Summary

In order for residents and faculty to stay well and healthy during remediation (also known as enhanced learning) a team approach is needed with planning, using a range of appropriate resources for both resident and faculty, attending to the whole person and applying a framework to structure and guide the remediation. Dalhousie uses either an Informal Enhanced Learning Plan (IELP) or a Formal Enhanced Learning Plan (FELP).
Across many programs and universities the experience is that lapses in professionalism are both becoming more frequent, and are challenging to remediate.

Documentation is key for all aspects of assessment of progress and becomes doubly important during remediation.
Documentation needs to be accurate and timely but does not need to be lengthy and should be shared with the resident. Specific descriptions of behaviours are key to deciding if an enhanced learning plan is needed.

A remediation plan needs:

- Clear measurable objectives and competencies to be achieved
- Strategies to achieve the competencies
- A time frame
- Clear documentation of timing of formative and summative assessment strategies (what will be assessed, how will it be assessed, by whom and at what frequency)
- Possible outcomes of the remediation
- Possible consequences of successful or unsuccessful remediation
- Outline of supports available and how they can be accessed

Prior to implementing remediation a full assessment and "diagnosis" should be completed.

The 6 elements of the Patient Centred Clinical Method provide a helpful framework for creating, planning and following up on academic or professional difficulties.

1. "Exploring disease and illness experience" becomes "gathering objective evidence and understanding the resident's experience" Consider the objective evidence of difficulty (assessment of knowledge, skills attitudes) and the resident's experience of the learning in the clinical setting
2. "Understanding the whole person in context" is critically important to create an effective remediation plan. The medical school experience, personal circumstances, health (physical, psychological). Attend to strengths as well as areas of concern.
3. "Finding common ground" to achieve shared goals, roles and understanding
4. Attending to the relationship throughout – ensuring that the resident as a person is supported while remediation is underway. Residents need to be strongly encouraged to seek support. Ensure feedback is always couched in descriptive not personally critical terms.

5. Being Realistic about what can be accomplished in a given setting, time frame and with available resources
6. There is a less obvious connection to the prevention element of the PCM

Faculty wellness

1. Clearly define the role each faculty member will undertake during remediation.
2. Ensure support and regular check-ins for the faculty member – site director, Program Director, Associate Dean PGME, lawyer Consider separating the remediation coach and the remediation supervisor or assessor. It is challenging to play both roles.
3. Consider having another person present during each meeting with the resident and make sure meetings are documented
4. Attend to boundaries – it can be easy to slide into the role of family physician, counsellor, therapist. Having another person present and debriefing regularly with a colleague or program leader will mitigate this
5. Remember our social responsibility to only graduate physicians who are safe and competent.

Common Challenges and approaches to solutions

Difficulty understanding and creating a plan

- Be comprehensive – context, background, life circumstances, strengths
- Always another side to the story
- Difficulties identified late in residency
- Respond to red flags EARLY – admin professionalism (payment of fees)

Challenges of multiple competing roles as a faculty member

- Ombudsperson
- Seek out resources and support – Site Director, Program Director, PG Dean, Physician Support Program
- Do not become the resident's therapist, physician etc.

Appeals, Legal issues

- Organized process for feedback
- Know policies and follow them
- Be factual and clear in all documentation – avoid opinion
- Be professional in all email communication
- Document
- Document
- Document
- Expect appeals
- Consult early and often with legal

System approaches

- Admissions
- Early support for all residents

- Proactive for high risk situations
- Early identification and intervention

Take Aways

- Enhanced learning plans/remediation is an integral part of our job
- Intervene early
- Attend to the resident's wellness
- Attend to the faculty wellness
- Use a framework
- Document Document Document
- Expect appeals and to involve lawyers

Remediation Assessment Grid

The resident and the Program Director, with input from other faculty members, should each complete the entire grid independently
The final grid as part of the remediation plan will include all non-confidential information from both resident and program
It may be valuable for the remediation supervisor to complete this grid on a regular basis during remediation
Any requirements for accommodation will also be attached as part of the assessment.
Note – each section should outline both strengths and areas of concern

References

Kalet A, Chou Y Editors. Remediation in Medical Education: A Mid-Course Correction © Springer Science+Business Media New York 2014
A comprehensive well-written practical resource for designing and implementing remediation for all aspects of medical education

Ellaway R, Chou C Kalet A. Situating Remediation: Accommodating Success and Failure in Medical Education Systems
There has been a widespread shift to competency-based medical education (CBME) in the United States and Canada. Much of the CBME discourse has focused on the successful learner, with relatively little attention paid to what happens in CBME systems when learners stumble or fail. Emerging issues, such as the well-documented problem of "failure to fail" and concerns about litigious learners, have highlighted a need for well-defined and integrated frameworks to support and guide strategic approaches to the remediation of struggling medical learners. his Perspective sets out a conceptual review of current practices and an argument for a holistic

approach to remediation in the context of their parent medical education systems. The authors propose parameters for integrating remediation into CBME and describe a model based on five zones of practice along with the rules of engagement associated with each zone. The zones are “normal” curriculum, corrective action, remediation, probation, and exclusion.

The authors argue that, by linking and integrating theory and practice in remediation with CBME, a more integrated systems-level response to differing degrees of learner difficulty and failure can be developed. The proposed model demonstrates how educational practice in different zones is based on different rules, roles, responsibilities, and thresholds for moving between zones. A model such as this can help medical educators and medical education leaders take a more integrated approach to learners’ failures as well as their successes by being more explicit about the rules of engagement that apply in different circumstances across the competency continuum.

Knowledge	Skills	Attitude*
Resident	Teacher	System

* Attitude problems (usually manifested as behaviours) typically include difficulties related to motivation, insight, doctor-patient relation- ships, and self assessment[1]

[1] Steinert Y BMJ | 19 JANUARY 2008 | VOLUME 336