

COMMENTARY

R & P: The Medical Education Scarlet Letters

Among all professions and cultures, communities have tried to remediate deficiencies in their citizens. Literature has documented many of these attempts to notify the populace of an individual's inability to conform to standard. Nathaniel Hawthorne's Hester Prynne was forced to display a scarlet "A" on her dress to expose her "deficiencies." All can agree it was a humiliating and awful attempt to improve the person and the community, but at least everyone knew what the problem was.

In this issue of *Academic Emergency Medicine*, Weizberg et al.¹ present the results of a survey of emergency medicine (EM) residency directors attempting for the first time to catalog and define the use of remediation and probation in EM training programs. This survey, with a response from roughly half of all programs, highlights a variable and seemingly covert process. One of the most surprising and noteworthy findings of this work is how infrequently key stakeholders are notified about remediation. Program directors (PDs) informed their faculty members of informal remediation or probation less than 30% of the time. For formal remediation, notification to the faculty (or even the GME office) occurred just over half the time. No one is advocating that we sew a letter "R" or a "P" to a resident's coat. However, for those in remediation or probation status, it requires us to ask: how can faculty members remediate a deficiency if they do not know what it is or who has it?

The study demonstrates convincingly that there is wide variation in the practice of remediation and probation. Only half the programs surveyed had an official institution-wide policy dictating remediation or probation. This is not surprising since there is little guidance from national organizations as to what remediation and probation should be in process or action. The Accreditation Council for Graduate Medical Education (ACGME) provides insufficient direction at the institution or program level. PDs and designated institutional officials looking for guidance in this area will be surprised to find limited information to steer best practice. The comprehensive reference list provided by Weizberg et al. sits at just nine articles. A key reference is the excellent work by Katz et al.,² which provides standardized definitions and a suggested guideline for the process.

We congratulate the authors on their important work. This paper helps us better understand "What happens

when a resident is *not* in good standing?" Their study demonstrates the wide variation among institutional procedures related to remediation and probation, while providing summative definitions for the terms *informal remediation*, *formal remediation*, *informal probation*, and *formal probation*. Surprisingly, these terms required definition. Despite decades of work by the ACGME to improve our collective ability to assess resident competence, there has been no commensurate effort to train residency faculty on the best methods to help the struggling resident. We therefore applaud the conceptual framework that emerged from this study, in Figure 1, for both its simplicity and its need. In it, the authors identify the requisite steps necessary from the identification of a resident in need, through the process of remediation, to the decision point of termination versus promotion. Weizberg et al. offer clear recommendations for standardizing the remediation and probation process managed by PDs, faculty members, and GME leadership.¹

So why was there so much variability noted in this study? Why do PDs not inform faculty members or their GME offices or even simply document remediation status? As the authors allude, it is likely for multifactorial reasons. We can speculate further on the many concerns raised by the authors, but almost certainly, the letters "R" or "P" in a resident's file are viewed as a stigma. We believe in our ability to get residents to the goal and, as such, would hope to avoid formal documentation for them to explain to classmates, faculty, and future employers.

This is suboptimal for all stakeholders. For residents, due to lack of standard expectations and process, remediation continues to carry the fear of the unknown ("Am I going to get fired?") and is viewed by them and their classmates as a true stigma. This is also true for PDs, who in an attempt to protect their residents delay the critical documentation required to move a resident towards a formal remediation plan. Employers, being unaware of formal definitions or a standard process, will continue to view remediation and probation as a "Scarlet Letter" regardless of a candidate's satisfactory completion of the program. Most importantly, we believe that most disabling to remediation and probation is having an uninformed faculty. You cannot keep the teachers in the dark. It does not make sense.

The ACGME bestows a heavy burden on PDs. The PD is the designated faculty member who is expected to offer a signature attesting that a resident has completed all program training requirements and that the resident is able to practice independently. To avoid stigma, PDs may push residents through the system. Those residents

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are certainly at risk for lawsuits, terminations, loss of licensure ... not to mention that they may endanger patients. The PD signature attests to completion of training according to two standards, either of which might require remediation:¹ the ACGME/Residency Review Committee (RRC) requirements and our local institution. Let's consider each set of requirements and their effect on the remediation process.

