

# Underlying Mental Health Concerns Among Struggling GME Learners

Karen Warburton, MD

# Case

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- 30 y/o female, IM resident (PGY-2)
- Self-referred for medical knowledge coaching
  - “mind goes blank” on rounds
  - Poor retention and recall -> has to relearn things over and over, can't present patients without notes, feels ineffective as a teacher
  - Has developed ambivalence about her career
  - USMLE 1 239, 2 245, 3 240
  - ITE 39% ile
- Differential diagnosis?

# Case

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- What I was thinking about
  - Cognitive dysfunction (memory/recall, concentration, executive functioning)
  - Mood disorder and/or performance anxiety
  - ADHD
  - Isolated medical knowledge deficit
- Referral to psychologist

# Test Selection and Data

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- Mood disorder
  - Beck Depression Inventory (BDI-II)
    - Learner scored a 19 indicating mild depression
- Anxiety
  - Beck Anxiety Inventory (BAI)
    - Learner scored a 25 indicating moderate anxiety (26 is the low score for “severe” anxiety)
- ADHD
  - CAARS (Conners Adult ADHD Rating Scale; Conners, Erhardt, and Sparrow 1998)
    - Scores on the CAARS did not indicate attention or hyperactivity difficulties
    - Scores were in the low range in both areas

# Treatment Plan

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- Cognitive Behavior Therapy for anxiety
  - Both anxiety and depression can impair memory recall and attention
  - Anxiety can cause distortions in thinking
- Neuropsychological assessment
  - If anxiety and depression are reduced and primary issue still remains, then plan to refer

# Factors that may underlie clinical performance deficits

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- Psychosocial stress
- Anxiety
- Depression
- Impairment
  - Fatigue
  - Medical illness
  - Substance abuse
- Cognitive dysfunction
  - Memory/recall, concentration, executive function deficit
  - ADHD
- Other
  - Burnout
  - Wrong career (or program) choice
  - Other personal attributes
    - Maturity, reliability, honesty, incorporation of feedback, situational awareness

# Barriers to Seeking Care

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- Gross CP et al. Arch Intern Med. 2000
  - < 65% of physicians regularly see a primary care physician
- Aaronson AL et al. Academic Psychiatry 2018
  - Time
  - Concerns about confidentiality
  - Stigma
  - Cost
  - Concern for effect on one's ability to obtain licensure

# What We Do

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- Learners undergo biopsychosocial assessment by remediation specialist
- If underlying mental health concern is suspected, appropriate referral is made:
  - Psychologist on remediation team
    - Additional diagnostic testing
      - Mood, anxiety, ADHD screen, (personality assessment)
    - Psychotherapy
    - Medication management
    - Cognitive testing
  - Employee Assistance Program
  - Fitness for duty evaluation



# Take Home Points

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- You have to ask
- Know your local resources
  - Ideal to have mental health providers who are used to working with medical trainees and have flexible schedules
- Coaching for the clinical performance deficit
  - Can sometimes be done in parallel
  - May need to be delayed
  - May no longer be necessary
  - \*ideally you can develop an integrated approach to mental wellbeing and clinical performance, which should decrease stigma\*

