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# DEALING WITH A PROBLEM LEARNER: Identifying and Aiding an Underperforming Fellow

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# Objectives

- Discuss methods to identify an underperforming fellow
- Review a classification system to diagnosis the problem
- Provide a framework for potential solutions

# ACGME & ABMS

| General Competency | Common Assessment Methods |
|---|---|
| Patient Care | ▪ Direct observation (live or video)<br>▪ Rating scales/evaluation forms<br>▪ Audit of clinical practice (e.g., quality performance measures)<br>▪ Simulation (including standardized patients)<br>▪ Case Logs/registries |
| Medical Knowledge | ▪ In-training examinations<br>▪ Oral questioning methods (e.g., SNAPPS)<br>▪ Direct observation (live or video) |
| Professionalism | ▪ Multi-source feedback (MSF)<br>▪ Patient surveys (can be part of MSF)<br>▪ Direct observation |
| Interpersonal and Communication Skills | ▪ Multi-source feedback (MSF)<br>▪ Patient surveys (can be part of MSF)<br>▪ Direct observation (live or video)<br>▪ Simulation (including standardized patients) |
| Practice-based Learning and Improvement | ▪ Audit of clinical practice (e.g., quality performance measures)<br>▪ Evidence-based medicine logs<br>▪ Case Logs<br>▪ Rating scales/evaluation forms |
| Systems-based practice | ▪ Audit of clinical practice (e.g., quality performance measures)<br>▪ Multi-source feedback (MSF)<br>▪ Rating scales/evaluation forms |

ACGME. *Milestones Guidebook* 2016

# What is a “Problem Learner”?

- ABIM: “trainee who demonstrates a significant enough problem that requires intervention by someone of authority, usually the program director or chief resident”

Steinert Y. *BMJ* 2008

# Scope of the Problem

- Between 7-28% of medical trainees will require remediation in the form of an individualized learning plan to achieve competence

- Residency
  - Psychiatry: 5.8% over 4 years
  - Family Medicine: 9.1% over 25 years
  - Internal Medicine: 7.0% on average

Steinert Y. *BMJ* 2008; Boileau E. *Adv Med Educ Pract* 2017; Guerrasio J. *Acad Med* 2014

# How Do we Identify the "Problem Learner"?

- Initial identification can be the most challenging step

- A **problem learner does not meet the expectations of a training program because of a problem with knowledge, attitudes, or skills**.

