

Remediation is NOT Punishment!

How to Design an Appropriate Remediation Learning Plan

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WORKSHOP OBJECTIVES

At the conclusion of this program, participants should be able to:

1. Explain *10 important principles* that form the foundation for an effective evaluation system.
2. Describe *six critical elements of an appropriate remediation learning plan*.
3. Explain the *proper documentation* needed to record performance problems and to verify completion (or failure to complete) the remediation process.
4. Develop an *educationally sound and legally defensible remediation learning plan* for a resident who exhibits unsatisfactory performance.
5. Describe the important information to include in a *letter of separation* for a resident who fails to meet the terms of a remediation learning plan.

WORKSHOP TOPICS

**Designing and Implementing an Effective Evaluation System:
Protection of the Public is the Most Important Principle!**

**Six Critical Elements of a Remediation Learning Plan:
The First Step is Establishing Clear, Succinct Policies and Procedures**

**Proper Documentation is Necessary in Remediation:
“If It isn’t Written Down, Then It Didn’t Happen” (Just Like Patient Care)**

BREAK

**Performance Problem? Problem Individual? or Both?
Conducting an Educational Consultation is the Key**

**Residents are NOT Employees:
Understand “Due Process” under Academic Law**

**Dismissal, Resignation, Transfer or Non-Renewal:
Residents May Leave but They Never Really Go Away**

Common Questions about Remediation in GME Programs

When does a resident/fellow's performance reach the point of requiring a formal remediation plan?

How do I determine the type of remediation needed?

How do you design an academic remediation plan for someone who has a psychological, behavioral, attitudinal and/or professionalism problem?

How long should the remediation period last?

Who should (and should not) be notified when a resident/fellow is placed on formal academic remediation?

What information do I include in a "Letter of Separation" for a resident/fellow who fails to meet the requirements of an academic remediation plan and is dismissed (or allowed to resign without receiving academic credit for all or some time)?

- 1. METHOD of Leaving (e.g., Dismissal, Resignation, Transfer, Non-renewal, Other?)**
- 2. REASON for Leaving (e.g., "failure to meet academic standards," misconduct, personal, health, etc.)**
- 3. Time *Enrolled in Program* (use EXACT dates, include time out on suspension, LOA, FMLA, etc.)**
- 4. Time *Receiving "Credit" for Training Completed* (use EXACT dates)**
- 5. Special Conditions (e.g., future benefits, prohibited from contacting others, from campus, etc.)**

What information do I share with others after the resident/fellow leaves the program, whether s/he completed, or failed to complete, the academic remediation plan?

EVALUATING CLINICAL PERFORMANCE: TEN IMPORTANT PRINCIPLES

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“Continuous Evaluation is Essential for Professional Growth”

1. **Ultimate Responsibility of the Institution, its Administrators and Faculty is the “Protection of the Public.”**
2. **Primary Responsibility of Administrators and Faculty is to Certify and Document that Residents have Satisfied ALL the Requirements of the Accredited Program.**
3. **A Program’s *Educational Integrity* is a Direct Reflection of the Rigor in its Evaluation Methods and Processes.**
4. **All Educational Activities (e.g., Didactic Lectures & Seminars, Clinical Rotations, Clinics, Research, etc.) are Critical Components of the Curriculum.**
5. **Each Day of Each Month in the Program is *Equally Important* in the Evaluation of Resident Performance and Achievement.**
6. **Rules, Regulations and Criteria for Performance Evaluations Should be Clear and Established Through “Consensus” Decisions involving the Administrators and Faculty.**
7. **Knowledge, Skills and Professional Behavior are *Equally Important* in Clinical Performance Evaluations.**
8. **SUBJECTIVE & ARBITRARY, ADVOCATE & ENABLER and CONFIDENTIAL & ANONYMOUS are *NOT* PAIRS of SYNONYMS.**
9. **“Fair” is not the same as “Flexible” when it comes to Enforcing Rules, Regulations and Requirements (i.e., Being Equitable).**
10. **We are NOT OBLIGATED to Graduate Every Resident We Accept into our Programs; We ARE OBLIGATED to Graduate COMPETENT Residents.**

The Five-Step Process for giving Critical Instructive Feedback

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If the interaction went smoothly, then it did NOT go well

1. **DENIAL** (Expect it---it's a normal response to the sting of criticism)
The person will likely try to protect himself/herself (we all do). In anticipation of this, begin the conversation by pointing out that you are talking with the person because you care; you are concerned about some aspect of his/her performance. You want to help him/her.

Strategy:

1. Describe the mistake/problem in clear, succinct and specific terms.
2. Describe what needs to be done to correct the mistake/problem.
3. Describe what will happen if the mistake/problem is corrected as well as what will happen if the mistake is NOT corrected.

Monitor your frustration level. It will rise as the person continues to deny the mistake or problem. If you don't seem to get through, *restate 1-2-3*. If you fail to break through the denial, call a "time-out" for a brief period, or stop and schedule another meeting.