The RRC standard has been made much clearer in these past few years through the development of the EM Milestones. Although certainly an imperfect document that will develop and mature in future iterations, the Milestones now provide educators with behavioral descriptors of competence for a variety of issues. Because this is a commentary, we will take the editorial liberty to change the term competence to minimal competence. To use a common analogy, your 16-year-old son is competent to drive a car once he passes the licensure test at the DMV. The first night he leaves your driveway with your car you will likely assess his skills as *minimally competent*. Shouldn't we instead want all of our licensed drivers to be experts, perhaps held to a standard necessary to compete in NASCAR? Obviously that is impractical, as with all things achievable, so we revert to a standard of minimal competence. If the milestones are minimal competence, then it would be simple to expect that if a resident is below an expected milestone at some point in training, he or she should be remediated to the level expected of his peers. Simple, right? Well, no. The milestones (demonstrable behaviors) offer expectations for each identified competency (content topic), as well as suggested methods of assessing resident progress for a particular competency. After a decade of the Outcomes Project and now with the Milestones, we collectively have become expert assessors (a good thing). However, the first iteration of these Milestone requirements does not include any suggested methods for remediation. This is where the ACGME Milestones fall short. What should the PD and the faculty do when they determine that a resident is not at an expected milestone? Huge effort is needed to make that assessment and even more to address the issue: one must diagnose the actual learner problem, develop a plan to fix the problem, reassess the issue to confirm progress, make the decision to remediate under a possible title of probation, then reassess again, then make another employment decision, which this time includes human resources and GME, and then, no matter the outcome, paperwork—lots of paperwork.

Let's offer a simpler future. The next iteration of the Milestones might be edited through joint effort of the original author team and the collective wisdom of the COR Remediation Task Force and the Joint Milestone Task Force. Statements about expected milestone achievement by a certain time in training (minimal competency) should be drafted ahead of time for each competency, "failure to attain this milestone by X date mandates remediation through the following methods ... Completion of the program may only occur if ..." If the milestone project could evolve to that level of prescription, the remediation process for many residents would be much richer. Importantly, it would be more empowering for PDs and likely result in more remediation (another good thing).

Now let's bring up a messier issue, that of individual program requirements. The PD signature also attests that the resident met all necessary training elements unique to his or her institution. This is an important distinction. We expect that all ACGME-approved training programs must train residents according to a national standard (minimal competency), in our case the EM Milestones. However, our guess is that every institution believes it trains residents better than a minimal competency standard. Therein lies the very difficult challenge for the PDs. To make these institutional expectations fair and clear for all residents, the PD would need to either edit expectations for the existing milestones or (God forbid) write additional milestones that reflect local expectations. Here is a case to consider:

"Student A" earns admission to the rocket science program at "Ivy League School #9." After 1 year, his GPA is below 2.0 and he risks expulsion. Does the school have an obligation to remediate this student to the necessary GPA to remain at the school? Or should they cut him free? Let's say he is expelled. He then goes on to study rocket science instead at his local community college, where he excels. Why? Going out on a limb here, but perhaps the demands of the "Ivy League #9" program were more rigorous than those of the community college. He was out of his league, so to speak. In another environment, he did well. To the Ivy League school, we say *nice work*. "Student A" is simply a number and you should not feel badly about letting him go. It is what it is.

Obviously that is not how we operate in medicine. PDs and faculty members have relationships with their residents that are very subjective and inherently more personal than large universities in which students are truly just a number. These relationships cannot be ignored, as they complicate the PDs' interpretations of what it means to start down the road of remediation with a resident—because the letters "R" and "P" truly are Scarlet Letters for medical professionals. State medical boards and hospital credentialing committees need to stop asking physician applicants and their programs if the graduate participated in a remediation program or were put on academic probation. It defeats the whole purpose. We spent all this effort to work with our residents to get them to meet the expectations described by the RRC and they succeeded—so label them as graduates and take away the stigma associated with remediation/probation. Stop forcing the stigmatized to revisit the issue over and over again during a professional career every time they interact with another credentialing board. Remove the term "academic probation" from our lexicon and you will change the expectation of credentialing boards. If they do not ask the question, it is much more likely that PDs would employ a remediation process as conceptualized by Weizberg et al.

Another point to consider: remediation is a huge time sink. It is done at the expense of everyone else in the program. There is less time for residency leadership to address other program issues, to innovate, or to advance the program goals. The remediation often requires a change in duty status for residents that can affect all clinical schedules and general ED operations.

From an administrative standpoint, it would be far easier to replace the resident with a transfer than to spend the time necessary to create and execute a productive remediation program for a single resident.

We agree with the authors that a process and clear definitions are required. We suggest that the RRC define expectations for milestone achievement and that recommended methods for remediation are included for each milestone level. In this way, the need for remediation will become a decision made solely by the Clinical Competence Committee. Remediation and probation have become the scarlet letters for residency training and beyond for any given trainee. And worse, the data suggest that the letters themselves are not displayed on the resident's lapel, but rather are invisible, making corrective action(s) even harder to affect by uninformed faculty. Our suggested framework makes a plea for an alternate approach: make the "R" and "P" scarlet letters of remediation and probation not only visible, but a well-defined and acceptable part of the journey for appropriate trainees.

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