# The Likeable Malperforming Fellow: Corrective Prescriptions

Lynn Kohan M.D.
Associate Professor Anesthesiology and Pain Management
University of Virginia
Twitter @kohanlynn

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## How common is it?

- Most PD's report encountering struggling learners
- 5-15% prevalence
- Why do learners struggle?

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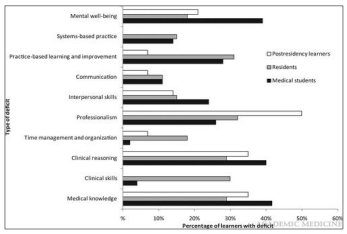
## Why do learners struggle?




Percentage of 151 learners with each type of deficit by level of training, University of Colorado School of Medicine remediation program, 2006–2012. Although trends emerged among the learners, the only statistically significant finding was that mental well-being difficulties were more common in medical students (P = .03). Most learners had more than 1 of the 10 deficiencies studied.

Guerrasio, Jeannette; Garrity, Maureen J.; Aagaard, Eva M.. Academic Medicine89(2):352-358, February 2014. doi: 10.1097/ACM.0000000000000122



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## What do I do about it?

**Often hard to address**

- More demanding
  - Intellectually and emotionally
  - More time
- Conflict adverse
- Effective strategies may not exist
- Impact on program reputation

**Why we need to do something**

- Self-monitor profession
- Impact on quality of care and safety
- Deficiencies will persist if not addressed
- Obligation to all learners

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## Different Models

**Remediation**

- Pre-disciplinary process involving GME office
- Stigma
- Connotes disciplinary action


**Coaching**

- Individualized mentorship and guidance from trained prof
- NOT involved in accessing the fellow
- Identify trainee early
  - Helps trainee
  - Avoids disciplinary process

AMA

Coaching in Medical Education

Warburton CIASN 2018

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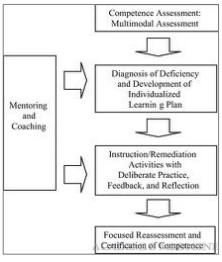
## Remediation Models

Proposed model of a program for remediation of performance deficits of medical trainees and practicing physicians.




Hauer K. Academic Medicine 2009.

Twelve tips for developing and maintaining a remediation program in medical education



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## Coaching


A one to one conversation between an advisor and a learner based on observation, provides feedback, and leads to actionable suggestions for improvement

https://www.trainingjournal.com/articles/features/coaching-model-library-introduction

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## Coaching—Formal Process

**Referral**
- Self referral
  - Confidential
  - Nothing in the file
- Program Director
  - Faculty concerns

**Plan**
- Individualized coaching plan
- SMART Goals 3-5 goals

- Coaching: where
  - Office with expert
  - Clinic or inpt setting
  - Simulation
- Coaching: who?
  - Expert
  - Peers
  - attending

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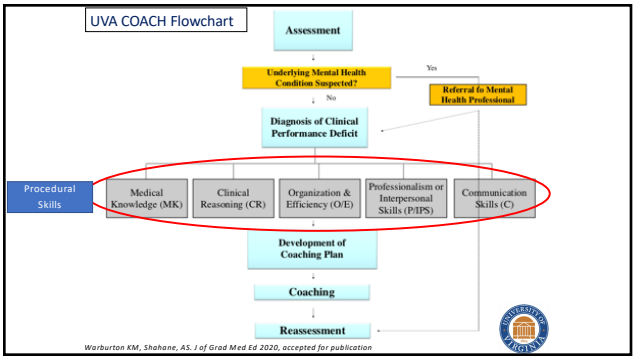


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## Assessment

- Review of written file (both UME and GME)
  - Pre-clinical performance
  - Rotation evals
  - Clinical evals
  - Standardized test scores
  - PD LOR from residency
  - Direct Observation
  - Direct communication with evaluators