2. **ANGER/UPSET** (Acknowledge the feeling not the comments)
When the denial wall (i.e., excuses) comes tumbling down, the person will likely become angry or upset. These feelings are **INNER-FOCUSED but OUTER-DIRECTED**.

Strategy:

1. Stay focused on the mistake or problem. Do not get distracted by the "lashing out" comments, insults or other statements---don't "bite the bait."
2. Allow the person to be angry or upset, but remind him/her the goal is to recognize and correct the mistake or problem.
3. Resist the tendency to feel that you have to justify your position or your actions **repeat 1-2-3 in Step 1**.
4. Watch the person's reactions. Call a "time-out" if the person becomes too upset or appears threatening. Give the person time to regain composure or cool off.
5. If the person becomes unable to continue the conversation or you are feeling too frustrated, stop and set a date for a follow-up meeting. If necessary, consult a mental health specialist to determine if the person should undergo a more formal evaluation.

NOTE: With some individuals, you may not progress through Step 1 or Step 2!

3. **UNDERSTANDING** (Hear it directly from the learner)

The key to correcting the mistake or resolving the problem is getting the person to “own up” and take responsibility for his/her learning, behavior and actions!

Strategy:

1. Watch for verbal and nonverbal signs that the person understands the nature of the mistake/problem and the necessary corrective steps.
2. Ask the person to **TELL YOU IN HIS/HER OWN WORDS** what s/he did wrong, what s/he must do to correct it, and what will happen if s/he does or does not correct the mistake or problem (i.e., **“I did X, I need to do Y to correct it, ...”**).

PLEASE DO NOT ASK: “Do you know what the mistake/problem is?” or
 “Do you know what you have to do to correct it?”
The person simply has to nod his/her head--which is basically meaningless!

3. Take notes as the person states the problem, the corrective steps and the consequences. This will serve as a record of the interaction. Writing notes is also a useful technique if the interaction gets heated.

Be careful-----when the person states what s/he did wrong, s/he may revert back to Step 1 by denying the problem or minimizing its seriousness. If the person does this, **repeat 1-2-3 from Step 1** and reiterate that your goal is to **HELP** him/her correct the mistake or resolve the problem. If the person tries to negotiate different corrective steps, move into Step 4.

4. **BARGAINING** (Know what is within your authority or control)

The goal is to correct the mistake or solve the problem, not to minimize it.

Strategy:

1. Remind the person (and yourself) that your goal is to help him/her correct the mistake or solve the problem.
2. Repeat the corrective action(s) described in Step 1. Some individuals will try to negotiate different corrective steps or consequences.
3. Decide whether there is room for negotiation. If so, decide what **YOU** are willing to negotiate. Remember to negotiate only those changes within your authority.
4. Don't hesitate to say, “Sorry, this is **NOT NEGOTIABLE.**”

NOTE: If you are unsure whether something is within your authority, be candid and say, **“Let me check with and I will get back to you.”**

5. **ACCEPTANCE/AGREEMENT** (Make it written or oral)

The goal is to reaffirm the person's responsibility to correct the mistake or problem and your willingness to help.

Strategy:

1. Restate the corrective steps to be taken and the consequences for achieving (or failing to achieve) them.
2. Conclude by emphasizing the importance of the meeting, recognizing the effort involved to reach this final stage, and providing encouraging comments.

GENERAL GUIDELINE: If repeated conversations occur or the “seriousness” of the problem increases, there should be a written record of the interactions (i.e., documentation). If the problem is not corrected, develop a formal remediation plan signed by both parties.

Key Points about Dealing with a “Problem” Resident or Fellow

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- 1. Keep your policies and procedures for evaluation, promotion, remediation, dismissal, resignation, non-renewal, grievance/appeal, etc. *simple and straightforward*. Avoid multiple “steps” or “layers of action,” especially in your grievance/appeal process.**
- 2. Be sure your legal department has “approved” your policies and procedures.**
- 3. Follow your policies and procedures when decisions need to be made.**
- 4. Avoid falling into the trap of “Enabling Behaviors” when the person makes a mistake or has a problem (e.g., ignoring him/her, making excuses for him/her, minimizing the seriousness of it, taking responsibility for correcting it, etc.)**
- 5. Investigate a reported problem or incident in order to determine, “Is this an isolated, one-time event?” or “Is this part of a pattern of performance?”**
- 6. Intervene IMMEDIATELY before the mistake or problem gets worse.**
- 7. Provide specific, “instructive feedback” along with the consequences.**
- 8. Document all meetings held with the resident/fellow or held to discuss the resident/fellow as well as collect any emails and/or notes from telephone conversations regarding the resident/fellow.**
- 9. Design a formal remediation plan for any mistake or problem that persists.**
- 10. Do NOT make educational decisions out of fear, intimidation or “threat of a lawsuit.” Don’t get distracted by non-educational factors (e.g., loan debt, etc.)**
- 11. Understand the basic requirements of “due process” in ACADEMIC LAW.**
- 12. Verify the identity of someone inquiring about a resident/fellow’s performance.**
- 13. Respond to questions about a former resident/fellow’s performance with this phrase, “I will be happy to comment on what the doctor told you when you asked him/her this question...”**
- 14. Respond to false (or inaccurate/incomplete) information provided by a former resident/fellow with this phrase, “If that is what the doctor told you, then I would ask you to contact the doctor again, tell him/her we talked and that I suggested that you ask him/her that question again...”**
- 15. Follow-up any telephone conversations about a former resident/fellow with a letter or formal email response to the person or organization making the inquiry.**

