

## BRIEF REPORT

# What Does Remediation and Probation Status Mean? A Survey of Emergency Medicine Residency Program Directors

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### Abstract

**Objectives:** Emergency medicine (EM) residency program directors (PDs) nationwide place residents on remediation and probation. However, the Accreditation Council for Graduate Medical Education and the EM PDs have not defined these terms, and individual institutions must set guidelines defining a change in resident status from good standing to remediation or probation. The primary objective of this study was to determine if EM PDs follow a common process to guide actions when residents are placed on remediation and probation.

**Methods:** An anonymous electronic survey was distributed to EM PDs via e-mail using SurveyMonkey to determine the current practice followed after residents are placed on remediation or probation. The survey queried four designations: informal remediation, formal remediation, informal probation, and formal probation. These designations were compared for deficits in the domains of medical knowledge (MK) and non-MK remediation. The survey asked what process for designation exists and what actions are triggered, specifically if documentation is placed in a resident's file, if the graduate medical education (GME) office is notified, if faculty are informed, or if resident privileges are limited. Descriptive data are reported.

**Results:** Eighty-one of 160 PDs responded. An official policy on remediation and/or probation was reported by 41 (50.6%) programs. The status of informal remediation is used by 73 (90.1%), 80 (98.8%) have formal remediation, 40 (49.4%) have informal probation, and 79 (97.5%) have formal probation. There was great variation among PDs in the management and definition of remediation and probation. Between 81 and 86% of programs place an official letter into the resident's file regarding formal remediation and probation. However, only about 50% notify the GME office when a resident is placed on formal remediation. There were no statistical differences between MK and non-MK remediation practices.

**Conclusions:** There is significant variation among EM programs regarding the process of remediation and probation. The definition of these terms and the actions triggered are variable across programs. Based on these findings, suggestions toward a standardized approach for remediation and probation in GME programs are provided.

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Residency programs are responsible for training residents to be competent and safe physicians. Thus, the American Board of Emergency Medicine requires program directors (PDs) to attest to the successful completion of residency training to become

eligible for board certification. Accordingly, the Accreditation Council for Graduate Medical Education (ACGME) mandates the use of core competencies and milestones to standardize resident assessment, allowing for identification and remediation of residents with

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performance problems to ensure that the public receives high-quality medical care. Implicit in the definition of a “problem resident” or a resident with performance problems is a trainee who requires intervention by someone of authority, usually the PD.<sup>1,2</sup> Residents with performance problems fall on a continuum from residents needing a small amount of help, to those who require significant intervention and are at risk for termination.<sup>2</sup> Remediation can be defined as “any form of additional training, supervision, or assistance above that required for a typical resident.”<sup>3</sup> While remediation is defined as the effort spent to improve a resident’s knowledge, skills, or attitudes, remediation can also be considered to define the status of the resident. Resident status falls from good standing, to remediation, to probation, and finally to termination.

Addressing residents with performance problems is daunting. In 2009 the Council of Emergency Medicine Residency Directors (CORD-EM) established a remediation task force to identify best practices and develop resources for EM remediation in graduate medical education (GME).<sup>4</sup> The group first recommended rigorous competency assessment to diagnose deficiencies and develop individualized learning plans with feedback and reflection. Second, they recommended focused reassessment and certification of competence. Once problem residents are identified, there are numerous remediation pathways, including frequent meetings, direct observation, simulation, and mock oral board case practice. While it is common for PDs to place residents on remediation or probation, the exact definitions and ramifications of these actions have not been put forth or standardized in EM either by the Residency Review Committee (RRC) or by the ACGME.<sup>5</sup> Likewise, Katz and colleagues<sup>4</sup> identified several challenges with remediation including difficulty with adherence to multiple policies from the residency program and the institution.

Despite the 2010 task force recommendations to clearly document remediation efforts and resident progress, uncertainty remains about managing the resident with performance problems.<sup>4</sup> We hypothesized that EM programs differ in their remediation practices. Therefore, the primary objective of this study is to determine if EM PDs follow a common process to guide actions when residents are placed on remediation and/or probation. Out of this process recommend uniform definitions

and a management strategy to guide PDs while managing residents on remediation and probation.