- Interview

https://www.ama-assn.org/system/files/2019-09/coaching-medical-education-faculty-handbook.pdf

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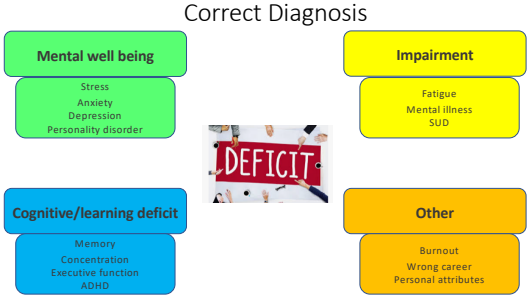
## Correct Diagnosis

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## Correct Diagnosis

- Medical knowledge
- Clinical reasoning
- Organization and efficiency
- *Professionalism/Interpersonal Skills*
- Communication skills
- Procedural skills

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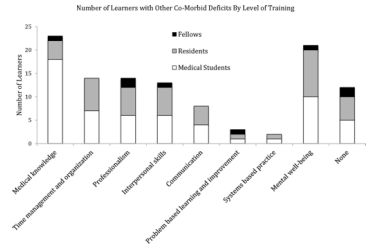


Figure 1. Comorbid deficits based on level of learner. Most learners had more than one deficit, based on the semi-structured interview, direct observation and academic records. Twelve of the 53 learners presented with only a clinical reasoning deficit.

Guerrasio J, et al. J Gen Int Med 2014

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## Correct diagnosis

- Medical knowledge vs clinical reasoning


https://www.facebook.com/pages/category/Doctor/Medical-Knowledge-185372151798677/

- Direct observation
- A thorough assessment made by those with expertise in remediation

- Common feedback:
  - " needs to read more"
  - "needs to be more efficient"


https://theposturework.com/5-common-fail-interventions-clinical-reasoning-to-select-wheelchair-seating-interventions/

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## Medical knowledge

- Direct observation
- Talk to evaluators
- Review of standardized tests

https://www.jobskin.co.uk/extending-our-medical-knowledge

- Interview
  - Ask about study habits
    - Are they not studying enough or do they study ineffectively
  - Test performance consistent with clinical skills
  - h/o learning disorder
  - Mental well-being

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## Assessment is Key

- Needs to be more than "read more"


https://medhacker.com/2011/07/16/virtual-patient-tests-before-a-real-patient-experience/

- Create an objective
  - Next ITE

- Symptom based rather than disease based
- Questions with review of incorrect answers

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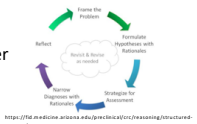
## Clinical Reasoning

- Different and actually more common than medical knowledge

- Bogged down in details and misses big picture
- Difficulty presenting in concise and clear manner
- Can not develop a prioritized ddx
- Difficulty recognizing urgent vs non urgent




https://fid.medicine.arizona.edu/preclinical/crc/reasoning/structured-approach

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## Targeted assessment of CR

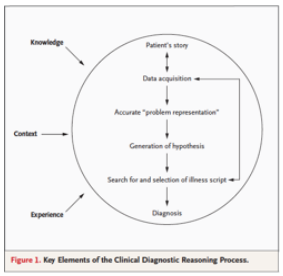


Figure 1. Key Elements of the Clinical Diagnostic Reasoning Process.

Bowen NEJM 2006

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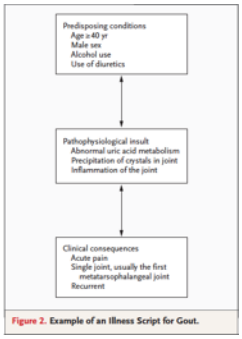


Figure 2. Example of an Illness Script for Gout.