ACADEMIC REMEDIAL LEARNING PLAN: SIX CRITICAL ELEMENTS

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REMEDICATION PROCESS IS CLEARLY DESCRIBED IN THE GME HANDBOOK AND INDIVIDUAL PROGRAM HANDBOOKS

The remediation process should delineate the conditions or events that initiate a remediation plan, the development and implementation of a plan, and the steps to be taken at the successful or unsuccessful completion of the plan.

PERFORMANCE PROBLEMS ARE IDENTIFIED FROM INFORMATION OBTAINED THROUGH A VARIETY OF SOURCES----*DOCUMENTATION*

Performance data from evaluation instruments, information obtained from individuals through emails and conversations, meeting minutes, incident reports, etc. are collected and analyzed. The performance problem(s) must be related to one or more of the ACGME Competencies.

THOROUGH ASSESSMENT OF PERFORMANCE PROBLEM(S) UTILIZES AN EDUCATIONAL CONSULTATION

An "educational consultation" can be used to fully understand the problem and formulate the corrective steps in a comprehensive remediation plan. The consultation may include the assessment of the resident's: a) cognitive functioning, b) perceptual abilities, c) mental, physical and/or emotional status, d) behavioral patterns, and/or e) drug/alcohol use. Any information obtained through the consultation may be incorporated into the remediation plan as determined by the program director and faculty.

NOTE: An education consultation is NOT used to decide "fitness for duty."

CORRECTIVE STEPS MIRROR PERFORMANCE PROBLEM(S)

The remediation plan is an educational activity that provides an opportunity to correct mistakes and/or deficiencies by increasing knowledge, improving skills or changing behaviors.

NOTE: Remediation is NOT punishment; it is NOT a "paper trail to termination" or is it something to "please Dr. X or the GME committee." Avoid giving residents "mixed messages" and emphasize the seriousness of the situation and importance of correcting the mistake or resolving the problem.

REMEDIAL LEARNING PLAN DESCRIBES THE PERFORMANCE CRITERIA NEEDED TO SHOW IMPROVEMENT

The remedial learning plan includes a clear, succinct description of what the resident must do, or cease doing, to show that the problem(s) have been corrected. When the remediation plan involves behavior changes or alcohol/drug treatment, it is important to also include in the requirements what the resident **MUST NOT DO** (i.e., zero tolerance) in order to meet the terms of the remediation plan.

REMEDIAL LEARNING PLAN HAS A TIMELINE, THE CONSEQUENCES AND THE SIGNATURES OF THE PROGRAM DIRECTOR AND RESIDENT

The remediation learning plan includes the amount of time required for the resident to demonstrate his/her ability to satisfy the plan's requirements. This time period varies for each remediation plan depending on the nature of the performance problems and the necessary corrective steps. It may be a short period of time (e.g., completion of a specific rotation; performance of a specific procedure, etc.) or a long period of time (e.g., until the "anticipated" completion date of the program). Consequences for meeting the remediation plan's requirements should be stated clearly, as should the consequences for failing to meet these requirements (e.g., continued remediation, suspension, dismissal, etc.).

The remediation plan must be signed and dated by the resident and program director!

LEGAL ASPECTS OF GME: Understand Academic Law

Treat ALL Situations as ACADEMIC MATTERS
(Except those where the resident is in trouble with the law!)

THREE LEGAL REQUIREMENTS:

- 1. Standards and Evaluation Process are Public Information**
(Contained in the Resident Agreement and the GME Handbook)
- 2. All Residents Judged by Same Criteria and Process(es)**
- 3. Review ENTIRE Record of Resident's Performance**

What is "Due Process" Under Academic Law?

- 1. Give Resident NOTICE of Problem**
- 2. Provide an Opportunity to Remediate (Recommended but NOT Required)**
- 3. Make "Reasonable Academic Decision" regarding Dismissal or Resignation.**
Resident may be allowed to resign without credit for some or all time in the program

What is "Due Process" in Cases of Misconduct?

