

## Review Article

# Remediation in Emergency Medicine: What are the issues?

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### Abstract

Residency training programs have the responsibility to ensure that their graduate develop the knowledge, skills and attitude required to practice their specialty independently. It is also important to be able to measure their competency. However, some residents will need remediation, with extra resources, time and effort to meet the set standards. Most residency programs will have some guidelines on remediation, pertaining to the different domains of concern.

#### However, are these best strategies?

Here, the author shares about the Emergency Medicine residency in Sing health, a health cluster in Singapore, and also shares her views on time and competency-based programs, as well as some suggestions on a hybrid model for remediation. She suggests flexibility, thinking out of the box methods and bearing in mind the inter-individual variations amongst our residents and doctors.

Eventually, there is really “no one size fits all” recommendations. It is about customization, flexibility and a deeper understanding of issues which also include adult learning, motivation and self regulation.

**Keywords:** Emergency Medicine; Remediation; Residency; Competency

## Introduction

Remediation refers to the process of facilitating corrective actions and interventions for residents, trainees and physicians who are not performing as expected or not on course in terms of achieving the required competencies. It represents a word that often conjures fear, dislike, negative sentiments and extra effort both on the part of the trainee, resident or even the supervising faculty. Milestones have usually been given for a certain level of knowledge and skills to be developed and mastered by a certain period or timeline [1-4]. The underlying reasons for the non-performance and inability to achieve the milestones are varied, ranging from affective, cognitive or inter-personal difficulties, or learning at a slower rate [4,5].

Remediation is necessary as the medical fraternity has the

responsibility of ensuring that the graduates are able to carry out their duties safely and in a competent manner, once they graduate from the training programs. In fact, that is why a remediation program is compulsory in any residency or training program, especially those utilizing time-based achievement of milestones and competencies [4-6]. The reason is that some residents may require a longer period to achieve the requirements and threshold than the stipulated ones. It is also to ensure that when these practitioners are no longer being supervised and have graduated from the training program, they are able to perform and function optimally, with the relevant level of competence, professionalism, as well as a foundation of ethical, evidence-based practice. Early detection and intervention is critical for the most productive and positive outcomes [1,6-9]. Although it happens, reluctance to fail a non performing trainee or resident is not acceptable, especially if the consequences downstream are taken into account. Moreover, it can be even more challenging in Emergency Medicine (EM), as the residents are required to have multifaceted and very diverse

skill sets and capabilities, which need to be inculcated during their training years. Accreditation bodies have proposed guidelines for remediation [2,4,6,7]. How useful are these and do they need to be customized appropriately to the local or Asian context? Some remediation interventions are focused on improving performance to pass certain examinations at a repeat sitting [10-12]. Is this a good enough framework to support an emergency physician through remediation? How about the issues of reflection, professionalism, insight and awareness, communications and inter-personal skills, or the “x” factor (a difficult to define characteristic but it encompasses what the layperson would define as the doctor being ‘professional’) which patients wish to see in their doctors.

## It Starts at the Selection Stage

In Singapore, residency training follows the ACGME-I (Accreditation Council for Graduate Medical Education-International) guidelines and framework [13]. Every training program aims to select the best range of candidates. The first step in the selection process for EM residency (as in other residencies) is usually academic results and performance. Most institutions also conduct some level of interview and these days, teleconferencing and skype is also utilized for long distance applicants and candidates. Other modalities such as supervising faculty feedback, 360 degrees feedback from healthcare staff, publications and fulfillment of criteria and guidelines set by the institution are also reviewed. Are these sufficient, when we know the dynamism in the practice of Emergency Medicine (EM) requires an individual who is well rounded, adaptable, flexible in some ways, able to think on their feet and make quick, accurate decisions and management plans? Are the current modalities in use, able to select candidates appropriately. Of course, we do hit the right match as well, especially when those applying for the EM residency are usually bearing certain qualities and expectations and the discipline does seem to have an attraction for those which certain characteristics and personality. We also get existing residents from the various levels to meet and interact with the potential new applicants. Feedback from them can be valuable as well as they themselves are going through the training and have an idea of the requirements. [6,11,12,14]

In Singapore there are two groups of doctors accepted into EM residency training programs:

1. Fresh graduates from medical school and
2. Medical officers who have been doing a few rotations in a variety of disciplines before applying to come into EM residency.

