Guiding Principles for Resident Remediation: Recommendations of the CORD Remediation Task Force

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Abstract

Remediation of residents is a common problem and requires organized, goal-directed efforts to solve. The Council of Emergency Medicine Residency Directors (CORD) has created a task force to identify best practices for remediation and to develop guidelines for resident remediation. Faculty members of CORD volunteered to participate in periodic meetings, organized discussions and literature reviews to develop overall guidelines for resident remediation and in a collaborative authorship of this article identifying best practices for remediation. The task force recommends that residency programs:

1. Make efforts to understand the challenges of remediation, and recognize that the goal is successful correction of deficits, but that some deficits are not remediable.
2. Make efforts aimed at early identification of residents requiring remediation.
3. Create objective, achievable goals for remediation and maintain strict adherence to the terms of those plans, including planning for resolution when setting goals for remediation.
4. Involve the institution's Graduate Medical Education Committee (GMEC) early in remediation to assist with planning, obtaining resources, and documentation.
5. Involve appropriate faculty and educate those faculty into the role and terms of the specific remediation plan.
6. Ensure appropriate documentation of all stages of remediation.

Resident remediation is frequently necessary and specific steps may be taken to justify, document, facilitate, and objectify the remediation process. Best practices for each step are identified and reported by the task force.

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Competence in medical practice is multifaceted and requires diverse skill sets. To this end, the Accreditation Council for Graduate Medical Education (ACGME) initiated the Outcomes and General Competencies project in 1999 and implemented the competencies in 2001 to provide a framework to develop accountability standards for the training and practice of physicians.[1] In so doing, the focus of training has expanded to include using dependable measures to assess outcomes in specific competency areas. Medical schools, residency training programs, and licensing boards are required to demonstrate that practitioners are competent in the skills necessary to provide high-quality medical care. Graduate medical education (GME) programs are responsible for ensuring that residents are competent at the completion of training. Learners with deficiencies should be remediated. This helps ensure that the public receives high-quality medical care. The process of resident remediation can be daunting. In 2009, the Council of Emergency Medicine Residency Directors (CORD) established a remediation task force to identify best practices and to develop shared resources for addressing remediation in GME in emergency medicine.

In an excellent review of remediation of physician deficiencies across the educational and practice spectrum, Hauer et al.[2] proposed a four-step model for the

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remediation of performance deficits of medical trainees and practicing physicians.[2] This included:

1. *Competence assessment:* Ideally, reliable and valid assessment tools are available to identify individuals with deficiencies. Different competence domains are amenable to different assessment modalities. The ACGME has developed a toolbox of assessment methods that can be used to assess the spectrum of competencies.[3]
2. *Diagnosis of deficiency and development of individualized learning plans:* The methods used to diagnose the underlying cause of performance deficits will vary based on the individual resident. The assessment tools used should lead to an individualized learning plan.
3. *Instruction/remediation with deliberate practice, feedback, and reflection:* The learning activities should address the identified deficiencies based on an outlined plan. A resident with a medical knowledge deficiency may benefit from a structured reading plan, while one with a deficiency in professionalism may require interventions directed toward specific undesired behaviors. The learner should have the opportunity for deliberate practice with formative and summative feedback on progress.
4. *Focused reassessment and certification of competence:* After the implementation of the remediation plan, the learner must be reassessed to determine if an acceptable level of performance has been achieved. Reassessment may use the same modalities used for diagnosis or may involve more focused tools to gain specificity toward focused deficits.