# If you Build it, They Will Come:

Developing a Remediation Program  
at Your Own Institution

Karen Warburton, MD

# Session Format

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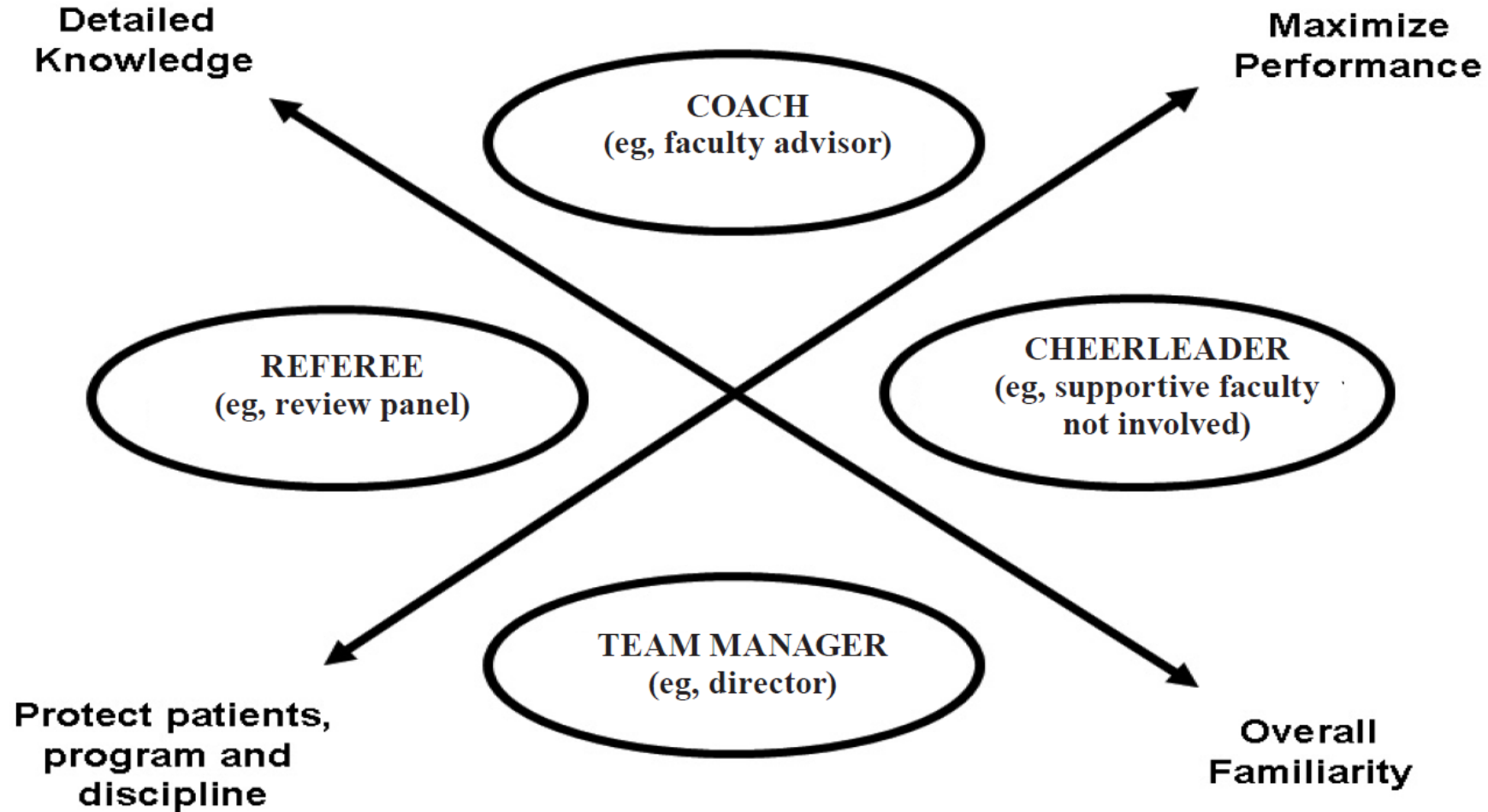
- (Extremely) brief didactic introduction
- Small group case-based discussions
- Report out to larger group

# Approach to the Struggling Learner

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- Universal first step
  - Feedback -> reflection in context of rotation
- If no improvement...
  - From there, depends on the rules and culture of the institution
  - Things that vary
    - What does the term remediation mean?
    - What goes in the record? Where is record stored?
    - When is the GME office notified?

## A Model for Conceptualizing Different Faculty Roles With Residents in Difficulty



The model is located on two axes based on familiarity with the details of the case (detailed to overall) and on whether the goal is to maximize resident performance or protect patients, the program, and the discipline.

# Setting up a Program: 3 Considerations

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- Changing the culture around remediation
  - Stigma and messaging
  - Design a system that facilitates early referral
- Leveraging local resources
  - Faculty development and coordination across departments
  - Which areas can be centralized?
- Documentation, legal concerns, and involvement of the GME office

# Small Group Exercise

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- You are the new Director of Remediation
  - There are 2 urgent learner referrals
- Group 1 – Develop a proposal
  - What resources do you need?
    - Training, time, people, administrative support, remediation tools, access to learning specialists, simulation center
  - What will you centralize? How will you coordinate across departments?
  - Come up with 1 question for the group
- Group 2 - Advertise
  - How will you message to trainees? To faculty?
  - Come up with 1 question for the group