- 1. Give Resident NOTICE of Problem**
- 2. Provide Opportunity to be Heard**
- 3. Do NOT have to Provide an Opportunity to Remediate, if the Resident "Knew or Should Have Known" the Action/Behavior was Wrong**
- 4. Make "Reasonable Academic Decision" regarding Dismissal or Resignation**
Resident may be allowed to resign without credit for some or all time in the program

Incidents which can Result in Immediate Dismissal from Program

- 1. Engage in Gross Misconduct**
- 2. Directly Endanger the Care of a Patient**
- 3. Commit a Felony**

SIMPLIFY POLICIES AND PROCEDURES!

- A. There is *no legal requirement* for multiple "steps," "layers of actions" and/or "appeals"**
- B. The GRIEVANCE HEARING should clearly describe how the committee will REVIEW THE PROCESS by which the decision was made (dismissal or non-renewal). The Grievance Hearing is NOT the time to review the decision itself!**

Resident: _____

Evaluator: _____

Clinical Experience/Rotation: _____

Time Period: _____

DIRECTIONS: Please take a moment to evaluate the resident's clinical performance using the rating scale below. Any score of a "1" or "5" must be accompanied by an explanation. If you are unable to judge due to insufficient contact, please check **CJ** (Cannot Judge).

	<u>Unsatisfactory</u> 1	<u>Marginal</u> 2	<u>Satisfactory</u> 3	<u>Very Good</u> 4	<u>Excellent</u> 5	CJ
I. Patient Care						
A. History and Physical Examination Skills	Usually incomplete, superficial, unreliable. Exams are cursory or awkward		Adequate interviewing skills; usually complete exams. including review of systems		Always precise, accurate and thorough; systematic, efficient, focused exams; consistently thorough, elicits subtle findings	
B. Clinical Judgment and Diagnostic Acumen	Unable to analyze & synthesize clinical data; poor selection of tests/studies; differential diagnosis incomplete		Able to analyze & synthesize clinical data; differential diagnosis is acceptable; test selection appropriate, includes risk analysis		Consistently integrates data, including risks & benefits; excellent selection of diagnostic studies; comprehensive differential diagnosis	
C. Patient Management Skills	Unable to initiate proper therapy, modify when needed, and/or make critical decisions "under pressure"		Initiates and maintains patient care in an orderly & appropriate manner most of the time; sometimes has difficulty handling pressure		Consistently initiates patient care in an orderly and appropriate manner; handles "pressure" exceptionally well	
D. Technical (Procedural) Skills	Inconsistent performance; all thumbs; disregards patient comfort and safety		Adequate use of instruments; minimizes patient discomfort and risk		Extremely capable; rarely makes errors; very attentive to patient comfort and safety	
II. Medical Knowledge						
A. General Knowledge	<u>Unsatisfactory</u> 1	<u>Marginal</u> 2	<u>Satisfactory</u> 3	<u>Very Good</u> 4	<u>Excellent</u> 5	CJ
B. Specialty Medical Knowledge	Limited understanding; major gaps in basics		Good understanding of essential information		Extensive knowledge; well integrated; impressive	
III. Practice-Based Learning & Improvement						
A. Record Documentation	Limited understanding; major gaps in basics		Good understanding of essential information		Understands complex pathophysiology in specialty	
B. Dictation of Operative Notes/Discharge Summaries	<u>Unsatisfactory</u> 1	<u>Marginal</u> 2	<u>Satisfactory</u> 3	<u>Very Good</u> 4	<u>Excellent</u> 5	CJ
	Incomplete, lacks critical information; contain inaccurate information; handwriting illegible		Patient records are complete and accurate; handwriting readable; needs occasional reminder		Comprehensive, concise and accurate records; handwriting readable; never needs a reminder	
C. Self-Directed Learning	Late, incomplete and/or delinquent notes; fails to heed warnings; many complaints		Operative notes, discharge summaries completed in a timely manner; responds to reminders		Dictations are well-organized and thorough; always on time; rarely needs a reminder	
	Shows no evidence of reading; ignores self-assessment & feedback; avoids technology		Shows evidence of reading; intermittent self-assessment; incorporates technology		Voracious reader; shows articles; performs self-assessment and accepts feedback; leader in use of technology	
IV. Professionalism						
A. Respect	<u>Unsatisfactory</u> 1	<u>Marginal</u> 2	<u>Satisfactory</u> 3	<u>Very Good</u> 4	<u>Excellent</u> 5	CJ
	Disrespectful; lacks compassion; inconsiderate		Usually respectful, compassionate & considerate		Consistently respectful, compassionate & considerate	
B. Integrity	Dishonest; avoids responsibility for errors		Honest; recognizes errors & takes responsibility		Unquestionable honesty; takes initiative to address errors	
C. Appearance	Fails to follow dress code; ignores feedback		Follows dress code; responds to feedback		Exemplary appearance; always adheres to dress code	