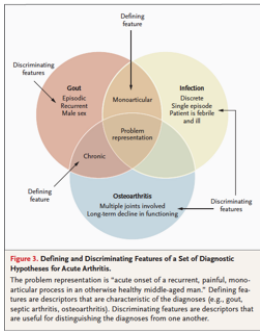


Figure 3. Defining and Discriminating Features of a Set of Diagnostic Hypotheses for Acute Arthritis.

The problem representation is "acute onset of a recurrent, painful, monoarticular process in an otherwise healthy middle-aged man." Defining features are descriptors that are characteristic of the diagnoses (e.g., gout, septic arthritis, osteoarthritis). Discriminating features are descriptors that are useful for distinguishing the diagnoses from one another.

Bowen NEJM 2006

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## Clinical skills

- Can use direct (or indirect) observation
  - History examination
  - Physical examination
    - Ask about relevance of information found from examination findings
    - Procedural skills
  - Hawthorne effect
    - People act different when they know they are being observed
      - Observe "behind the curtain"
- Simulation

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## Procedural Skills

- Observation
- Modeling
- Simulation
- Augmented Reality
- Virtual Reality

*No matter how well trained people are, few can sustain their best performance on their own. That's where coaching comes in*

https://www.newyorker.com/magazine/2011/10/03/personal-best

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## Time Management and Organization

- Time Management
  - Frequently late
  - Missed assignments
  - May arrive first and stay latest
  - Always behind in clinic
- Organization
  - Notes and presentations disorganized
  - Cannot present patients in rational manner
  - Not prepared

https://realiflow.com/wp/get-1-on-1-support

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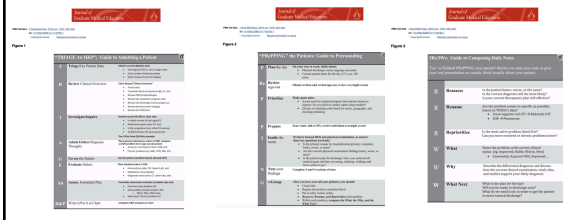
## Time Management and Organization Tools



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## Communication

- Personality
  - Shy, reserved
  - Struggle with patient interviews
- Non-verbal skills
  - Compassion, empathy


https://bohatala.com/human-communication-skills-research-report-analysis/

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**Table 4.** Coaching micro skills and results in context of good supervisor communication promoting resident reflection and self-assessment

| Skill | Result |
|---|---|
| Providing feedback or *active listening* | Encouraged residents to describe their perspectives about their data. The tone of the conversation and direction of the questions towards an action plan were central to resident acceptance |
| Using *open-ended questions* | Encouraged resident reflection on their experiences and realistic consideration of their external performance data in light of performance standards |
| Using *clarifying questions* | Promoted self-assessment that was grounded in external data thereby increasing the accuracy[31] |

Arnison, H., Lockyer, J.M., Zetkulic, M., Könings, K.D. and Sargeant, J. (2019), Identifying coaching skills to improve feedback use in postgraduate medical education. Med Educ, 53: 477-493. doi:10.1111/medu.13878

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## Time Involved

Learner Deficits and Academic Outcomes of Medical Students, Residents, Fellows, and Attending Physicians Referred for Remediation

Guerrasio, Jeannette; Garrity, Maureen J.; Aagaard, Eva M.

Academic Medicine89(2):352-358, February 2014.

doi: 10.1097/ACM.0000000000000122

| Type of learner deficit | Hours of faculty face time | | | |
|---|---|---|---|---|
| | Mean | Interquartile range | 5%–95% range | *P* value* |
| Medical knowledge | 10 | 2–30 | 1–70 | .89 |
| Clinical skills | 3 | 2–4 | 1–4 | .33 |
| Clinical reasoning | 20 | 5–38 | 2–74 | <.001 |
| Time management and organization | 16 | 2–24 | 1–50 | .09 |
| Professionalism | 10 | 5–28 | 2–60 | .17 |
| Interpersonal skills | 17 | 6–30 | 2–60 | .47 |
| Communication | 19 | 5–39 | 2–76 | .23 |
| Practice-based learning and improvement | 2 | 1–3 | 2–3 | .28 |
| Systems-based practice | 12 | 5–24 | 5–24 | .75 |
| Mental well-being | 9 | 5–20 | 1–38 | .03 |

†Reported time does not include time for planning, assessment, or preparation. Data collected from faculty assigned remediation tasks for 151 learners (medical students, residents, fellows, and attendings).
*Comparison of learners with to learners without the deficit. Italics denote statistical significance.