**METHODS**

**Study Design and Population**

An anonymous electronic survey was distributed to EM PDs via e-mail using SurveyMonkey. Reminder e-mails were sent to nonresponders. The survey was sent directly to PDs. This study was reviewed by the institutional review board and determined to be exempt. Consent was implied by completion of the survey.

**Survey Content and Administration**

**Survey Development.** To provide content validity evidence, four PDs with more than 25 combined years of experience collaborated to construct the survey. The authors are integrally involved in, and provide content expertise in, the area of remediation practices given their roles on the CORD Task Force on Remediation and long-term experience as PDs and medical education leaders. Further, survey questions were formulated through a joint effort with members of the task force. For response process validity, questions were then field tested on the assistant or associate PDs from the authors’ programs, and feedback was gathered about the questions and they were revised (Data Supplement S1, available as supporting information in the online version of this paper). The instrument collected demographics and then asked respondents to indicate the actions that define four designations: informal remediation, formal remediation, informal probation, and formal probation (Table 1). These designations were categorized for both medical knowledge (MK)-based and non-MK-based deficiencies.

**Data Analysis**

Outcomes were descriptive, reporting the rates for each designation. Comparisons of actions for MK and non-MK deficiencies were compared using Fisher’s exact test using GraphPad InStat.

**RESULTS**

Eighty-one programs (51%) responded. The majority (72%) were 3-year programs. Only half (50.6%) reported

Table 1  
Actions for Remediation and Probation Status Designations

Action to be Taken	Informal Remediation		Formal Remediation		Informal Probation		Formal Probation	
	MK	Non-MK	MK	Non-MK	MK	Non-MK	MK	Non-MK
Letter into official file	13.7	20.3	86.3	81.6	20.0	20.0	83.5	86.8
Letter into nonofficial file	56.2	53.6	18.8	19.7	45.0	42.5	8.9	10.5
Notify GME office	4.1	4.3	53.8	56.6	22.5	30.0	83.5	80.3
Inform faculty	37.5	29.0	68.8	65.8	42.5	40.0	70.9	69.7
Limit clinical privileges	6.8	10.1	26.3	23.7	22.5	20.0	55.7	51.3

The difference between MK and non-MK actions are not significant (p > 0.05).  
All values reported as percentages.  
GME = graduate medical education; MK = medical knowledge.

having official institution-wide policies dictating remediation or probation. Additionally, nearly all programs (90.1%) have a designation of informal remediation; 98.8% have formal remediation, 49.4% have informal probation, and 97.5% have formal probation. The results are summarized in Table 1. The findings reveal that there was great variation among PDs in the management and definition of remediation and probation. The majority of programs place an official letter into the resident's file and notify the GME office regarding formal remediation and probation; however, up to 15% of PDs neither place official documentation into the file, nor notify the GME office with formal probation. Additionally, only about 50% notify the GME office when a resident is placed on formal remediation. There was no significant difference ( $p > 0.05$ ) between MK remediation and non-MK remediation for any of the variables.

## DISCUSSION

Although there is general acceptance that remediation involves extra attention needed for residents with performance problems, the specific administrative action that follows once a resident is on remediation or on probation is ill-defined. Although most programs recognize formal remediation as a status, there is still much practice variation regarding documentation in the residents' file and notification of the GME office. There is further variability once a resident is placed on probation. In the end it is the responsibility of the clinical faculty, not solely the PD, to address resident deficiencies and provide greater supervision. Our survey demonstrated that once formal probation status was initiated, about 70% of programs informed the faculty. This is greater than in general surgery, where only 50% of PDs informed attending staff about resident probation.<sup>6</sup> There is a need for a uniform approach to define the categories and the process by which each is handled.

The lack of a uniform approach to the problem resident might be multifactorial. First, the very term "remediation" carries a negative connotation with heavy repercussions, including reporting the remediation period to prospective employers and licensing boards. Thus, there is widespread use of informal remediation. At times documentation of this status occurs in a nonofficial file (sometimes called a "shadow file"). This may later become problematic if substandard performance continues and there is a lack of documentation. Lack of documentation is also found in other specialties. In one family practice residency there was rarely documentation in committee minutes or PD memos.<sup>7</sup>

A second reason for lack of a uniform approach may be due to the fact that each resident with performance problems are unique. Residents often have problems in more than one domain, such as patient care and professionalism, which requires a combined remediation plan to effectively address crossover.<sup>8</sup> Additionally, the threshold for placing a resident on remediation is not clear and likely varies by program.