Steinert Y. *BMJ* 2008

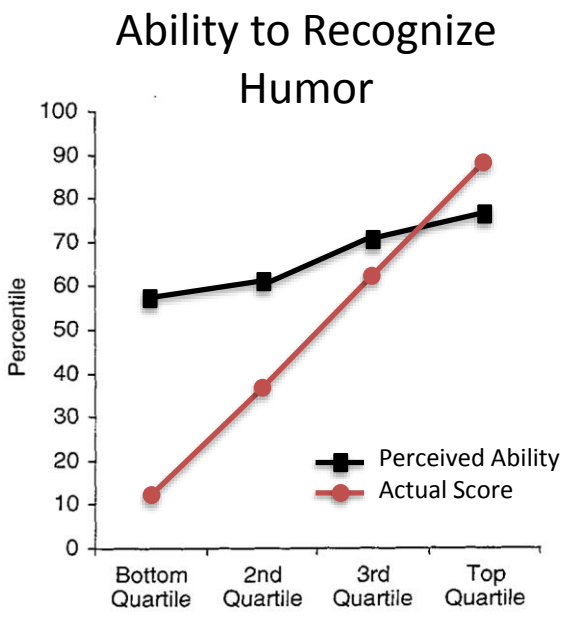
# Confirming the Problem

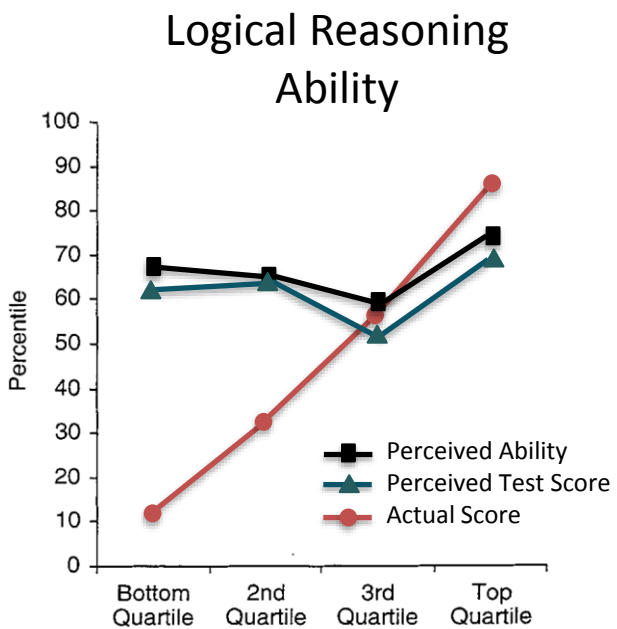
- "*Ignorance more frequently begets confidence than does knowledge*" –Charles Darwin

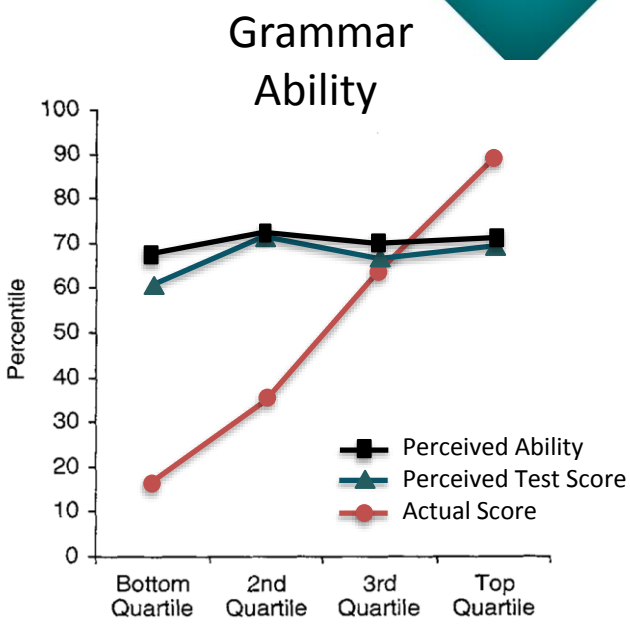
- Only 2%–6% of struggling learners will self-identify

Kruger J. *J Pers Soc Psychol* 1999; Boileau E. *Adv Med Educ Pract* 2017

# Confirming the Problem




Kruger J. *J Pers Soc Psychol* 1999

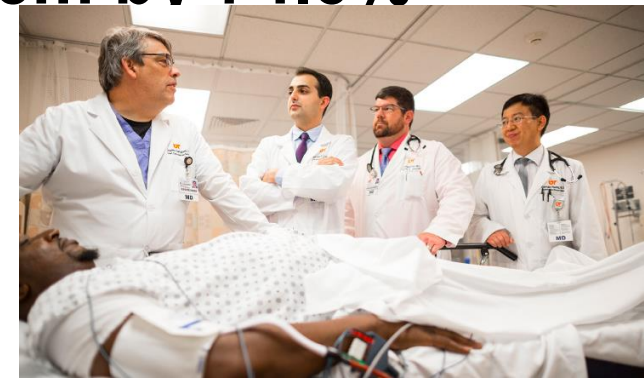
# More Difficult to ID as Training Advances?

- **Easiest at the undergraduate/medical school level**
  - Expectations are relatively homogeneous
  - Frequently tested within their schools
- **The GME level becomes more challenging**
  - Training differentiates along specialty lines
  - Trainees are expected to learn AND provide service to patients
- **Physicians in practice are rarely assessed in their work environments**

Hauer KE. *Acad Med* 2009

# Why Is Initial Identification Challenging?

- The Association of American Medical Colleges (AAMC) surveyed clinical faculty at ten schools and **"unwillingness to record negative evaluations" was rated as a problem by 74.5%**



Tonesk X. *J Med Educ* 1987; ; Boileau E. *Adv Med Educ Pract* 2017

# Teachers Find This Challenging

- Clinical teachers' perceptions are considered to be a reliable predictor of learners' difficulties
- Many teachers report an overwhelming desire to protect or rescue their learner
- Others report inadequate time to diagnosis the problem