PLEASE COMPLETE OTHER SIDE

	Unsatisfactory	Marginal	Satisfactory	Very Good	Excellent
V. Interpersonal & Communication Skills					
A. Case Presentations	1 Disorganized and incomplete; difficult to comprehend; stoppy	2 Inappropriate sign-outs; lacks understanding during cross coverage	3 Organized; contains the most important information; lacks details occasionally	4 Exceptionally well-organized and concise; very polished presentations	5 Thorough, detailed sign-outs; handles cross coverage well
B. Sign-out/Cross Coverage	1 Avoids contact with patients; insensitive, disrespectful; does not listen; tactless.	2 Does not cooperate well, interact amicably and/or work productively with others	3 Good contact with patients; deals with their emotional and personal needs when necessary	4 Very skillful; shows sensitivity, respect and insight; patients express confidence and make compliments	5 Cooperates extremely well, a real team player; works productively with others; others express confidence
C. Effectiveness with Patients and Families	1 Displays a general lack of interest in teaching; poor presentations; many complaints	2 Teaches students, interns and colleagues when asked; no complaints; adequate presentations	3 Works well with others; cooperative and productive most of the time	4 Demonstrates a strong interest in teaching others; many positive comments; excellent presentations	5 Demonstrates a strong interest in teaching others; many positive comments; excellent presentations
D. Effectiveness with Faculty, Staff and Other Health Professionals					
E. Clinical and Didactic Teaching Skills					
VI. System-Based Practice	Unsatisfactory	Marginal	Satisfactory	Very Good	Excellent
A. Resource Utilization	1 Poor utilization; resists improvement	2 Adequate utilization; strives to improve	3 Listens to billing and compliance staff; attends necessary meetings; complies with regulations	4 Effective utilization; reduces errors; remarkable improvements	5 Incorporates information from billing and compliance staff into practice; complies with regulations and promotes compliance among peers
B. Billing / Compliance / Insurance	1 Antagonizes billing and compliance staff; does not attend meetings; ignores regulations	2	3	4	5

SUMMARY:

A. Please use this space to explain any ratings of "1" or "5":

B. Areas of strength:

C. Areas to improve:

D. Overall rating of resident performance during this clinical experience/rotation:

UNSATISFACTORY

MARGINAL

SATISFACTORY

VERY GOOD

EXCELLENT

Signature of Evaluator: _____

Date: _____

**MEDICAL UNIVERSITY OF SOUTH CAROLINA
GRADUATE MEDICAL EDUCATION COMMITTEE
ASSESSMENT OF RESIDENT PROFESSIONALISM**

This form is designed to elicit your evaluation of the resident listed below. Please address this evaluation constructively. Your evaluation information will be provided to the residents using a "summary report" format to insure that your comments remain anonymous. Thank you for your time and effort.

Resident Name: _____ Ward/Unit/Clinic/Office: _____

Time period of assessment: _____ Evaluator's Name: _____

Directions: Please take a moment to assess this resident using the scale below. If an item is not applicable or you are unable to judge an area, please circle N/A (not applicable) CJ (cannot judge). For any item that you rate a "1" or a "5", please provide an explanation

1 = POOR 2 = FAIR 3 = GOOD 4 = VERY GOOD 5 = EXEMPLARY N/A/CJ

Reliability/Work Habits

1	2	3	4	5	N/A CJ
Not conscientious about responsibilities, often tardy, unwilling to assist with usual work or absent from assigned duties			Conscientious about duties and responsibilities, always prompt, willing to regularly assist and volunteers to help others.		

Comments: _____

Compassion/Empathy

1	2	3	4	5	N/A CJ
Does not recognize or respond to psychosocial aspects of illness, inadequate recognition of patients and families needs for comfort and help, develops inappropriate emotional involvement.			Recognizes and responds to psychosocial aspects of illness, always appreciates patients and families needs for comfort and help, avoids inappropriate emotional involvement.		

Comments: _____

Responsibility/Motivation

1	2	3	4	5	N/A CJ
Does not accept responsibility for own actions and decisions. Does not respond to feedback, argumentative.			Fully accepts responsibility for own actions and decisions. Responds to feedback and works to improve.		

Comments: _____

Teamwork

1	2	3	4	5	N/A CJ
Does not demonstrate ability to work as a part of a team, dismisses other's suggestions and disregards abilities of others. Often rude or obnoxious, hard to work with.			Demonstrates strong ability to work as part of a team, listens attentively to other's suggestions, recognizes abilities of others. Pleasant, personable, easy to work with.		

Comments: _____

Please Complete Other Side

MUSC, Graduate Medical Education Committee
Assessment of Resident Professionalism

Medical Record Documentation

1	2	3	4	5	N/A C/I
Poor, incorrect or illegible documentation of patient care and procedures, delayed or incorrect orders. Often fails to adhere to established policies and protocols.			Concise, complete and legible documentation of patient care and procedures. Timely, correct orders. Follows the established policies and protocols.		