The latter will be more senior and have slightly more clinical exposure and experience. However, it is interesting to note that the

numbers requiring remediation in either group is not statistically significantly different, over the 6 years we have been running this program in Singapore.

With the fast paced development of EM and the progressive vision Emergency Physicians (EP) need to have, institutions and the panel making the selection have to be aligned with a robust recruitment process and move with the times, otherwise we chance the candidates not performing up to expectations, going through remediation or even dropping out.

## The Diagnosis, The Journey

(Please refer to Annex A for the sample of the Emergency Medicine remediation process)

As a doctor is being supervised and mentored during his training, non performance or the inability to meet strategic milestones and lapses in any critical domains are highlighted. They are then counseled accordingly with the appropriate interventions and course of action. If there is no improvement and no positive outcomes, the doctor may then be identified for formal remediation. Information gathering takes place through various sources: consolidated interviews from various stakeholders, chart reviews, peer and senior or faculty inputs, performance at summative and formative assessment as well as the scores and the ability to achieve milestones satisfactorily, with time. Secondary causes too are sought [9-11].

The critical first step is to identify the struggling resident or trainee who needs remediation [6,10-12]. In the program here, inputs come from the supervising faculty, other physician faculty, 360 degrees feedback from members of the healthcare teams, other staff in the department and their supervising attending when they are out on their rotations to the various specialties and disciplines. Our aim is always to recognize these residents who need remediation early because; early intervention is key to successful remediation. Residents themselves rarely bring up issues pertaining to or give negative feedback on their peers. From our experience, struggling residents rarely come forwards themselves.

The model of assessment in medicine is complex and multifaceted. Supervising faculty may thus be reluctant to fail underperformers and this would mean learning problems can remain hidden and unaddressed, with the consequence of sub-standard performance downstream.

One of the essential steps in the early phase is to identify specific competencies that are problematic and challenging for the residents concerned. The usual gaps are those related to medical knowledge and patient care. This can result in the provision of

inadequate and suboptimal care to patients. This type of academic difficulties is often noted amongst residents in the earlier years of training. For the senior residents, the reasons for remediation include lack of leadership capabilities to manage an emergency resuscitation room, deficits in communication and inter-personal skills or affective deficiencies [2,9,12,14,15]. There were also a few residents who were not able to clear their examinations requirements and thus, required remediation, based on the existing criteria.

Once the decision has been made the resident in question will be briefed by the supervising faculty and program director and a remediation plan will be put forth to address the lapses and deficiencies. The resident's own perception of their capabilities and weaknesses is also important to understand. This will assist faculty in their understanding of the resident and if he/ she has insight into the issues concerned.

Residents have to be a major player in this remediation plan writing process. Their inputs are critical in the formulation of shared goals. The remediation plan will come with strategic timeline, achievement, self- analysis and monitoring, as well as reflection. The latter is a part which most of our residents struggle with. This is also where we strive to make them understand that they need to achieve certain milestones and skills as well as capabilities not just in the context of remediation, but as a means to lifelong learning and practice as a competent emergency physician.

Successful remediation requires time to develop and implement as well as time to monitor the progress. If residents are deficient in more than one domain and lack competency, their remediation plans need to be customized and targeted to each area of deficiency specifically as well. Some of the deficiencies require direct supervision, whilst others may get by with indirect supervision.

Residents, especially those involved in remediation, must be made to understand the difference between short term goals and long term mastery as well as learn to inculcate reflective practice such that it becomes automatic in them. Metacognition too is a very useful technique in helping them develop their professional identity. Simply put, it is about thinking about their thinking process and emotions [14-17].