Steinert Y. *BMJ* 2008

# The Concerns of Faculty—Initial Step

- **Professional Considerations**
  - Extra Workload Involved for the faculty member
  - Lower Faculty Evaluations
  - Fear of Litigation, Grievances

- **Personal Considerations**
  - Guilt, Shame, Personal Failure
  - Emotional Discomfort
  - Relationship with the Student

Yepes-Rios M. *Med Teach* 2016

# The Concerns of Faculty—Initial Step

- **Student-Related Considerations**
  - Financial
  - Personal, Ending Career Goals
- **Institutional Considerations**
  - Health Professions Shortage
  - Lack of Institutional Support, Pressure to Pass
  - Diminished Institution Reputation
  - Inflated Grading

Yepes-Rios M. *Med Teach* 2016

# The Concerns of Faculty—Initial Step

- **Evaluation Process Barriers for Failing A Student**
  - Lack of Experience and/or Confidence in the Evaluator Role
  - Uncertainty, Variability in Evaluation Standards

- **Remediation Process Barriers**
  - None or Limited Remediation Process

Yepes-Rios M. *Med Teach* 2016

# What Helps Faculty to ID?

- **Duty to Society**
  - Would I want this individual caring for me/my family?
- **Institutional Support**
  - Clear process for bringing forth concerns
- **Remediation Venue**
  - General plan for how to help a troubled learner

Yepes-Rios M. *Med Teach* 2016

# PDs: Comfort Level in Dealing with Problem Trainees

- Identify problem resident 88%
- Diagnose residents difficulties 76%
- Manage problem resident 58%

Yao D. *JAMA* 2000

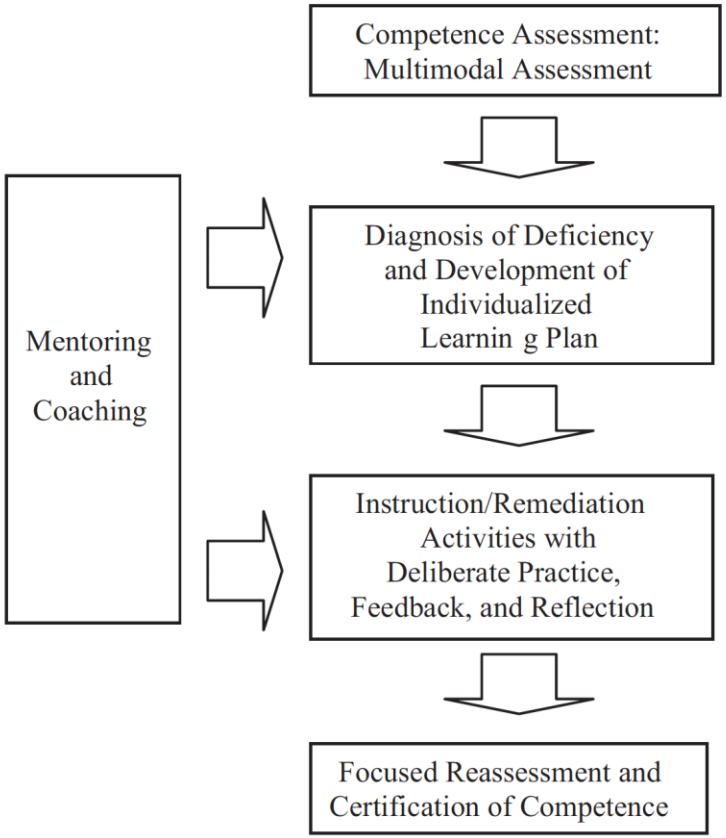
# Fear of Litigation

- 49% of Program Directors fear legal repercussions
- 15% result in lawsuits

Yao D. *JAMA* 2000

# How Can We Help Our Faculty to Recognize and Help Those Trainees in Trouble?

# Remediation Program Model




Hauer KE. *Acad Med* 2009

# Step 1: Identifying Deficiencies

- **Multiple assessments are required** because deficiencies may exist in many domains of competence
  - Observed encounters with actual patients
  - Standardized patient encounters
  - Written or Web-based assessments of clinical reasoning
  - Record reviews
  - Chart-stimulated recall
  - Supervisor and peer observations
  - Multiple-choice examinations of knowledge

