
• Don’t learn from the abstract
Slow vehicles thank you
Cases

1. **Poor Interpersonal Skills:** A resident that appears unintentionally awkward, insensitive and unfriendly; has trouble reading social cues; limited situational awareness

2. **Unprofessional Behaviors:** An aggressive, condescending, argumentative, short tempered, disrespectful resident

3. **Other...**
Cases

1. **Poor Interpersonal Skills:** A resident that appears unintentionally awkward, insensitive and unfriendly; has trouble reading social cues; limited situational awareness

2. **Unprofessional Behaviors:** An aggressive, condescending, argumentative, short tempered, disrespectful resident

3. **Other...**

   **In Groups:**
   How might you use simulation to remediate your struggling resident?
Objectives:

1. To describe the reasons for referral for remediation of unprofessional behaviors

2. To determine the impact of the remediation intervention as assessed by participants and their referring supervisors
Intervention

- Focused training using standardized patients and hybrid simulation
- 3-4 simulated cases per session
- After each interaction, the remediating individual received a detailed report with observations and recommendations from the remediation team
Participants

Who – 9 residents and faculty referred for remediation of poor professional behaviors related to communication and interpersonal skills; 19 referring program directors, department chairs and the Office of Professionalism
- Representing 11 specialties

How – Quantitative analysis of focused interview of participants and referring supervisors

When – 2-4 years after remediation intervention, interviews conducted from June – Dec 2017
<table>
<thead>
<tr>
<th>Per Referred Resident &amp; Faculty</th>
<th>Per Referring Supervisor</th>
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</thead>
<tbody>
<tr>
<td>Isolated incident</td>
<td>Pattern of behavior that led to referral</td>
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<tr>
<td>Inappropriate behavior</td>
<td>Inappropriate behavior</td>
</tr>
<tr>
<td>Miscommunication/General communication challenges</td>
<td>Miscommunication/General communication challenges</td>
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<tr>
<td>Unprofessional response to feedback</td>
<td>Unprofessional response to feedback</td>
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<tr>
<td>Poor organization and task completion</td>
<td>Poor organization and task completion</td>
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<tr>
<td>Patient, Medical Student, and/or Staff Complaints</td>
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<tr>
<td>Per Referred Resident &amp; Faculty</td>
<td>Per Referring Supervisor</td>
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<td>--------------------------------</td>
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<tr>
<td><strong>Inappropriate behavior:</strong></td>
<td></td>
</tr>
<tr>
<td>• Mean, angry, anxiety inducing, sad, defensive</td>
<td>• Aggressive, condescending, disregarding, argumentative, short tempered, intolerance of others, disrespectful, opinionated, poor listening skills, disengaged, lacking empathy, defensiveness, standoffish, interrupting, sexiest jokes, controlling, too passive</td>
</tr>
<tr>
<td>Per Referred Resident &amp; Faculty</td>
<td>Per Referring Supervisors</td>
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<td>--------------------------------------------------------</td>
<td>---------------------------------------------------</td>
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<tr>
<td>Improved self-awareness, resilience and well-being</td>
<td>Improved self-awareness, resilience and well-being:</td>
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<td>More professional interactions</td>
<td>More professional interactions</td>
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<tr>
<td>Improved work effectiveness</td>
<td>Improved work effectiveness</td>
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<tr>
<td>Improved feedback and evaluations</td>
<td>Improved feedback and evaluations</td>
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<tr>
<td>Change in career trajectory</td>
<td>Change in career trajectory</td>
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Conclusions

Challenging Behaviors
• Referred individuals were more likely to see their behavior as an isolated incident than their supervisors
• Supervisors were more descriptive when reporting challenging behaviors

Observed Behaviors
• This method of simulation remediation was associated with:
  • Long term retention of learning strategies
  • Long term improved behaviors
• Regan L et al. Remediation methods for milestones related to interpersonal and communication skills and professionalism. JGME 2016;2(1):18-23.