# Appendix

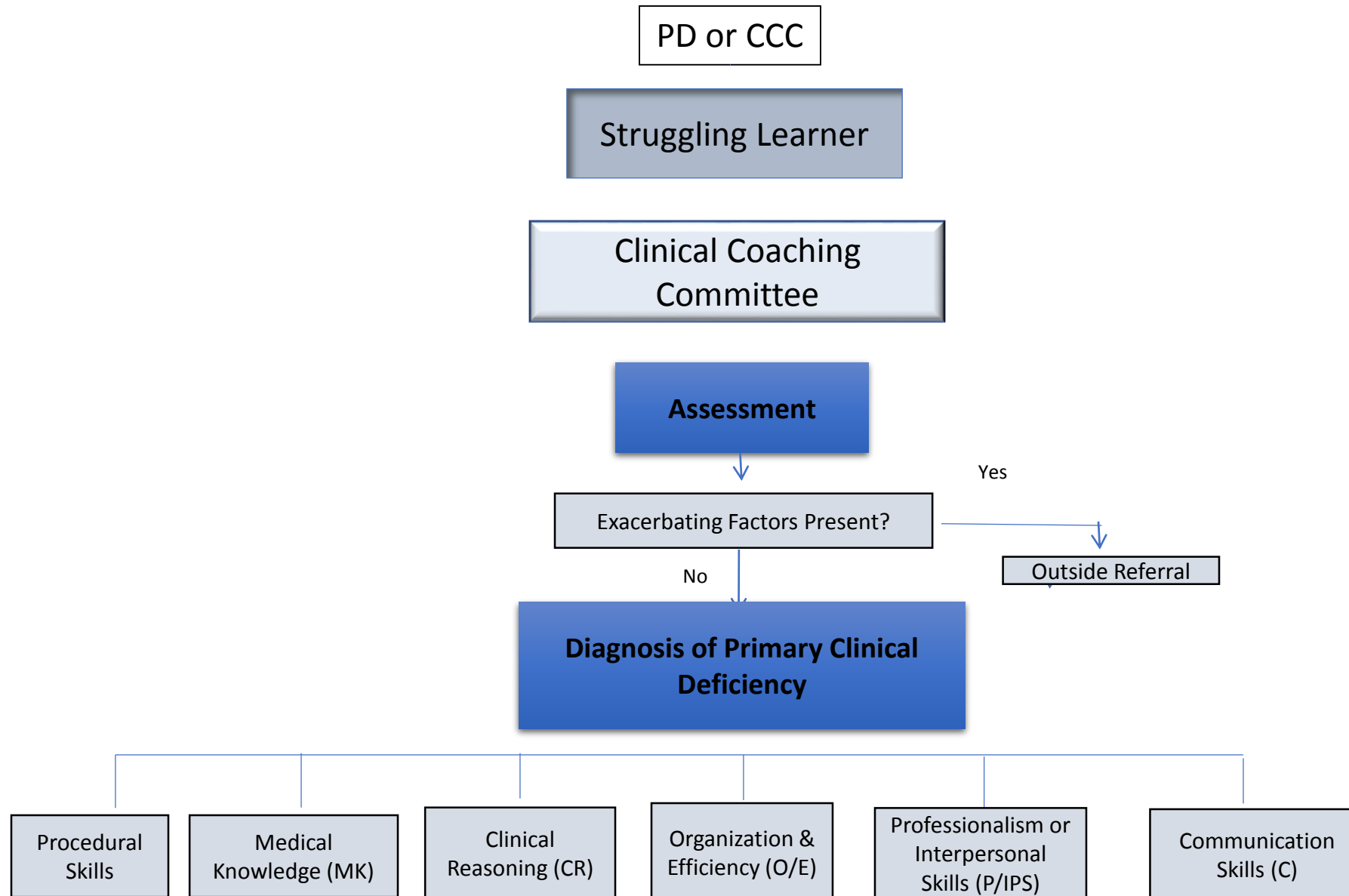


# Remediation vs Coaching

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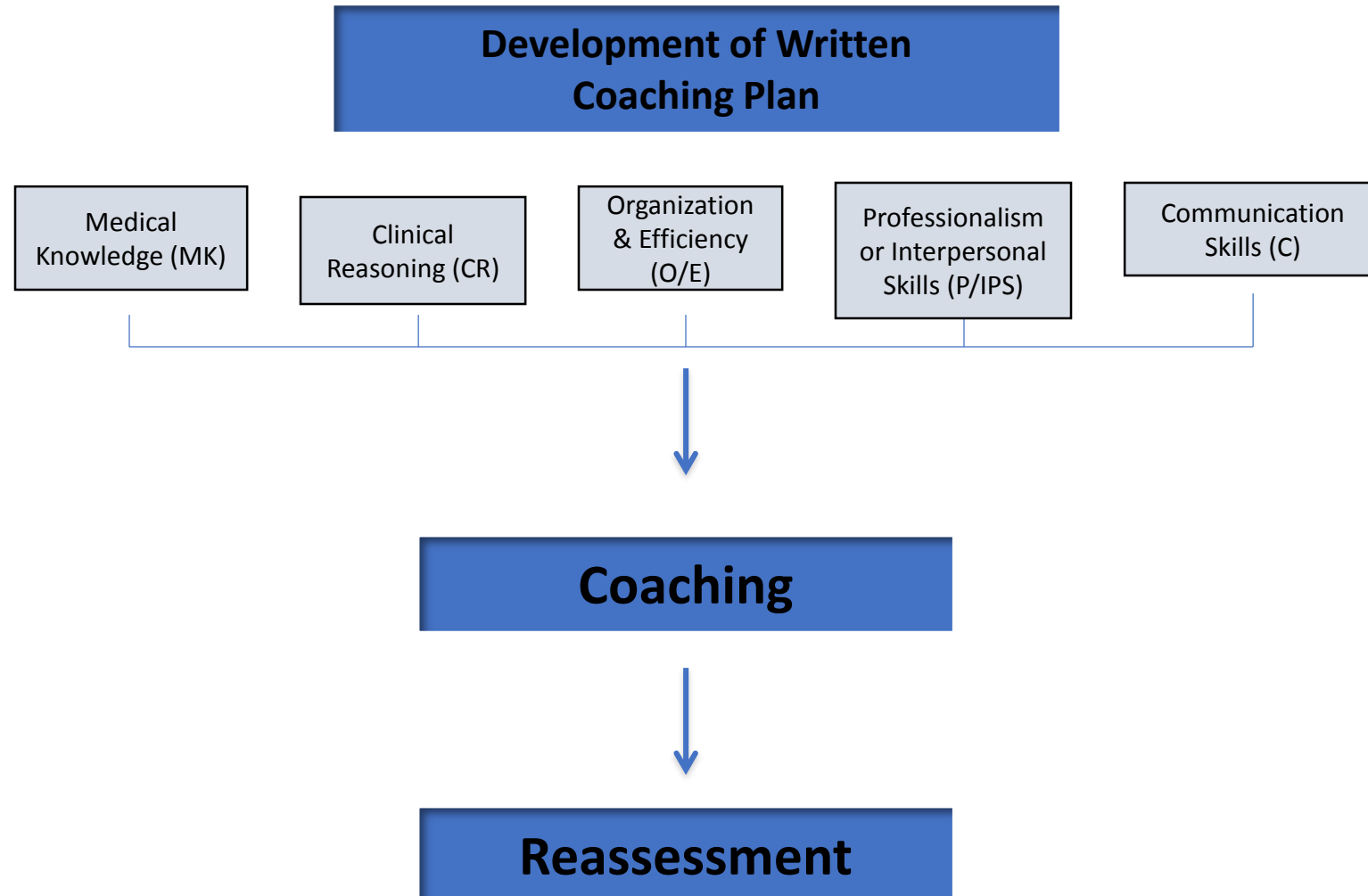
- Remediation
  - Stigma
  - May connote disciplinary action
- Clinical coaching
  - Individualized mentorship and guidance from an individual who is committed to his/her success and not directly involved in his/her reassessment.
  - Ability to identify and refer trainees early in the course of struggle before disciplinary action, or what has traditionally been called remediation, is necessary
  - Referral is not mandatory

# Example: Clinical Coaching Program



# Example: Clinical Coaching Program

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# Development of Individualized Coaching Plan

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- SMART goals
- Is the learner safe to stay on service?
- Where will coaching take place?
  - Someone's office (domain expert, advisor)
  - Inpatient service (own service, affiliate, NTS)
  - Clinic
  - Simulation Center
- Who are the coaches?
  - Experts
  - Residents, fellows, CMRs
  - Attending of record
- What is the timeline?

# Documentation & Legal Considerations in the Remediation of Graduate Medical Trainees

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Director, Student and Resident Remediation

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# DISCLOSURe

- Jeannette Guerrasio: Book Royalties for *Remediation of the Struggling Medical Learner*, 1<sup>st</sup> and 2<sup>nd</sup> editions published by the Association of Hospital Medical Education.