Hauer KE. *Acad Med* 2009

# ACGME Milestones

| 1. Gathers and synthesizes essential and accurate information to define each patient's clinical problem(s). (PC1) | | | | |
|---|---|---|---|---|
| **Critical Deficiencies** | | | **Ready for unsupervised practice** | **Aspirational** |
| Does not collect accurate historical data<br><br>Does not use physical exam to confirm history<br><br>Relies exclusively on documentation of others to generate own database or differential diagnosis<br><br>Fails to recognize patient's central clinical problems<br><br>Fails to recognize potentially life threatening problems | Inconsistently able to acquire accurate historical information in an organized fashion<br><br>Does not perform an appropriately thorough physical exam or misses key physical exam findings<br><br>Does not seek or is overly reliant on secondary data<br><br>Inconsistently recognizes patients' central clinical problem or develops limited differential diagnoses | Consistently acquires accurate and relevant histories from patients<br><br>Seeks and obtains data from secondary sources when needed<br><br>Consistently performs accurate and appropriately thorough physical exams<br><br>Uses collected data to define a patient's central clinical problem(s) | Acquires accurate histories from patients in an efficient, prioritized, and hypothesis-driven fashion<br><br>Performs accurate physical exams that are targeted to the patient's complaints<br><br>Synthesizes data to generate a prioritized differential diagnosis and problem list<br><br>Effectively uses history and physical examination skills to minimize the need for further diagnostic testing | Obtains relevant historical subtleties, including sensitive information that informs the differential diagnosis<br><br>Identifies subtle or unusual physical exam findings<br><br>Efficiently utilizes all sources of secondary data to inform differential diagnosis<br><br>Role models and teaches the effective use of history and physical examination skills to minimize the need for further diagnostic testing |
| ☐ | ☐ | ☐ | ☐ | ☐ |
| Comments: | | | | |

ACGME. *The Internal Medicine Milestone Project* 2015

# "What" is the Problem?

| Apparent Deficiencies | |
|---|---|
| Insufficient medical knowledge | 48% |
| Poor clinical judgment | 44% |
| Inefficient use of time | 44% |
| Inappropriate interaction with staff/colleagues | 39% |
| Provision of poor medical care | 36% |
| Unsatisfactory Clinical Skills | 31% |
| Unsatisfactory humanistic behavior | 23% |
| Excessive/unexplained tardiness or absences | 21% |
| Unacceptable moral or ethical behaviors | 15% |

Yao D. *JAMA* 2000

# Processes that Identified Problem

| Process that Identified Problem Trainee | |
|---|---|
| Direct observation in clinical settings | 82% |
| Critical incident | 59% |
| Poor performance at morning report/conference | 45% |
| Neglecting patient care responsibility | 33% |
| Chart review/medical record audit | 26% |
| In-training examination | 23% |
| Mini-CEX (clinical evaluation exercise) | 8% |

Yao D. *JAMA* 2000

# Individuals that Identified Problem

| Individuals that Identified Problem Trainee | |
|---|---|
| Chief Resident | 84% |
| Attending physicians, through verbal comments | 76% |
| Program director | 74% |
| Other residents | 49% |
| Attending physicians, through written evals | 41% |
| Nursing staff | 31% |
| Self | 2% |
| Patients and families | 2% |

Yao D. *JAMA* 2000

# Step 2: Diagnosis and Develop Plan

- Diagnosis of the underlying problem that led to the performance deficits

Hauer KE. *Acad Med* 2009

# Framework for Analyzing Problem

| Knowledge | Attitudes | Skill |
|---|---|---|
| Example: Gaps in knowledge of basic or clinical sciences | Example: Difficulties with motivation, insight, self assessment, doctor-patient relationships | Example: Difficulties with interpreting information, interpersonal skills, technical skills, clinical judgment, or organisation of work |
| *Be sure to identify not only challenges but also strengths* | *Attitudinal problems, which usually manifest themselves in behaviours, are often easy to identify but challenging to resolve* | *Skill deficits often overlap with gaps in knowledge. Strengths must also be identified* |