Additional information sources exist that specifically address the issues surrounding resident remediation. A ''problem resident'' guideline has been described that focuses on clarifying the issues, assessing contributing factors, and evaluating the plan's effects. Resident perception and involvement in the plan were emphasized.[4] Another framework for approaching struggling residents recommended clarifying roles and categorizing issues into either competency or legal and procedural issues.[5] A more formal blueprint for developing a remediation plan has been described, including tips on plan development and documentation.[6] Competency-based matrices with promotion criteria for each level of training have been developed and used to guide evaluations and address deficiencies.[7] The details and experiences with specific remediation plans have also been described.[8–12] Survey reviews of remediation in other specialties have discussed the incidence and successes of plans in general.[13–15] Within the scope of practicing physicians, Williams[16] published a comprehensive review of the incidence of physician underperformance issues with a discussion of causes.

The remediation task force developed consensus recommendations based on expert consensus at organized, case-based discussion at the 2009 and 2010 CORD academic assemblies, general discussions of the task force at 2008 and 2009 ACEP scientific assemblies and 2009 SAEM annual meeting, review of listserv dialog, conference calls, and review of the relevant medical literature. This project was approved as exempted from review by the institutional review board at Maricopa Medical Center.

CHALLENGES IN RESIDENT REMEDIATION

The goal of every training program should be to ensure that each of its graduates provides outstanding medical care that is safe, timely, effective, efficient, equitable, and patient-centered.[17] However, there are multiple challenges faced by programs when determining the competence of trainees and developing and implementing effective remediation plans.

1. *Lack of validated tools:* Although several tools have been developed to better assess the ACGME core competencies,[3,18] few have been validated. Programs are left to implement these and other unvalidated tools to gather evidence on resident progress. Even for those few tools that have been validated, there are no strict criteria for defining what performance cutoffs require formal remediation. This is largely left to the discretion of the individual program directors. Without perfect tools for every situation, it is difficult to pinpoint where a resident's true deficiencies lie and to appropriately assess what actions may be needed to correct them.
2. *Identification of contributing/confounding issues:* Additional resources, investigation, or testing may be needed to maximize the chance of identifying a cause and altering a resident's behaviors. Stress at work and home, chemical dependency, mental illness, and personality disorders can all affect resident performance.[16,19] Cognitive deficiencies may be related to underlying language or processing problems. Noncognitive attributes (such as maturity, reliability, honesty, integrity, and incorporation of critique) can also be difficult to quantify.[20]
3. *Development and implementation of a remediation plan:* Remediation is resource-intensive; plans may involve individual mentoring by faculty, increased supervision, development of a personal learning plan, acquisition of additional learning materials, and neuropsychological or psychometric evaluation. Few residency programs have unlimited time and resources to develop and implement optimally individualized plans.
4. *Ensuring remediation outcomes:* Following the implementation of a remediation plan, the trainee must be reassessed to determine whether the identified deficit has been successfully remediated. Many of the tools used for evaluating residents within a program can be used to reevaluate the progress of less-than-competent trainees. However, some of the best validated tools (e.g., the American Board of Emergency Medicine in-training examination) are offered only at predetermined intervals. Changes in practice take time to establish. If trainees are identified late in training, there may be insufficient time to retest and determine whether the remediation plan was successful.
5. *Adherence to multiple policies:* Because policies must be in place to protect a trainee's dual status as a learner and an employee, legal and institutional poli-

cies often specify the plans that can be instituted to remediate and reassess individuals with identified deficiencies. Further, because options for remediation may be limited, residency directors and their programs may be hesitant to identify a resident as being less than competent due to fear that the program will be held accountable for the certification of a trainee with identified deficits.

WHAT IS REMEDIABLE?

Attempting remediation implies that a problem is correctly identified, a performance-changing plan implemented, and outcomes assessed to determine the success of the efforts.[2] Trainees who demonstrate less than the required level of competence in one or more ACGME core competencies show discrete performance gaps that may be amenable to remediation. However, this necessitates a measurable outcome to assess success. Once an area of weakness is identified, the goal of remediation should be to help the resident identify, accept, and treat the cause; learn from the area of weakness; and work to meet standards in areas in which he or she is deficient. If this can be accomplished, the resident may be considered successfully remediated.