Comments: _____

Interpersonal Communication Skills

1	2	3	4	5	N/A C/I
Does not express self clearly, tends to be harsh or abusive, often impolite and inconsiderate.			Expresses self very well, not abusive or rude, always polite and considerate. Great communicator.		

Comments: _____

Personal Appearance

1	2	3	4	5	N/A C/I
Often fails to follow established dress code. Does not respond to feedback. Presents risk to self and/or others.			Always follows established dress code. Often used as an example for others to emulate.		

Comments: _____

Descriptive Words (Please circle the word or words that best describe this resident):

- | | | | | |
|----------------|---------------|---------------|-------------|---------------|
| Abrasive | Conscientious | Impatient | Organized | Tactless |
| Apathetic | Considerate | Inconsiderate | Obnoxious | Undependable |
| Arrogant | Cooperative | Indifferent | Poised | Understanding |
| Attentive | Dependable | Inept | Resourceful | Unfriendly |
| Capable | Efficient | Intelligent | Rude | Unintelligent |
| Careless | Friendly | Irresponsible | Sarcastic | Unorganized |
| Clear-thinking | Honest | Logical | Sincere | Unscrupulous |
| Cocky | Immature | Mature | Tactful | Wise |

STRENGTHS: _____

SUGGESTIONS FOR IMPROVEMENT: _____

Would you recommend this resident to a member of your family for medical care? Y / N
If No, please explain? _____

PLEASE RETURN THIS FORM TO: _____

**MEDICAL UNIVERSITY OF SOUTH CAROLINA
GRADUATE MEDICAL EDUCATION COMMITTEE
RESIDENT TO RESIDENT ASSESSMENT FORM**

This form is designed to elicit your evaluation of the resident listed below. Please address this evaluation constructively. Your evaluation information will be provided to the residents using a "summary report" format to insure that your comments remain anonymous. Thank you for your time and effort.

Name of Resident being assessed: _____

Name of Resident completing form: _____

Department: _____ Date: _____

I. Basic Clinical Skills:

LOW	AVERAGE	SUPERIOR
Repeatedly makes errors in clinical management/surgical skills. Orders, work-ups often incomplete. Regularly omits important information	Occasionally makes minor errors. Infrequently makes major errors. Sometimes omits important information. Orders and work-ups usually complete.	Rarely makes major or minor errors. Work-ups and orders are extremely thorough and complete. Rarely have to check up on their work.

II. Conflict Resolution Skills:

LOW	AVERAGE	SUPERIOR
Rigid, unable to compromise, argumentative, avoids talking about issues/decisions. Involves others unnecessarily in matters that do not concern them.	Tends to involve chief, confronts individual most of the time. Somewhat flexible, able to discuss issues.	Addresses issues as they arise in a non-combative, relaxed manner. Straightforward and fair. Very good negotiator.

III. Reliability and Dependability:

LOW	AVERAGE	SUPERIOR
Fails to carry out duties and assignments, sometimes lies about completing assignments. Not adhering to standards of care. Conveys a lack of concern.	Completes most of the work -- makes sure it all gets done, but passes a few assignments to others.	Gets work done all of the time. Always willing to assist others and take on additional assignments

Please Complete Other Side

IV. Personal Interaction Skills:

LOW	AVERAGE	SUPERIOR
Generally has difficulty interacting with others, abrupt, not pleasant to work with, abrasive, uncommunicative (hard to discuss matters with team).	Gets along with most people, but has difficulty with some groups (or individuals).	Communicates well with students, residents, staff, faculty and patients (across the board), likeable, friendly and caring.

V. Patient Care/Clinical Judgment:

LOW	AVERAGE	SUPERIOR
Often makes dangerous, poor or "risky" decisions. Makes repeated mistakes even after feedback. Others express no confidence or trust in their decisions or judgement.	Meets most of standards of care most of the time. Occasionally makes "questionable" decisions. Others express trust and confidence in their decisions..	Patient management decisions are consistently high. Meets and often exceeds standards of care. Others express extreme confidence in their decisions. Strong patient advocate.

VI. Attitude and Work Habits:

LOW	AVERAGE	SUPERIOR
Only interested in what they have to do. Rarely offers to help others, not a team player. Often late, fails to return pages, leaves before the work is done. Passes off work to others!	Almost always on time. Does what needs to be done – sometimes goes above and beyond. Helps out others occasionally. Dependable.	Always on time. Always ready for work – not a slacker. Helps out others when not busy. Very hard working. Very dependable.