Steinert Y. *BMJ* 2008

# Framework for Analyzing Problem

| Teacher | Learner | System |
|---|---|---|
| Example: Teachers' perceptions, expectations, or feelings; personal experiences or stresses; colleagues' perceptions, expectations, or stresses | Example: Relevant life history or personal problems, including acute life stresses, learning disabilities, psychiatric illness, or substance misuse; learner expectations and assumptions; learner reactions to identified problems | Example: Unclear standards or responsibilities; overwhelming workload; inconsistent teaching or supervision; lack of ongoing feedback or performance appraisal |

Steinert Y. *BMJ* 2008

# Identifying the Deficit

| | | |
|---|---|---|
| **Cognitive causes** | **Insufficient knowledge**[7,17,18,20,22,34,35,53–56,58] | Insufficient investment in studies[17–19,34]<br>Learning disorders[17,18,22,34,35,54,56]<br>Organization related difficulties[19,20,34,51,52,54] |
| | **Clinical reasoning**[7,18,34,71] | Insufficient knowledge[20,34]<br>Difficulty organizing information[34,51,55,56]<br>Clinical reasoning difficulties[71] |
| **Noncognitive causes** | **Attitude problems**[7,18,20,22,35,52,53,57] | Ignorance of professional responsibilities[20]<br>Different values and beliefs[17,18,34,55]<br>Poor insight and self-regulation[18,22]<br>Poor social skills[7,19,22,52,56]<br>Insufficient motivation[22,52–56]<br>Conflicts in the workplace[34,35,54,58] |
| | **Affective problems**[7,17,19,34,53] | Anxiodepressive mood disorders[17,19,20,34,35,51–55]<br>Other mental health issues[19,20,22,35,56,58]<br>Substance abuse[17,19,20,22,34,35,56,58]<br>Stress (family, personal, relational)[34,35,52–54,58] |

Boileau E. *Adv Med Educ Pract* 2017

# Documenting Objective Data

- Tangible examples must be gathered.

- This should be done for:
  - Clinical teachers:  Verify their impressions
  - The learner:  More likely to see credibility in the feedback received
  - The institution:  Will be able to justify its decisions

Boileau E. *Adv Med Educ Pract* 2017

# Step 2: Diagnosis and Develop Plan

- Development of an individualized learning plan based on learner characteristics and identified needs
  - Articulation of clear expectations for acceptable performance
  - Guidance in assessing their own performance accurately
  - Coaching in self-reflection and in planning for improvement
  - Clarity about whether this remediation is required or voluntary
  - What the consequences of remediation or non-remediation will be

Hauer KE. *Acad Med* 2009

# Step 3: Remediation Activities

- Provision of the prescribed learning activities
  - A set of specific experiences should be prescribed
  - Should offer participants opportunities for deliberate practice followed by feedback
    - Guided clinical experience
    - Practice with simulations or standardized patients
    - Study and knowledge testing
    - Review of medical charts with stimulated recall
    - Observation of their clinical performance

Hauer KE. *Acad Med* 2009

# Treating the Problem: Knowledge

- Spend additional time with the learner (and monitor what they do)
- Communicate clear expectations
- Provide enhanced teaching and learning opportunities
- Arrange for peer or mentor support
- Reduce the clinical workload, with more protected time for education
- Design a remedial programme, with defined goals, objectives, strategies, and evaluation methods

Steinert Y. *BMJ* 2008

# Treating the Problem: Skill

- Spend additional time with the learner (and monitor what they do)
- Communicate clear expectations
- Provide enhanced teaching and learning opportunities
- Arrange for peer or mentor support
- Design a remedial program, with defined goals, objectives, strategies, and evaluation methods
- Offer a skill based training course tailored to individual needs

Steinert Y. *BMJ* 2008

# Treating the Problem: Attitude

- Communicate clear expectations
- Arrange for peer or mentor support
- Design a remedial program, with defined goals, objectives, strategies, and evaluation methods
- Recommend counselling and/or therapy