A struggling resident may or may not possess the inherent ability to meet standards. The Federation of State Medical Boards[21] differentiates the terms competence, dyscompetence, and incompetence. Competence is defined as possessing the requisite abilities and qualities (cognitive, noncognitive, and communicative) to perform effectively in the scope of professional physician practice while adhering to professional ethical standards. The physician with an identified lack of competence fails to maintain acceptable standards of one or more areas of professional physician practice, but may be equipped to overcome the areas of deficiency with additional guidance and effort. The incompetent physician lacks the requisite abilities and qualities to perform effectively in the scope of professional physician practice. The incompetent physician may not meet standards even after appropriate assistance and direction are provided.

Unfortunately, some deficiencies may not be amenable to successful remediation. A resident may strictly follow the remediation schedule to learn the techniques of intubation, but remain unable to reliably secure an airway. This resident would not meet the threshold to practice emergency medicine and may fail remediation despite adhering to a set plan. For those who are incompetent, or for whom remediation is unsuccessful or not an applicable concept, counseling should be given to provide options for succeeding, even if this means pursuing a career outside of medicine or the resident's desired field of training.

Institution-specific guidelines may exist to define processes for remediation, probation, leaves of absence, suspension, and termination or dismissal. These may be used as consequences of failed remediation or may be implemented independently. Egregious violations of professionalism, for instance, may require immediate suspension or termination. In general, there is a spectrum of progressive consequences in addressing resident issues. On the least formal end, verbal or written feedback about an incident is given with proper documentation. Remediation, with a concrete plan, lies in the center. Probation, a formal disciplinary process that is reportable to licensing and credentialing entities, lies on the more serious end of the spectrum. At the far end is termination.

There are multiple elements in successful remediation. Among them are expectation setting, identifying and investigating deficiencies; developing an individualized learning plan; monitoring; resolution; and developing a remediation document.

SETTING EXPECTATIONS FOR RESIDENT PERFORMANCE

Clear expectations are the foundation for remediation (Table 1). By setting concrete and achievable goals, and ensuring that residents understand and accept them, program directors define performance targets. Residents can understand the rationale behind remediation if, and only if, they are aware of the metrics by which they are being gauged. Success or failure will be defined by whether or not these targets are eventually met.

In general, remediation focuses on a resident not meeting the goals and objectives for the program, postgraduate level, or rotation. These expectations should be concrete, well-defined, readily available for residents and staff to review, and as objective as possible. Evaluations that refer directly to established goals and objectives of the rotation are an ACGME requirement and help anchor an unacceptable evaluation to an achievable target. Once a need for remediation is identified, reaching the specific required endpoint becomes the target goal of remediation.

Faculty must also be familiar with expectations of resident behavior and performance. Attending physicians must be able to reliably recognize residents who do not perform at expected standards, identify them to the program director, document their concerns, and assist with resident development. Faculty should be encouraged to describe, preferably in writing, any behaviors that do not meet expectations. Faculty should be instructed to comment on behaviors and facts rather than judgments of the individual learner so that the

Table 1
Guidelines for Setting Expectations for Resident Performance

1. Define concrete expectations through written goals and objectives
2. Establish and maintain well-defined policies
3. Delineate consequences for failure to meet expectations
4. Outline procedure for remediation/probation/dismissal
5. Orient residents and faculty to residency goals, objectives, and policies
6. Provide ongoing reminders of expectations
7. Identify support networks available to residents

specific suboptimal skills can be identified.[22–24] Comments in rotation evaluations may be more accurate in identifying issues compared to numerical or overall ratings.[25] Firsthand information should be prioritized over hearsay and rumors. If faculty participate in robust feedback, system trends that point toward a need for remediation can be identified early.