The remediation journey is often lonely and can be challenging. The residents need regular feedback and nurturing, which is non-judgmental. It is often also a platform to allow late-developers to progress. Thus, remediation offers a safe space to help inculcate a developing mindset amongst those involved.

In the conduct of the regular and frequent follow-up and counseling between faculty and the resident in remediation, the following represents a useful practical list:

- The session should be planned outside clinical shifts, so that they are not rushing off to review patients and have a clear state of mind
- Ensure sufficient time for heart to heart talk and sharing
- Prioritize points to cover at each meeting session, so as not to overload. This gives time for in-depth discussion and sharing
- Discuss each issue and potential solutions. Let the residents participate actively and come up with suggestions
- Set end points and targets but also discuss the process and journey to get there
- Offer referral to help network, resources etc
- Fix the next follow up session, so residents can prepare and plan

## **The Role of Faculty and a Community of Practice**

The role of a remediation supervisor is critical. He or she has to frame a mutually agreed plan with the resident, monitor, counsel and document remediation processes and follow up. He / she also has to ensure the progress of the development work in the context of the resident's professional goals as well as the institution's expectations for professionalism and performance. This is a very labour intensive process and the person performing this has to have an understanding of these processes, be of the right character and motivation to be able to carry out this nurturing and advisory requirements. A faculty with strong teaching commitment and a motivation towards excellence as well as someone who can adopt a non-judgmental stance will be most suited. The learners and residents will then be able to be open, highly engaged and show less resistance in their participation in the remediation journey. The faculty with a vision to set small achievable steps which are customized, with effective framing, can do wonders with slower learners and struggling residents. The person should be able to bridge remediation as an opportunity to learn and grow as well as to develop critical skills and knowledge, instead of letting it take a punitive and shaming stance. Only then can the faculty and resident build an effective working relationship. Taking this approach, from personal experience, can create the necessary changes we wish to see in residents, promote learner ownership and autonomy as well as inculcate self-regulation amongst the struggling residents. The monitoring throughout the remediation journey is also critical, as faculty need to watch for distractions, over-dependence and lack

of progress and development. If the faculty has been trained as a debriefed or is familiar with the debriefing process, this can value add as well as the residents will need regular feedback and managing of their emotions and morale.

In Singapore, which is in South-east Asia, the culture and values are quite different from the west. Thus, in planning and conducting remediation, it is important for us to bear this in mind. Our Asian residents are less vocal, highly respectful of seniority and the mentor-mentee relationship. Thus, faculty supervising the remediation, being aware of these, will have to be trained to encourage the residents to express themselves, speak up and be frank in sharing their issues and opinion. The issue of “face” (a combination of pride and ego) is also important. For these residents who are being formally remediated, they may feel it as a stigma on their performance records, and may have to handle questions and comments from peers and family. As doctors, there are always expectations for them to be able to maintain good performance and work ethics. Self esteem and confidence are also linked to this. Thus, how the institution, program, department and faculty, frame remediation can affect how the residents feel and perform. It can be challenging to identify the residents’ or learners’ problems but faculty often find it even harder to confront residents with their perceptions.

The bottom line of getting the best and most productive outcomes from remediation must be to have carefully selected and trained faculty involved as coaches. The trained faculty with a wealth of patience, experience and mastery of all the domains of expertise will be optimal. On the other hand, a master clinician who is “unconscious and automatic” may not be the best person to help residents through their remediation. Kalet A. et al has come up with a list of recommended competencies for faculty and it is a good foundation to start with, especially if there are limited experience with remediation and the area is still developing expertise in your country [6] Building a community of practice of remediation faculty can be the medium to long term goal for programs. This group can even have inter-professional experts and faculty and become a rich resource and repertoire of strategies and regular platforms for sharing [6,11,12,15].