Steinert Y. *BMJ* 2008

# Step 3: Remediation Activities

- Goal is deliberate, conscious practice under the guidance of experienced supervisors who can offer specific and timely feedback
  - Usefulness of simulators in procedural skills training suggests that this approach is successful

Hauer KE. *Acad Med* 2009; Lynagh M. *Med Educ* 2007

# Fairness is Critical

- Must ensure “due process” to guarantee fairness, confidentiality, and informed consent
  - Confirm the learner is aware of the program’s educational objectives and rules of promotion
  - Feedback should be given on a regular basis and evaluations should be based on first hand exposure and objective data

Steinert Y. *BMJ* 2008

# As is Documentation

- Documentation is critical
  - Clinical and skills assessments
  - Evaluations
  - Interventions performed
  - Discussions with the fellow

Steinert Y. *BMJ* 2008

# Which Interventions Help?

| Intervention | |
|---|---|
| More frequent feedback sessions | 65% |
| Assigned mentor for structured supervision | 53% |
| Probation | 35% |
| Psychiatric/psychological counseling | 35% |
| Strict behavioral guidelines | 32% |
| Remedial didactic curriculum | 28% |
| Leave of absence | 9% |
| Formal psychomotor function testing/assessment | 7% |
| Substance abuse rehab program | 7% |

Yao D. *JAMA* 2000

# Step 4: Reassessment

- Retesting of participant to ensure that acceptable levels of performance have been achieved, so that competence can be certified
  - Medical education leaders need to take appropriate action if remediation does not achieve the desired result

Hauer KE. *Acad Med* 2009

# Example of a Remediation Program

- **Remediation program faculty**
  - Represent multiple medical specialties
  - Medical education specialists who have been recognized locally and nationally for their teaching abilities

- Medical students are referred by their clerkship or course directors
- **Residents and fellows are referred by their program directors**
  - Receive repetitive negative comments on rotation evaluations
  - Have failed or are in danger of failing a rotation
  - Are no longer in good academic standing and have been placed on a letter of warning or focused review.
- Attending physicians participate through self-referral only

Guerrasio J. *Acad Med* 2014

# Example of a Program

- Remediation specialist conducts a semi-structured intake interview with each referred learner in a non-threatening manner
  - Designed to address the ACGME competencies
  - Includes:
    - Medical knowledge
    - Clinical skills
    - Clinical reasoning
    - Time management and organization
    - Interpersonal skills
    - Communication skills
    - Professionalism
    - Mental well-being

Guerrasio J. *Acad Med* 2014

# Example of a Program

- After the interview, the remediation specialist convenes a "Success Team"
  - The learner
  - A remediation specialist
  - May or may not include:
    - Faculty from the learner's specialty
    - A psychiatrist or mental health professional
    - Student Affairs Dean or Program director

Guerrasio J. *Acad Med* 2014

# Example of a Program

- Reviews all available evaluations, etc
- Determines the likely areas of deficiency
- Which deficit to target first during the remediation process
  - Addresses deficits individually so as not to overwhelm the learner

Guerrasio J. *Acad Med* 2014

# Example of a Program

- **Creates and implements a remediation plan to address the identified deficit**
  - Deliberate practice
  - Timely and regular feedback
  - A chance for the learner to reflect on his or her performance
- **The remediation specialist:**
  - Facilitates the remediation plan with other involved faculty
  - Provides individual remedial skills teaching and feedback as needed

Guerrasio J. *Acad Med* 2014

# Example of a Program

- Program directors are notified of the plan
- Receive weekly progress updates via telephone or e-mail
- Once the first deficit has been addressed, learning plans are subsequently created for each additional deficit

Guerrasio J. *Acad Med* 2014

# Example of a Program

- The Success Team chooses a reassessment method based on the deficit and notifies the learner
- Reassessments are performed by faculty members from other departments or hospital sites who are unaware of the learner's remediation status and consist of multiple-choice question exams, standardized patient encounters or direct observation

Guerrasio J. *Acad Med* 2014

# Example of a Program

- **The program director receives the results and makes the ultimate decision about success or failure** of the remediation efforts
- **The decision to place a learner on probation after the initiation of remediation is made by the program director**
  - It is never made by members of the learner's Success Team
  - The initial learner assessment and remediation plan, as well as reassessment results, are made available to those determining probationary status