VII. Descriptive Words (Please circle the word or words that best describe this resident):

- | | | | | |
|----------------|---------------|---------------|-------------|---------------|
| Abrasive | Conscientious | Impatient | Organized | Tactless |
| Apathetic | Considerate | Inconsiderate | Obnoxious | Undependable |
| Arrogant | Cooperative | Indifferent | Poised | Understanding |
| Attentive | Dependable | Inept | Resourceful | Unfriendly |
| Capable | Efficient | Intelligent | Rude | Unintelligent |
| Careless | Friendly | Irresponsible | Sarcastic | Unorganized |
| Clear-thinking | Honest | Logical | Sincere | Unscrupulous |
| Cocky | Immature | Mature | Tactful | Wise |

VIII. General Comments:

FORMAL ACADEMIC REMEDIATION PLAN
Medical University of South Carolina Office of Graduate Medical Education

Resident's Name: _____ **Date:** _____

The following performance deficiencies have been discussed with the resident:
(Check the competencies with less than satisfactory ratings, include supporting data & discussion points.)

Patient Care

Medical Knowledge

Practice-based Learning and Improvement

Interpersonal and Communication Skills

Professionalism

System-based Learning

Plan for Improvement & Evaluation Criteria: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	Timeline for improvement
--	---

Date set for reassessment: _____

Signature of Resident *Date*

Signature of Program Director *Date*

SIX TRAPS IN THE EVALUATION PROCESS **(How to avoid them to be consistent and fair)**

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1. REVIEWING ANOTHER PERSON'S PERFORMANCE FROM AN AUTOBIOGRAPHICAL PERSPECTIVE

This occurs when we compare an individual's performance to how we performed in the same situation, rather than using the established standards or criteria. We tend to accept unsatisfactory performance or make excuses for inappropriate behavior.

Accept the Position, Accept the Responsibility

2. BEING THE TARGET OF "RESPONSIBILITY RICOCHET"

This occurs when a person is able 'turn the tables' and shift the responsibility for his/her actions onto others (e.g., "Why are YOU picking on me?" "Why are YOU giving me this grade/rating?" "I was just...."). When this happens, we tend to "back pedal" and second guess ourselves.

Use 'Instructive Feedback' to Correct Mistakes

3. MAKING JUDGMENTS USING "NON-EDUCATIONAL" FACTORS

This occurs when we fail to stick to the established criteria and/or procedure by using other factors such as effort or likeability (e.g., "she is trying really hard" or "he is a really nice fellow"). We can also get sidetracked by issues related to student loan debt, personal finances, health problems, date or time of occurrence, etc., and fail to address the problem(s). We then use one or more of these non-educational factors to make academic decisions about an individual's performance or progress (or lack of progress) instead of the actual evaluation data that is available.

Stick to the Established Criteria, Avoid Arbitrary Decisions

4. USING ONLY ONE ASSESSMENT INSTRUMENT

This occurs when we rely on one evaluation tool to assess complex clinical skills or one specific incident to identify a serious behavioral problem.

Complex Skills Require Multiple Measurements

5. INTRODUCING THE "HALO" (or "HORNS") BIAS

This occurs when we over-generalize an individual's performance and tend to see everything s/he does in a positive (can do nothing wrong) or negative (can do nothing right) light. This causes us to overlook mistakes (halo) or be unusually harsh (horns).

Focus on the Performance, NOT the Person

6. CREATING ARTIFICIAL BARRIERS OR OBSTACLES

This occurs when we give special treatment to an individual or a group, thereby arbitrarily changing the standards or process. Three examples of contrived obstacles (created by faculty) are "Senioritis," "Jobitis," and NOMRS ("not our/my resident/student"). We tend to give these individuals "breaks" that others did not receive, or we tend to ignore or minimize their mistakes.