ACADEMIC MEDICINE

Faculty Face Time Required for Remediation by Type of Learner Deficit, University of Colorado School of Medicine, 2006–2012*

Wolters Kluwer



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## Results

Learner Deficits and Academic Outcomes of Medical Students, Residents, Fellows, and Attending Physicians Referred for Remediation

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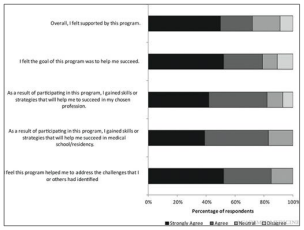


Postremediation program survey responses, University of Colorado School of Medicine, 2006–2012. The majority of the 120 learners who responded to the survey agreed or strongly agreed that the program had been beneficial to them. None of the learners strongly disagreed with any of the items.

Wolters Kluwer



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## Results

Learner Deficits and Academic Outcomes of Medical Students, Residents, Fellows, and Attending Physicians Referred for Remediation

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Academic Medicine89(2):352-358, February 2014.

doi: 10.1097/ACM.0000000000000122

| Learner level | Outcome, no. (%) of learners | | | | | |
|---|---|---|---|---|---|---|
| | Graduated | Were in good standing or on unrestricted practice | Transferred and graduated | Remained on probation or restricted practice | Transferred but did not graduate | Withdrew |
| Medical students (n = 72) | 37 (51) | 29 (40) | 0 (0) | 4 (6) | 0 (0) | 2 (3) |
| Residents (n = 65) | 31 (48) | 20 (31) | 8 (12) | 2 (3) | 1 (2) | 3 (5) |
| Postresidency learners (n = 14)† | 2 (14) | 7 (50) | 2 (14) | 2 (14) | 0 (0) | 1 (7) |

*Of the 151 learners referred to the program during the study period, 136 (90%) had what the authors considered to be successful academic outcomes: graduated from their training programs, were in good academic standing, transferred to another program and graduated, or were practicing without restrictions. No learners were dismissed.
†Postresidency learners include fellows and attending physicians.

ACADEMIC MEDICINE

Academic Outcomes as of October 2012 of Learners Referred to the University of Colorado School of Medicine Remediation Program by Level of Learner, 2006–2012*

Wolters Kluwer



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The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

## Outcomes of a Coaching-Based WHO Safe Childbirth Checklist Program in India

Katherine E.A. Semrau, Ph.D., M.P.H., Lisa R. Hirschhorn, M.D., M.P.H., Megan Marx Delaney, R.N., M.S.N., M.P.H., Vinay P. Singh, P.G.D.G.B.M., B.Tech., et al., for the BetterBirth Trial Group*

Better adherence to checklist after coaching program.

No change in morbidity and mortality.

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medical education in review

**What do we know about coaching in medical education? A literature review**

Ben Lovell

**3 categories for coaching**
well-being and resilience
improved non-technical skills
improved technical skills

**Weak to moderate evidence**
well-being and non-technical skills
**Strong evidence**
technical skills

Lovell, B. (2018), What do we know about coaching in medical education? A literature review. Med Educ, 52: 376-390. doi:10.1111/medu.13482

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Review > Surgery. 2015 Nov;158(5):1168-91. doi: 10.1016/j.surg.2015.03.007. Epub 2015 May 5.