Guerrasio J. *Acad Med* 2014

# Example of a Program

- Of the 151 learners referred to the remediation program:
  - 72 (48%) were medical students
  - **65 (43%) were residents**
  - **14 (9%) were post-residency learners**
- 6.6% of the learners self-referred
- More men (59%) than women (41%) were referred

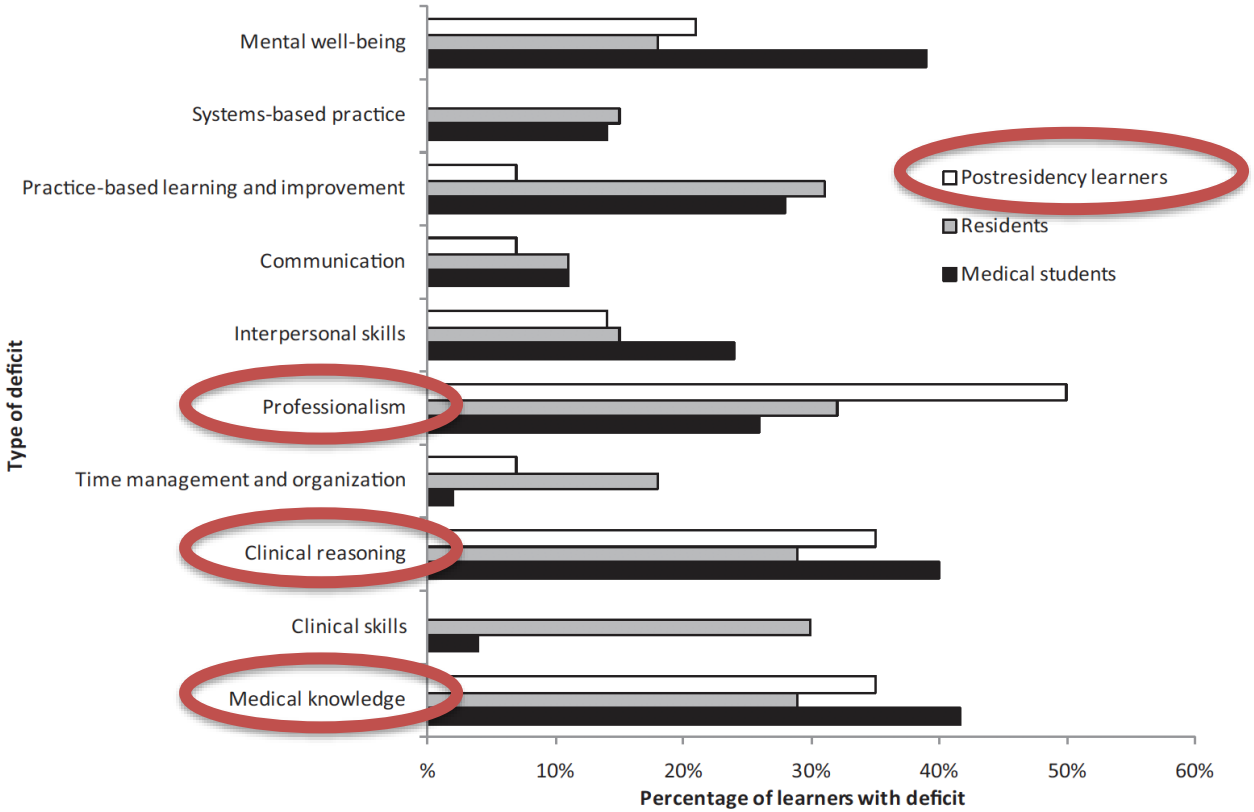
Guerrasio J. *Acad Med* 2014

# Example of a Program

- **Most learners had more than one deficit**
  - 2.14 deficits for medical students
  - 1.59 for residents
  - 1.80 for fellows and attendings