Residency policies must be clearly written, and consequences for violating policies must be clearly defined. Violation of a policy (residency, institution, department, etc.) creates an understandable paper trail and creates an achievable endpoint for remediation. Residency programs are required to provide easy access to all policies. Having an agreed-to residency code of conduct, developed by the residency program and signed by all residents, is one additional way of creating an additional baseline behavioral standard. It also serves as a document that can be the reference for residents who require remediation in professionalism or communication.

Institutional expectations are usually set by the institution's GMEC. Most GMECs have explicit policies regarding procedures that must be invoked if performance expectations are not met. These may relate to resident issues before, during, and after a remediation period. Early notification and involvement of the appropriate contacts in the GMEC may facilitate creating and fulfilling a meaningful remediation plan and allow access to additional resources to maximize benefit to the resident. For example, the GME can assist with referral to specialists who perform neuropsychometric assessments and may be facilitated by the GMEC via various preexisting resident-related resources. Additionally, the GMEC may have additional personnel or funding sources for residents in need of personalized remediation plans.

Residents should be exposed to expectations, policies, and procedures as early as possible when beginning training. Orientation is a crucial time for reviewing formal and informal recommendations. It is one of the rare times when expectations can be set for the residents without the distractions of clinical service. It can be used to discuss the definition of remediation and review the identification, process, approaches, and implications of remediation before the need is apparent. It is an opportunity to create the initial resident expectations. It is also an opportunity to bring up deficiencies that are not remediable in the course of a residency (for example, grossly unprofessional behaviors) and those that require involvement of nonresidency personnel (for example, alcohol rehabilitation for physicians). Beyond orientation, residents should have ongoing reminders of expectations and their progress toward goals and objectives and adherence to standards. This should be presented and discussed, at a minimum, during regular summative evaluations.

Residents should be familiar with the support mechanisms available to them, including faculty mentors, assessment tools, counseling, personal physicians, the GME office, etc. They should have an early understanding of what role each of these may play and what degree of confidentiality can be expected from each source. They should have free access to this support network and be encouraged to use resources beyond the residency when appropriate.

IDENTIFICATION OF DEFICIENCIES

Information on resident performance is collected in many ways within most programs. Objective evaluation includes concrete numbers such as in-training examination scores, procedure logs, or the number of patients seen per shift. Subjective evaluation includes feedback from and opinions of faculty, nurses, peers, and patients. Direct observational evaluation and feedback can be obtained via the standardized direct observation tool and proctored interactions. Informal evaluation includes gossip and other unwritten information. Spontaneous evaluation may come from complaints or commendations from patients, faculty, or others. Institutionally generated evaluations may include the identification of errors through the quality improvement process.[26] Self-evaluation may come during semiannual evaluations, or residents may ask for help with specific issues. However, it has been shown that the least accurate self-assessments come from the least skilled and most confident practitioners.[27] When identifying deficiencies, it is important to use all available sources to identify trends in behavior.

Early identification of poor performance is key to successful remediation. This gives the resident maximal time in which to acquire lagging skills and allows for intervention before maladaptive behaviors become habitual. Seemingly minor issues, when repeated or escalating, should be addressed with the resident as early as possible. There are many challenges involved in the identification of performance gaps. These include limited evaluation tools, limited supervision, time constraints, and the fact that many faculty lack comfort with delivering negative feedback[28,29] and do not have formal training in the constructive delivery of feedback.[30] Learners expect formative and timely feedback.[31] Program directors should be familiar with their evaluation tools and ensure that there is training-wide redundancy in the concepts being evaluated.[32] This helps ensure surveillance of residents and covers as many areas of performance as possible. The program director should ensure that performance evaluations are reviewed frequently by the resident and program mentor to ensure that deficiencies are identified early.

When an issue is identified that involves subjective information, it should be investigated as quickly and as confidentially as is feasible. Program directors are encouraged to involve investigators with minimal potential for bias. This occasionally necessitates involvement of faculty outside the residency or outside the department altogether. Residents should be informed when an issue is being investigated except in rare instances when doing so would compromise the investigation. Obtaining the resident's perception of the event is crucial to understanding his or her level of insight and to maintaining the appearance of fairness.