Be Fair, Be Firm, Be Positive

TOP TEN Reasons We Avoid Talking to Someone About a Problem

Franklin J. Medio, PhD

1. ***"I don't want to be mean or be the bad guy"*** (No one really does)
How will the person feel about things being said behind his/her back? Approach this conversation as a "teachable moment." You are not doing this to be mean; you are doing it to help the person improve his/her performance. Don't allow yourself to be manipulated into feeling you're doing something wrong.
2. ***"I don't want to upset her"*** (You probably will----be prepared)
It is normal for her to get upset. No one wants to hear about a mistake or deficiency. She will be even more upset if you give her false reassurance and she goes along thinking everything is fine; only to find out later that you knew there was a problem but chose not to discuss it with her.
3. ***"I don't want to make a big deal out of this"*** (Medicine is a big deal!)
Remember our first and foremost responsibility is to patients. Be careful not to overreact but, at the same time, avoid the trap of minimizing the seriousness of a mistake or problem. Stay focused on the immediate problem and clearly state what the person must do to correct it.
4. ***"I don't want to ruin the person's career"*** (They have to "earn" the privilege)
We have a crucial "trust" with the public to maintain our standards and integrity. *The period of medical school and residency education is the time to determine if a person is qualified to earn a medical degree and a license to practice.* We are obligated to address a problem or deficiency in someone's performance. Some students and residents "fail out" of a program in spite of their best efforts and our best efforts.
5. ***"I don't want to end up in court"*** (A legitimate concern)
This is a possibility, but a fairly remote one. Be sure to follow the established procedures and policies that are educationally sound and legally defensible. Seek legal advice to be sure you have addressed any legal matters but do NOT make an educational decision out of fear, intimidation or "threat of a lawsuit."
6. ***"I am not sure how he will react"*** (You probably are)
You just don't know to what degree. If you have any concerns about his welfare, or your safety, you need to address them. Be aware that an under-reaction or over-reaction may signal that other problems exist.
7. ***"I (or others) may have contributed to the problem"*** (It is a possibility)
If this is true, then acknowledge it. Don't compound the current situation by using that as an excuse for not talking with the person. Ironically, past failures to address the mistake or problem often contribute to the current problem. If you or others did not talk to the person in the past, apologize for not doing so but then discuss the immediate mistake or problem that needs to be corrected.
8. ***"I know s/he realizes it was wrong and will not do it again"*** (Unlikely)
Wishing, hoping or thinking the mistake will be corrected or the problem will go away usually does not work. These individuals rarely resolve the mistakes or problems spontaneously. Talking with him or her is more likely to succeed. This will enable you to determine if s/he has an insight to their problem.
9. ***"I think it's too late in the program or in the year..."*** (Not really)
The decision to take action is NOT determined by when the mistake or problem occurs. There is no good time or bad time, right time or wrong time. Address the mistake or problem with the person whenever it occurs. Remember, it's never too late to help another person improve.
10. ***"I don't like confrontation"*** (No one really does)
View the interaction with the person as an opportunity to help. Confront the problem, not the person. Approach this person as you approach a patient when you have to deliver "bad news"---talk with the person in a caring way because you are concerned about him/her, and do it in a compassionate manner.

RESOURCES for EDUCATIONAL CONSULTATION

1. Neuropsychologists

Neuropsychologists should have completed an APA accredited neuropsychology fellowship - many of these persons have a university affiliation.

International Neuropsychological Society www.the-ins.org

National Academy of Neuropsychologists www.nanonline.org

Contact a board or committee member of one or both of the above organizations, let them know what clinical problems/questions you're interested in investigating and ask them for some recommendations of neuropsychologists and their contact information.

Briefly, the methodology is to administer:

- a) test of general intelligence (WAIS-III);
- b) tests that hold up well to general brain dysfunction, that might include a reading achievement test (WRAT-III);
- c) one or more tests across the major cognitive domains Attention/Concentration; Memory/Learning; Speech/Language; Visuospatial-Motor; Conceptualization/Abstract Reasoning; and Executive Function.

In reference to specific referral questions, additional tests can be included in the area of special interest (e.g., executive and visual-spatial-motor). Inferences can then be drawn from the data regarding general intellectual/cognitive status, cognitive strengths and weaknesses, significant deficits and presence of brain pathology. This information can then be applied to real-life problems and situations (ecological validity), making further inferences and recommendations or opinions about performance levels and even suitability for specific functional or occupational roles. Usually, one or more personality tests are included in the battery (e.g., MMPI, Millon Personality Inventory) is also included to address functionality from the standpoint of personality and emotional factors. Such an assessment with a comprehensive narrative report likely will take 8 or more hours at a cost of \$135 - \$200+ per hour. If there was some regularity in the referrals, the psychologist might be agreeable to a discounted hourly fee or a flat fee for the total evaluation.

Tests of Executive Function: Wisconsin Card Sorting Test; Stroop Color and Word Test; Trail Making Test; Tower of London test; Category Test; Delis-Kaplan Executive Function Test and behavioral Assessment of the Dysexecutive System [Comprehensive Batteries of Executive Function].

Tests of Visual-Motor and Visual-Spatial Functions: Purdue Pegboard Test, Grooved Pegboard Test, Finger Tapping Test, Tactual Performance Test; Block Design of WAIS-III; Rey Complex Figure Test.

(Most of these tests are "complex" in that they overlap cognitive functions. For example, interpretation of the Rey or Block design can also address executive functioning.)

2. LIFE Curriculum Project

Kathy Andolsek, MD, MPH

www.lifecurriculum.info

kathryn.andolsek@duke.edu

3. Society for Simulation in Healthcare

www.ssih.org

MEDICAL UNIVERSITY OF SOUTH CAROLINA
Office of Graduate Medical Education

FINAL EVALUATION OF RESIDENT/FELLOW

Name: _____

Residency Program: _____

Period of Training: _____ to _____

This document will certify that the above named individual was evaluated by the residency program faculty during this specified period of training sponsored by the Medical University of South Carolina.

These evaluations document that Dr. _____ has satisfactorily completed the requirements of the ACGME-approved residency program and has demonstrated sufficient professional ability to practice competently and independently in the specialty of _____.

Special Comments or Commendations:

Awards or Honors:

Residency Program Director: _____

Date: _____