THE RESIDENT IN ACADEMIC DIFFICULTY

SIU SOM Program Directors Session

April 20th, 2016

AGENDA

- Thanks
- Introductions
- 5 Vignettes
  - General discussion
  - Trigger questions
  - Pearls

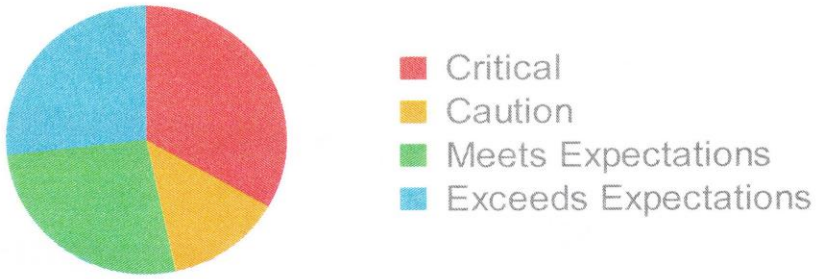
- Resident A is midway through his training. He has been on a LOD for several months and, although he sometimes appears to be putting forth effort, has not been receptive to feedback. In the last several weeks two attendings and a charge nurse have reached out to you with concerns about Dr. A's clinical skills, even under supervision. Dr. A's last milestone evaluation was mostly 2's with a smattering of 3s, which is not unusual for your residents at this level of training.

- You're sitting in your CCC meeting with all of Dr. A's evaluations. Most of the evals have 3's or 4s on the 1-5 scale, even one by an attending who has called you with serious concerns. Two of the evaluations have comments that he "needs to read more" and "needs to work on clinical skills". The CCC members are in consensus that Dr. A is not ready to be promoted to the next level and some CCC members question whether he is capable of successfully achieving competence.

- What do you do when supervisor evals don't reflect CCC concerns?
  - How can you maximize faculty compliance with evals?
  - Are your instruments optimal?
- If a resident is on the radar screen, is it appropriate to give supervisors a heads up?
- When do you have the difficult conversation about career path?
- What do you do if the process becomes adversarial?
- Is remediation effective? How is success defined?

/ #8

Percentage of Resident/Fellow Evaluations completed by Faculty per New Innovations

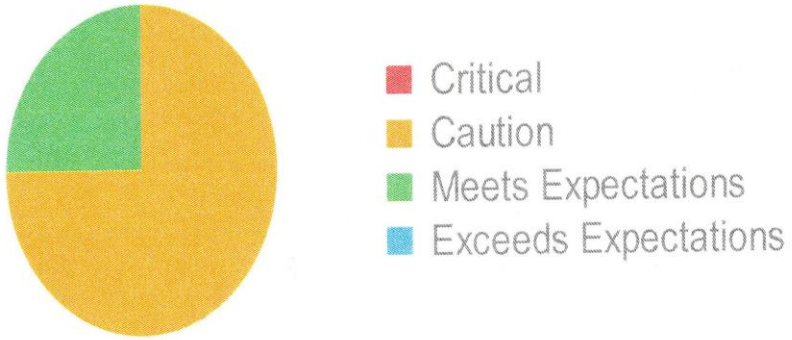


Thresholds

Critical	0 - 69
Caution	69 - 79
Meets	79 - 99
Exceeds	99 - 100

/ #9

Enter the percentage range specified in WebADs for Faculty who completed evaluations of residents/fellows within two weeks



63 (7.3%) RESIDENTS ON LOD 2010-2015

Reason			**Remediate?**		**?Graduated or back in Good Standing**		
Professionalism	Academic	Both	Yes	No	Yes	No	NA
14 (22%)	**26(41%)**	**23 (37%)**	**18 (29%)**	**45 (71%)**	**50 (79%)**	**10 (16%)**	**3 (5%)**

2010-2016

17 Residents remediated											
How Long?		**Did They Graduate?**			**Board Certified?**			**Job?**			
1 Year	< 1 Year	Yes	No	N/A	Yes	No	N/A	Yes	Res	Unk	N/A
9	**8**	**9**	**2**	**6**	**2**	**8**	**7**	**7**	**2**	**2**	**6**
9 Residents Graduated											
					2	**7**	**0**	**8**	**0**	**1**	**0**

2010-2016

17 Residents remediated											
How Long?		**Did They Graduate?**			**Board Certified?**			**Job?**			
1 Year	< 1 Year	Yes	No	N/A	Yes	No	N/A	Yes	Res	Unk	N/A
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9 Residents Graduated											
					2	**7**	**0**	**8**	**0**	**1**	**0**