It is strongly recommended that the program director involve other faculty and develop an advisory panel to make any decisions regarding remediation. This panel

may be convened for a specific resident or issue or may be a standing committee tasked with addressing promotion and remediation issues. Committee discussion and consensus will minimize any perception of bias on the part of the program director and allow for more objective and defensible decisions. Educational committee discussions can lead to consensus and changes in remediation plans or progression of a resident.[33] Additionally, open discussion can help clarify performance patterns that are difficult for any one attending physician to discern.[34] The program director should maintain confidentiality in the remediation process and should avoid discussions with personnel outside of this group.

Part of the remediation process should involve frank discussion with the resident about appropriate expectations of confidentiality. While most information should be confidential, there are situations where confidentiality may not be expected. For example, if a resident has frequent complications of central line placement, it would be appropriate to ask faculty members to pay close attention during that resident's placement of central lines.

While confidentiality is essential, program directors should be aware that it is not necessarily bidirectional. The resident is owed discretion and confidentiality, and the program director cannot discuss the remediation with the resident's peers or faculty without a need to know. The resident undergoing remediation, however, is rarely bound to the same confidentiality agreement and occasionally shares select information about his or her remediation with colleagues. Program directors should be aware that the information that does eventually surface regarding the issue can be one-sided and at times inaccurate. It may be helpful to discuss what can and cannot be said by each party to members of the residency program. The need to preserve confidentiality makes addressing these discrepancies difficult, if not impossible. One possible approach is to remind inquiring individuals of the formal policy and procedures pertaining to remediation. Questions can (and generally should) be answered with a reminder that all residents can expect due process and confidentiality.

DEVELOPING THE REMEDIATION PLAN

Before determining a remediation plan, efforts should be made to correctly diagnose the underlying problem so the plan can target the unique issues limiting the resident's success. Once developed, the plan should be discussed with the resident. When appropriate, plans can be further modified based on the resident's input.

Resident buy-in is critical in the success of any remediation plan. Some program directors have successfully solicited residents to develop their own remediation plans to use as a framework. Residents may also be encouraged to choose an advocate for remediation discussions. Alternatively, an impartial intra- or extradepartmental faculty member or advisor can be assigned to assist.

All parties involved in the discussion of remediation should be encouraged to be as direct and explicit as the situation allows. While congenial interactions are greatly preferred, sugar-coated issues and misunderstanding must be avoided. The ideal remediation plan must be concrete, understandable, and objective.

MONITORING REMEDIATION

The specific methods of monitoring a remediating resident will be based on the deficiency in performance. These methods should be objective, measurable, appropriate, and feasible. Most importantly, they must be realistic. An overly aggressive monitoring plan that cannot be implemented is frustrating to both the resident and the program director. Conversely, a plan with a vague or ill-defined monitoring system is also frustrating and may not lead to the desired improvement.

At the prespecified intervals, the resident's progress and adherence to the plan should be evaluated. At least quarterly reassessments of progress are required by the ACGME.[35] It is important that program directors adhere to and implement prespecified consequences for unmet expectations. Failure to do so undermines the utility and impact of any remediation plan.

RESOLUTION

At the conclusion of the remediation period, the program director and the advisory group should meet to determine whether remediation was successful. The ideal remediation plan will have objective means by which to assess performance and outcomes. The resident may be formally reevaluated at the conclusion of the time period, or reevaluation can be ongoing. Remediation ends when the resident either successfully incorporates new information that puts him or her at or above the minimal acceptable standards for the program or fails to adhere to or successfully achieve the terms of remediation.