Guerrasio J. *Acad Med* 2014

# Example of a Program




Guerrasio J. *Acad Med* 2014

# Example of a Program

- The mean number of hours of **faculty face time required for remediation was 18.8 per learner**
  - Medical students required 17.8 hours
  - Residents 19.8 hours
  - Post-residency learners 15.7 hours
- **Faculty face time significantly reduced the odds of probation by 3.1% per hour**

Guerrasio J. *Acad Med* 2014

# Example of a Program

- 9% of the learners were placed on probation during remediation

- **Poor professionalism was the only predictor of being placed on probation**

Guerrasio J. *Acad Med* 2014

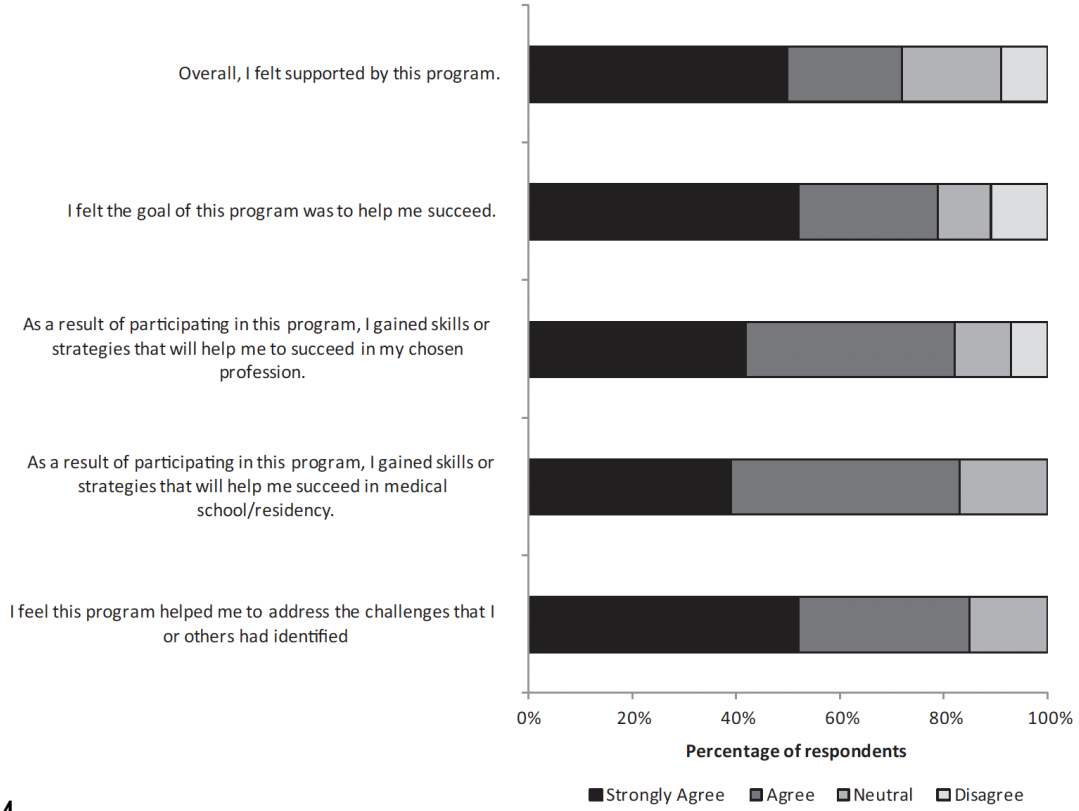
# Example of a Program

- **90% of the referred learners graduated** from their training program, were in good academic standing, or were practicing medicine without restrictions

- 10% were on probation or restricted practice, had transferred to another training program and failed to graduate from that program, or had withdrawn from their training program

Guerrasio J. *Acad Med* 2014

# Feelings of the Learner




Guerrasio J. *Acad Med* 2014

# What Happens with IM Residents?

- Finished residency on time 57%
- Finished residency but delayed 18%
- Transferred to another IM program 9%
- Transferred to another residency program 10%
- Left medicine 4%

Yao D. *JAMA* 2000

# Outcomes

- Almost 90% of problem learners succeed after a structured intervention or remediation program

# Conclusions

- Identifying an underperforming fellow can be challenging
- A plan of action for the underperforming fellow is key to success
- Remediation is possible, and usually successful

# Questions?