PEARLS

- Documentation should match faculty concerns…and share with resident
  - LODs, evals, emails, documentation of verbal conversations….
- When improvement plans are discussed with residents (even if not level of LOD), document, ask resident to initial or sign and give them a copy
- Struggling residents…track their evals between CCC meetings, follow up assertively with mentors and supervisors

PEARLS

- Keep LODs current with clear dates and timelines
  - Honor evaluation dates
  - Update resident frequently regarding progress (or lack thereof…and put a note in file)

- Phone a friend
  - Broquet, Jennifer, Frank, fellow PDs, CMOs, Wes NcNeese, Jeanne Koehler
  - Encourage resident to seek advocate, invite advocate to assessment meetings

Resident B is a popular PGY 2 trainee with good clinical skills and strong work ethic. Her in-service performance has been marginal to poor, which surprises you because she seems to have a good knowledge base in case discussions. You have just learned that she has failed Step 3. She has 6 months to retake it to be eligible for promotion to PGY 3. You are both getting anxious about this.

- What resources do we have for poor test-takers?
- When should I consider testing for learning disabilities and how do I access?

PEARLS

- High-yield non-cognitive behaviors that are most likely to benefit from a Performance and Learning Strategy Evaluation include:
  - Organizational skills
  - Time management
  - Cognitive skill development
  - Interpersonal/teamwork challenges
  - Test taking problems

- A resident with a pattern of chronic noncompliance with program policies, expectations or follow-up on prior educational interventions is not likely to benefit from this type of assessment.

Resident C is a PGY I who matched into your program from an outside institution. He started out as a strong performer. Now, midway through the year, you notice that rotation evaluations have gone from "outstanding" to "meets expectations ". This month he arrived late for two clinics (very apologetic and stating he overslept) and failed to follow up on abnormal labs on a patient. Your chief resident says Dr. C is usually working on notes long after his peers are done and has to be reminded to go home at the end of his duty period. He has turned down so many invitations for social activities that the other residents have stopped asking. You talk with Dr. C about your concerns and he promises that he will work harder.

- “Academic Struggles” , Mental Illness and “Impairment”
  - How do you differentiate?
  - Are there any differences in procedures?
  - What resources are available?
  - When/How does a resident qualify for ADA accommodations?

PEARLS

- Stress or even mental illness does not = impairment….but if you believe a resident is impaired…you have to act
- Phone a friend - don't handle this alone
- Keep compassion/concern about resident's mental health separate from performance expectations

Resident D is a PGY 1 with a great attitude and work ethic. Patients love him. By mid - July you realize that Dr. D has real deficits in presentation skills, knowledge base and clinical reasoning. The faculty are in consensus that Dr. D is simply not prepared to be a resident. However, he is such a nice guy and a hard worker you decide to just give him some time to catch up.

PEARLS

Please don’t do this

Your CCC is meeting on March 30th to review Resident E, who is in her final year of training. Dr. E has repeated her final year and has minimally met all of the expectations spelled out in the LOD/remediation plan . However, in reviewing faculty evals, milestones and 360 evals, no one on the CCC feels that Dr. E is ready to practice independently.

RESIDENT CONTRACT

The Physician shall be notified in writing by the Program Director, subject to the approval of the Affiliated Hospital, in the event the Physician's contract shall not be continued or if he or she will not be promoted to the next level of training for the following year…

- **2015 or earlier** - Said notice shall be provided at least four months prior to the expiration of the contract year or when a resident will not be promoted to the next level of training... However, if the primary reason(s) for the non-renewal or non-promotion occurs within the four months prior to the end of the agreement, the Program Director will provide the Physician with as much written notice of the intent not to renew as the circumstances will reasonably allow, prior to the end of the agreement.

- **2016 or later** - Said notice shall be provided at least 60 days prior to the expiration of the contract year or when a resident will not be promoted to the next level of training.

PEARLS

- Remember 4 month language in contracts pre and post 2016
- We STRONGLY encourage the 4 month standard, even for post 2016 trainees
- Structure CCC meetings so that no high risk residents are reviewed this late in year….that goes double for senior residents
- Make sure LOD expectations are based on outcomes, not process
- Avoid setting “satisfactory on rotations evaluations” as LOD expectation

Final Thoughts ?
Words of Wisdom?