Residents who successfully remediate should be allowed to resume their positions within the training program. Depending on the stipulations outlined in the remediation plan, this may necessitate an extension in the time period for residency training. Successful remediation should be documented in the resident's file. If the remediation is going to be reported to other individuals (for example, when the applicant applies for jobs), the success in remediating deficiencies should also be reported. Program directors may want to discuss the exact wording of these notifications with the resident prior to notification of others. Periodic reassessment is often warranted to ensure that the resident continues to maintain the behaviors that were remediated.

If it becomes apparent that a resident is not meeting the goals of remediation, the early involvement of the GMEC and legal counsel is essential. Program directors must know their institutional policies and requirements for due process. Excellent documentation, adherence to due process, and fair and equitable treatment are essential.[36] The resident should be given written notice of the assessments and should be provided access to the relevant policies pertaining to resident probation, termination, and disciplinary action. The resident

should be counseled about his or her options. It is strongly recommended that these discussions occur with an unbiased third party present. Every effort should be made to advise the resident regarding future options based on his or her strengths.

COMPONENTS OF A REMEDIATION PLAN DOCUMENT

A written remediation plan should be crafted for all residents on formal remediation (see Table 2). This contract is recommended to document the reasons for remediation, the steps to be taken within the individualized learning plan, the desired outcomes, and the consequences for failure to remediate. A copy should be given to the resident, and another copy placed in the resident's file.

Written plans should address which core competency or competencies are not being met. There should be a detailed description of the events that led to remediation, including summaries of feedback and evaluations. Any specific outlying behaviors demonstrated by the resident should be described. The time frame for remediation, usually 3–6 months, should be set. The objective measures being used to assess compliance with the remediation plan must be described in detail. There also must be a description of the measures used to define successful versus unsuccessful remediation. An approximate schedule for meetings with the program director or designee should be set, to review progress. Concrete details of the individualized learning plan should be laid out. The consequences of failure to successfully meet remediation goals should be set. This may include additional sanctions, more intense interventions, and/or the potential for probation or dismissal or termination. The contact should specify what information may be communicated to others within the residency and without. Specifically, if applicable, the contract should include the exact phrasing describing the resident's deficiencies and the remediation process that may be used for communication with future employers and licensing boards. Last, the dated signatures of all relevant personnel should be included. At a minimum this should include the resident, the program director, and the faculty member responsible for ensuring compliance and progress.

Table 2
Suggested Components of a Remediation Plan Document

1. Core competency being addressed
2. Detailed description of the events/behaviors that led to remediation
3. Time frame for remediation
4. Objective measures being used to assess compliance and success
5. Approximate schedule for meetings with the program director or designee
6. Individualized learning strategy and plan
7. Consequences of failure to successfully remediate
8. What information will/may be communicated to others and to future employers
9. Dated signatures of all relevant personnel

COMMONLY ENCOUNTERED PROBLEMS

1. The Evaluation Tools Fail to Provide Objective Supporting Data

It is often the case that the faculty is aware that the resident has a problem that needs to be fixed, but the program director does not have objective data to support a remediation process. This may be due to limitations with the tool itself or faculty failure to provide honest feedback. The solution may be to amend the tool to provide prompts for specific behaviors or to instruct the faculty to specifically note that in their assessments. It is also common for faculty to be reluctant to give negative feedback in the clinical setting or on their evaluations, yet look to the program leadership to "fix the problem." This is where the program director can take a leadership role in guiding the faculty to give honest feedback and to let the faculty know that it will be used constructively and not as a punishment. Another issue is when the faculty is aware there is a problem, yet do not know how to articulate it. Again, the program director can be helpful in giving them the verbiage to describe the problem.

2. The Faculty Fail to Complete Evaluations

This is a common problem and often puts the program director in the awkward position of providing feedback with limited supporting data. In this case the program director needs to tell the faculty that although they all want this resident's behavior to change, the program director cannot take any actions without objective supporting data. Completion of evaluations should be a requirement of supervising faculty and may be incentivized.