# Objectives

- Describe appropriate legal considerations associated with remediation efforts
- Identify techniques to decrease legal risk

# Session Format

- A case will be presented in increments
- Small groups discussions
- Key points will be highlighted through larger group report out



What are you hoping to get out of the session?

# Case for Illustration

- John honored many of his classroom-based science courses during his first year of medical school.
- He missed many required small group sessions and assignments for which he received minimal consequences.
- He was noted to have arrogant confrontational behaviors towards peers and staff throughout his clinical clerkships.
- He used his high exam scores and minimal consequences to justify his arrogant confrontational behaviors towards peers and staff.

# Case for Illustration

- Despite repeated feedback from faculty, his advisor, and peers, his behavior does not change.
- The concerns were poorly documented in his evaluations and therefore there were no academic consequences and the concerns did not appear on his MSPE.

# Case for Illustration

- When he began his internship, he was immediately referred for remediation due to his arrogant and unprofessional behavior towards colleagues.
- He was also rude to the nursing staff, misled attendings about data that he had collected in patient encounters, and was caught lying about his whereabouts when he was suppose to be on clinical service.

1. Why do you need to document these behaviors? (briefly)
2. What needs to be documented?
3. Where do you keep the documentation?

# Why Document

- Used to convince a student that they have a deficiency
- Gives the remediation team information to build a remediation strategy
- Used to justify grades, remedial actions, and dismissal
- Protects individuals and institutions from legal action

# What to Document

- Expected performance for each course and each academic year
  - written goals and objectives
  - defined performance targets
  - grading policies
  - consequences for failure to meet expectations
    - which may also include an outline of the procedures for remediation, probation and dismissal

# What to Document

- Identification of the Learner's Deficits
  - Compile: e-mail communications or written evaluations, assessments from multiple sources and place them into the academic record
  - Documentation of comments regarding a learner's performance is **as valid** for making academic decisions as written evaluation forms.

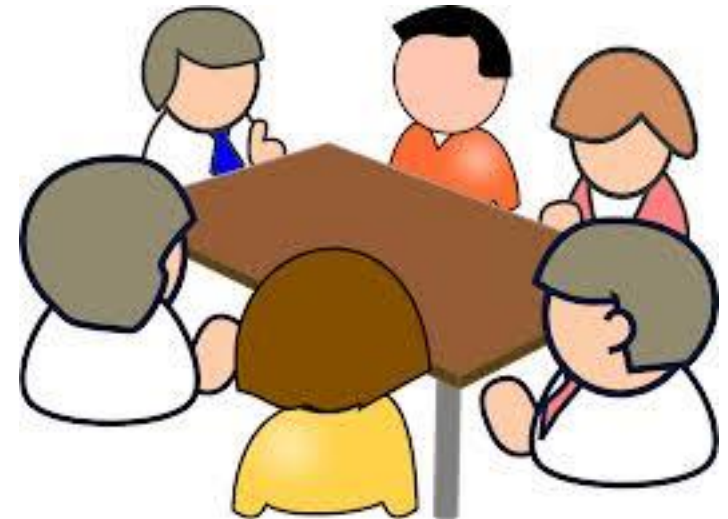


# How to Document

- Each document should include
  - the date of observation or identification of deficit(s)
  - who made the observation
  - specific examples of objective behaviors or actions that highlight the deficiency(ies)
  - whether or not feedback was given to the learner (ideally with proof)

# What to Document

- Academic discussions about the learner
  - summary of each meeting held to discuss the learner's academic progress
    - with date and list of attendees
  - document decisions to share performance difficulties with upcoming faculty and your reasoning
    - note if the learner was notified



# Case for Illustration

- In reviewing John's academic record, the following information has been included:
- Documentation that all residents(including John) received directions on how to access each rotation's and academic year's expectations for competent performance
- A dated e-mail from a faculty member reporting his interpersonal skills deficit and poor professionalism. The faculty member is concerned that John is disrupting the learning environment for other residents and students. "John often brags about his skills in front of other residents. Whenever residents in conference are discussing a case, he interrupts the conversation to shout out the answer and has called his peers stupid." The email also stated that the behaviors continue despite providing him feedback with alternative behavior strategies.