**Systematic review of coaching to enhance surgeons' operative performance**

Hyeyoun Min [1], Dianali Rivera Morales [2], Dennis Orgill [3], Douglas S Smink [4], Steven Yule [5]

Affiliations + expand

PMID: 25956742 DOI: 10.1016/j.surg.2015.03.007

Surgical coaching interventions have positive impact on learners' perception, attitude, technical and non technical skills, and performance measures.

**Quality of Evidence**
Perception: GRADE very low
Attitude and opinion: GRADE very low
Technical Skills GRADE high RCT, Very low Observational studies
Nontechnical skills: GRADE very low
Performance measures: GRADE very low

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## Summary

- Identify deficits
- Diagnose
- Coach
  - Deliberate feedback
  - Self-reflection
- Co-manage with the learner
- Help them to better achieve self-assessment

- Has the learner caught up to his/her training level
- Is the improvement sustainable

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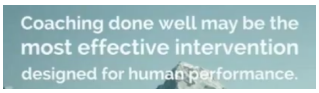


Atul Gwande M.D.

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## Extra Resources

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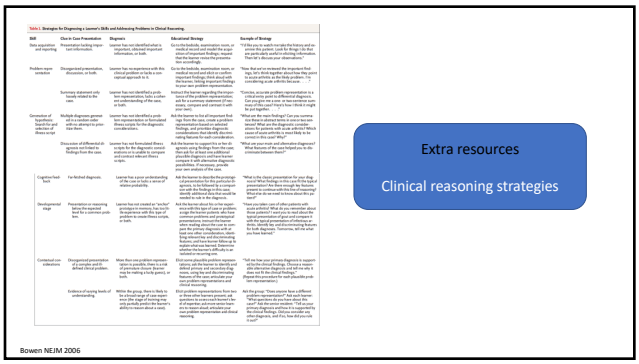

Extra resources

Clinical reasoning strategies

Bowen NEJM 2006

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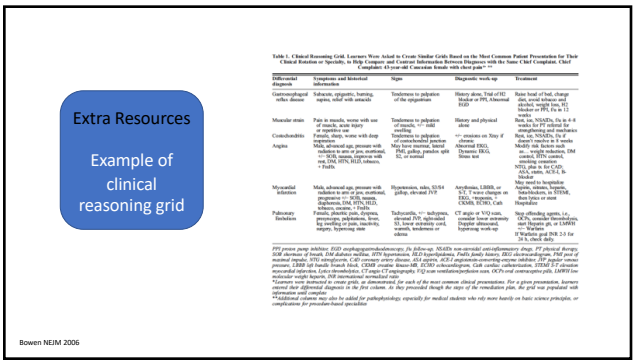

Extra Resources

Example of clinical reasoning grid

Bowen NEJM 2006

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## Interpersonal skills

- Desire to become better (different from professionalism)
- Trouble reading social cues
- Transfer blame
- Conflict with others in different roles

https://www.medicaloffcengr.com/communication-skills/

## Professionalism

- Lack of respect
- Questionable ethics, honesty, reliability

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## Tools

Table 1

Resolving Disagreements: Model and Skills

| Models and skills |
|---|
| 1. Elicit the other person's perspective |
| a. Identify belief model |
| b. Identify emotions |
| c. Identify behavioral expectations |
| 2. Acknowledge the other person's perspective |
| a. Active listening |
| b. Empathy skills |
| 3. Present your own perspective: beliefs and expectations |
| 4. Identify common goals |
| a. First, identify the situation you both are trying to achieve |
| b. Then, negotiate the method(s) for achieving that state |
| 5. Set Boundaries |
| a. State boundaries in professional terms (practice guidelines, policies, external constraints), rather than personal terms (blaming) |
| b. State what is *inside* rather than *outside* your boundaries |

Egener B. Addressing physicians' impaired communication skills. *J Gen Intern Med*. 2008;23(11):1890-1895. doi:10.1007/s11606-008-0778-7

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