3. The Resident Does Not Believe a Problem Exists

This is very common, and without resident buy-in there is little chance for any remediation program to be successful. The first step is to make sure that the person administering the remediation has substantial supporting data from the majority of observers that is clear and consistent. Having a mentor chosen by the resident present during all official meetings can be extraordinarily helpful. Confrontation of the resident by a group of faculty (or nurses or residents when appropriate) can also dispel any ideas that this is a consistent perception rather than the program director's perception.

4. The Resident Feels That He or She Will Now Be Labeled as a Failure

This requires a consistent supportive message from the program director and faculty that everyone wants the resident to succeed and that it is a measure of the program's success that *all* qualified trainees graduate. It is also helpful to ensure the trainee that every trainee receives feedback, not all of it perfect, and that every one of his or her colleagues is given an aspect of their performance that is a focus for improvement.

5. The Resident Under Remediation Is Improving … but Slowly

This is where the program director must have a frank discussion with the faculty about the likelihood of this

resident's success. If it is felt that given time this resident will succeed, then consider extending the resident's training period, giving him or her a rotation with reduced work hours or putting him or her in a less stressful clinical setting, to give the resident time to get back on his or her feet. Conversely, if it is felt that the resident's problem(s) are not amenable to remediation, then it is incumbent on the program director to be honest with the resident and give him or her adequate warning that removal from the program or nonrenewal of the contract is likely. The sooner the resident is aware of this, the sooner he or she can make plans and choose a new career direction. In many cases it is a mismatch between skills the resident has and those required of our specialty. In this case, counseling about a career path that is a better match for the resident's skills is a successful approach.

6. The Resident Issue Is Not Amenable to Remediation

Some deficiencies do not lend themselves to remediation. This can occur when the deficiency is not remediable (for example, physical or psychological deficits incompatible with an emergency medicine practice, recurrent dishonesty) or when the deficiency is egregious (for example, criminal activity). These situations will often fall under the institution's human resources policies, and subsequent actions may already be clearly outlined. Program directors are advised to document the situation thoroughly in case of appeal. In these cases, the resident may need guidance to assess other career options, and all efforts should be focused on this endpoint rather than to prolonging the inevitable dismissal. Deficiency of effort (for example, missing shifts, recurrent tardiness, impatience during procedures, intolerance of patients) may only deserve a brief attempt at remediation as the resident's ability to practice the correct behavior is solely based on the resident's determination to learn and incorporate the correct behavior. Prolonged remediation periods are unlikely to have any effect, but a prolonged period of observation may be necessary to ensure that the desired behavior is maintained.

Table 3
Program Director Guidelines for Remediation

1. Intervene early
2. Maintain maximal confidentiality when possible
3. Document the process thoroughly
4. Develop an individualized learning plan
5. Adhere to the specifics of the remediation plan
6. Employ signed remediation contracts
7. Encourage honest faculty feedback
8. Involve an advisory group to decide actions
9. Have an observer present for meetings
10. Maintain a supportive posture
11. Be consistent
12. Take pride in the successes
13. Offer additional guidance to residents who fail remediation
14. Follow and emphasize due process
15. Review and adhere to institutional policy and procedures
16. Involve the GMEC and legal counsel

GMEC = graduate medical education committee.

DISCUSSION

Early intervention is of key importance. As soon as a potentially remediable issue is identified, the program director should begin to consider whether intervention is warranted (see Table 3). The CORD Remediation Task Force strongly recommends early assessment of interns to facilitate this and to create the expectation of meeting competency-based objectives.

All investigations of a resident should be done while maintaining maximal confidentiality. The resident should be made aware of the concerns at the time an investigation is begun, unless that notice could interfere with the investigation. Involved personnel should be reminded which aspects of a resident's problems are public knowledge and which are to remain private.

Documentation of all aspects of any investigation and assessment is absolutely essential. This includes keeping pertinent e-mail messages and written comments, whether obtained through formal or informal routes. All meetings and important discussions with the resident should be summarized in writing. This documentation should be kept in the resident's file. Should the concern prove to be baseless, the documentation may be amended or removed.