Finally, residents who have been on probation carry a red flag for future employers and licensing boards. Probation is generally not bestowed lightly, and usually occurs after egregious behavior or failed remediation.

Thus the threshold for different PDs may vary. To that end, Yao and Wright<sup>1,9</sup> recommended probation be "reserved for disciplinary action taken for clearly unacceptable behavior such as confirmed substance abuse, falsifying information, or unethical behaviors."

The ACGME Common and EM Program Requirements provide little clarity regarding remediation.<sup>5</sup> They do require a summative evaluation to verify that the resident has demonstrated sufficient competence to enter practice without direct supervision. In addition, "A plan to remedy deficiencies must be in writing and on file. Progress and improvement must be monitored at a minimum of every three months if a resident has been identified as needing a remediation plan."<sup>5</sup>

Creation of a standardized practice of when and how to execute remediation and probation would guide PDs in the assessment of the academic and clinical performance of trainees. It would also assist future employers in their understanding of a resident's training that included a remediation period. Thus, successfully completing a remediation period need not hold a negative connotation. Rather, it would reassure an employer that an identified deficiency was corrected and brought up to an acceptable standard. A standardized process would provide a clear definition and process of management of performance problems. This would provide clarity for the resident, the program, the GME office, and other stakeholders.

We argue that remediation definitions and processes should be similar across EM and recommend three standards. First, remediation should be considered the additional training, supervision, or assistance above that required for a typical resident. The majority of this effort should be performed through informal remediation where the resident is placed on warning. However, internal documentation for resident and program reference is maintained. This might be done through the clinical competency committee, or one PD recommended a "commendation and concerns" file. The goal is to maintain informal documentation in the case that the resident fails to improve performance. Some PDs may choose to remove the documentation from residents' file after graduation.

Second, if a resident fails to progress, he or she should be placed on formal remediation. This includes clear documentation addressing the problem areas as well as a specific corrective plan for remediation, with a timeline and any additional training expectations. Formal remediation should include documentation of the problem, remediation plan, and expected outcomes, so there is clarity for the resident, the clinical competency committee, and the program leadership. The purpose of documentation is in the case the resident fails to improve and there is need for documentation of the problems, plan, and efforts made. PDs should place a written letter of documentation that the PD and resident sign into the resident's file. Whether the GME office is involved should be based on the strategy of that GME office.

Finally, if a resident is on probation, it is the duty of the PD to notify the GME office and formally document the extra time, effort, and resources used to correct the identified deficiencies. Probation is an official institu-

tional status that is documented by both the program and the GME office. Like formal remediation, there must be clear documentation, a corrective plan, and a timeline. Status of probation should be included in the final verification of training and communicated on requested letters of reference for the resident. With egregious performance, a resident might go immediately to probation. Further, if probation is not successful, the resident may need to be terminated. In this case careful documentation is key, as well as engagement of the GME office and possibly the human resources office. A lack of documentation early in remediation may delay the process.

This standardized approach would be helpful to residents, faculty, PDs, and competency committees, as well as future employers. Further, the findings of this study are likely generalizable to other specialties so the recommendations might be applicable to other programs. Finally, next steps might be to gain further support for this proposed standardization through CORD or the RRC.

### **LIMITATIONS**

Limitations of the study include the problematic definition of remediation and probation. It is difficult to attain clear content validity if the words mean different things to different respondents. There may be some response bias, as our response rate was only 50%. It is uncertain what effect this would have on the results. There may have been some response process validity, as the responses included multiple options for the reasons for types of remediation and basis for remediation.

### **CONCLUSIONS**

We found significant variation among emergency medicine residency programs' definitions of remediation and probation. Based on the results, we make recommendations for a standardized definition that would benefit trainees, educators, and future employers.

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### **Supporting Information**

The following supporting information is available in the online version of this paper:

**Data Supplement S1.** Survey.