# Case for Illustration

- A dated e-mail from another faculty member reporting that he doesn't let his interns do procedures or conduct family meetings, as he states that he can do a better job.
- There are two phone conversation documented by the Associate Program Director who received unsolicited calls by faculty. In the conversations, the faculty members expressed that "John orders the nurses around, and makes demeaning comments like, 'Do you know what that means?' and "I thought you speak English."
- Evaluations

# Case for Illustration

- A documented conversation between several peers and the Program Director, in which other residents voiced their concerns about John's behavior and how it is impacting their learning experience.
- 2 additional e-mails from his rotation attending concerned that John often disappears during the day. There were two instances in which John was not at another academic requirement as he reported. They also reported that John appears to fabricate information about patients that he did not collect, including historical and physical exam information, labs and culture results.
- A dated e-mail referring him to the remediation team, letting John know that they will be given access to his entire academic record.

Is this sufficient documentation?

# Documentation

- CLEAR
- ACCURATE
- TIMELY
- COMPLETE





Is remediation legally required?

# Documenting the Remediation Plan

- the competency being addressed
- a specific description of the behaviors or actions of concern
- the time frame for remediation
- the specific plan
- objective measures that will be used to assess the deficit post remediation
- the date the plan was communicated to the learner
  - provide either written evidence or a witness to a verbal conversation

# Case for Illustration

- After John failed his reassessment following 4 weeks of remediation, he was reported back to the CCC.
- The CCC reviewed his entire academic record. He was then invited to appear before the CCC to present his position.
- He demonstrated poor insight into his deficiencies and a lack of ownership in address his challenges.

What academic Actions would you take next?  
Why?

# Case for Illustration

- The committee decided to skip a warning or focus review and to place him directly on probation because of his ongoing egregious behavior, his failure to progress, and additional episodes of dishonesty.
- As part of his probationary status a fitness for duty evaluation was required.

# Focused Review vs. Probation

## Focused Review

- Internal process
- Serves as a warning prior to possible probation
- Not considered disciplinary
- Not reported to outside reviewers... with some exception

## Probation

- Internal Process
- Serves as a warning prior to possible dismissal
- Is disciplinary
- Is reported to outside reviewers
  - future education programs
  - employers
  - credentialling agencies
  - insurers



# Documentation of Focused Review or Probation

- Promotions committee meeting date(s) when decision was made to change the academic status from good to focused review,
- Date that the status change will take effect,
- Deficit(s) or competencies to be remedied,
- Summary of the information that led to the decision, including source of information, assessment technique, and format such as written, or verbal.
- Date when the learner's status will be reassessed, typically 90 days after change in status,
- Performance or actions required to reverse the change in academic status, and how that will be measured,
- Consequences for achieving or failing the reassessment.



# Case for Illustration

- As part of his probationary status a fitness for duty evaluation was required. While he completed the alcohol and drug-monitoring program, he refused their recommendations for substance abuse treatment.
- He never acknowledged that he had interpersonal skills problems, and struggles with professionalism. Overall, he failed to progress.
- He continued to maintain that he was a leader among his peers. After much debate, the Promotion's Committee decided to dismiss him. Despite an initial fear of litigation and threatening letters from his lawyer, John never sought legal action.

# Failed Remediation

- Recurrent unprofessional behavior - when a cause cannot be elucidated and remediated
- Egregious unprofessional behavior
  - including criminal activity
- A learner that appears “not teachable”
- Refusal to participate in remediation

# Limits to Remediation

- Finding additional financial resources
  - Provide one-on-one teaching
  - Additional books or review courses,
  - Time with standardized patients or in simulation labs
- Institutional culture
- Patient safety
- Student's effort and abilities
- Schedule flexibility
- Limited trained faculty to conduct remediation
- Faculty time for direct observation and feedback

# Key POINTS

- Academic vs. Disciplinary
- **Adhere to your institution's policies!**
  - Keep you policies simple

# Key POINTS

- Residents should be given:
    - 1) notice of the deficiencies,
    - 2) an opportunity to provide a meaningful response, AND
    - 3) that the decision maker be fair and unbiased\* and not act in an arbitrary or capricious manner
- \*this includes reviewing the residents entire academic record and were procedures equally applied to all students in a similar situation

# In summary

- Trainees are dismissed from residency.
- This is usually preceded by a carefully documented attempt at remediation.
- When due process has been served and *the institution's policies are applied without discrimination*, the courts have repeatedly upheld academic and disciplinary decisions
- Our job is to hold the learner accountable for their responsibilities and to point out the need for improvement as it arises.
- Medical schools and residency programs have lawyers, to assist faculty and committees to ensure that they are following the school's policies. Consult them early in the process.