For any resident issue requiring remediation, an individualized learning plan should be developed. Involving the resident in this process can help with compliance and buy-in. The process and desired outcomes should be concrete and measurable. The plan should be written and discussed with the resident. Throughout the remediation period, a program director must take care to be consistent and adhere to the specifics of the plan.

Residents should be required to sign the documentation of any investigations, the remediation plan, and any updates. While this may generate resident anxiety that a paper trail is being established, the benefit is that it removes confusion over the status and plan of remediation. It can also help to clarify and validate the facts relating to the issue at hand. Written remediation plans can therefore serve as "contracts" that lay out the rationale for remediation, the specific details of the plan, and the expectations of each party.

Faculty documentation is important to appropriately identify and monitor issues. Faculty who are unwilling to put comments or concerns in writing[34] may need to be educated on the implications and consequences of refusal to document. Program directors who receive verbal feedback from a faculty member may take their own notes and include these in the resident's file with or without that faculty member's permission.

A standing committee within the residency to address resident issues is helpful to evaluate resident progress within the program and to issue recommendations for residents requiring remediation. Program directors should rarely, if ever, independently place a resident on remediation. This allows the potential appearance of bias and undermines the ability of the

program director to participate in the remediation plan in a nonjudgmental and supportive fashion.

Program directors should consider having a witness present during any formal discussions with the resident. A neutral faculty member may be chosen by the resident, or appointed by the residency, and can act as a resident advocate and observer of the process. This person should submit his or her own written notes along with the program director's written summary of the meeting. If the resident advocate is not available, another witness may be chosen, with a focus on minimizing breaches in confidentiality.

Residents will be more receptive to remediation if they feel they are being supported and developed than if they feel threatened or persecuted. One mechanism that program directors may use to "decriminalize" remediation is renaming the process. Designations such as academic support program, individual learning program, focused board preparation plan, interpersonal improvement effort, or performance improvement plan are examples. Included in decriminalization is the recognition that successful remediation should return the resident to the same standing as other residents. If the resident's difficulties are known to others, successful remediation plans should give thought to how to remove a previously poor reputation. More punitive remediation approaches should be applied in a limited fashion to issues that are less amenable to remediation, but cannot be repeated (for example, lying or missing shifts without explanation).

Consistency is of utmost importance in remediation. Expectations should be applied in the same way to all residents, as should consequences of failing to perform to standards. During remediation, the same individual should maintain the supervisory role throughout the process. This may be the program director or a designee. Prompt responses should follow any deviations from the plan.

There can be a large sense of accomplishment for both the resident and the program director at the end of a successful remediation plan. Successes should be points of pride. Failures can be taken as opportunities to reevaluate the plan and to reevaluate the resident's level of competence, variable competence, or incompetence. Residents may require career guidance and honest evaluations of their ability to complete program requirements and function within emergency medicine.

Legal issues relating to resident discipline are most likely to focus on due process and fair and equitable treatment. There should be adequate documentation of why remediation was necessary, the process, and the outcomes. Institutional policy should be followed, in addition to any other applicable policies. Involvement of the GMEC and legal counsel at an early stage can help a program director through the process.

CONCLUSIONS

It is incumbent upon training programs and their program directors to ensure that graduates are competent to deliver care. Completion of training and board eligibility imply that minimum requirements are met and that the trainee is ready to practice competently and independently. If a resident demonstrates lack of competence or incompetence with the behaviors, knowledge, or skills necessary for practice, a remediation plan must be developed, implemented, and completed prior to program completion to ensure that graduates have the skills to avoid endangering the public.

When considering the need to remediate a resident, a stepwise process is recommended. Careful documentation at each step is important, as is communication with the resident, early involvement of the GMEC, and ensuring a fair and equitable process that aims at successful reintegration of the resident.

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