## Framework of Competence

The assessment of residents in our Singapore residency programs, is based on the ACGME framework, covering 6 domains, namely patient care, medical knowledge, practice-based learning and improvement, systems-based practice, [13] professionalism and interpersonal skills and communications. Professionalism is a domain which can be challenging to grade as it encompasses a variety of factors. Using the recommended guidelines and frame-

work can be useful and certainly gives a structured approach. However, in real life situations, our residents and doctors may not fit exactly across these domains and the suggested timeline. A review may be needed, because using the current methods, we may encounter residents who fulfill all criteria of the framework and have passed the relevant post graduate examinations, but are not ready to function as an attending, to run and coordinate a busy emergency department, a resuscitation room, have good interpersonal communications skills, work well in inter-disciplinary teams and are able to carry out all the relevant systems-based practice required in an institution. Are we ending up with examination-savvy doctors, lacking in empathy, human factors, kindness and other non-technical skills required of an emergency physician?

Are the time-based criteria and grades based checklists (eg, grading performance of skills from 1 to 10 on a mini-CEX) good enough for assessment? Perhaps moving forwards, we will need to better define and describe each grade and clarify the threshold between fair, good and excellent. Also, with the competency list of hundreds of skills and tasks as well as Entrusted Professional Activities (EPAs), perhaps a more flexible timeline can be given as many residents may require a longer period to master the skills and task requirements. It can thus be by using a hybrid model between flexible timeline and competencies.

Besides the ‘hardware’ and residency specific tasks and competencies, it would also be useful for faculty to be able to share and value add in a variety of ways (eg leadership roles, certain administrative roles, public speaking and presentation, amongst others). All these other skills and capabilities can definitely be synergistic when the faculty is mentoring and supervising residents. Also, being aware of adult learning theories or self regulating theory (SRT) is useful. The latter is applicable in creating positive behavior. When the trained faculty is informed and aware of what they can execute and share with their residents. The components of SRT are [18-19]:

1. Standards: of desirable behavior
2. Motivation: to meet the standards
3. Monitoring: of situations and thoughts
4. Will power: internal strength
5. Awareness can lead to purposeful actions and setting of appropriate goals for the desired outcomes.

## Conclusion

Residency programs and institutions should rigorously review their approach to remediation and the strategies, to ensure its relevance and impact. Going by strict or rigid guidelines and framework may not be the best approach. Having different modal-



ties, approaches and thinking out of the box can at times be more effective in approaching the slower learners and those requiring remediation. Most importantly, time is needed for faculty to build rapport, deepen understanding with their mentees and together, write a customized remediation plan that works and produces the desired outcomes.

### Annex A: The Emergency Medicine Remediation Model

The systematic step in the remediation process is as follows:

1. Identification of resident for remediation
2. Detailed interview by core faculty supervisor and then programme director
3. Joint plan writing and signing of agreement by resident and assigned core faculty supervisor ( this will stipulate clearly the lapses, action plan and domain specific interventions)
4. The initial remediation contract is set at 3 months, with monthly review and detailed discussion/ feedback session with the assigned core faculty supervisor. The monthly reviews will cover clinical performance, 2 case-based discussions, chart recording and review, mini-CEX and inputs gathered from other departmental staff. Besides this it also depends on the lapses and gaps for the remediation in the first place. If there are deficiencies in certain skills, then competency attainment will have to be demonstrated. These areas of deficiencies and non-performance will be assessed accordingly using suitable methods such as clinical experience and exposure, skills training, simulation based assessment, communications by direct observation etc
5. Review of progress at the end of the initial 3 months. If satisfactory progress is being made, but more time is needed, an agreement contract extension is planned, with the desired outcomes and performances clearly outlined. If there is no further need for remediation, the resident is allowed exit as appropriate to rejoin his/ her residency training. If there is no improvement, another contract extension is carried out. To date, with the ACGME-I programme in Singapore for 6 years, there has not been a resident who required more than 6 months of remediation.

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