Remediation Methods for Milestones Related to Interpersonal and Communication Skills and Professionalism

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A program director receives the following complaint from 2 members of the faculty: a postgraduate year (PGY) 3 resident seems argumentative during patient handoffs and is neither receptive to discussions about patient care concerns nor to feedback about their interactions. Under these circumstances, how should the program director approach this problem, which reflects deficiencies in interpersonal and communication skills (ICS) and professionalism competencies? What remediation strategies should be considered and can the milestones guide the remediation? Are there any best practice recommendations that can serve as a template across specialties for professionalism and ICS that program directors can use for their residents?

As part of the new accreditation system, the Accreditation Council for Graduate Medical Education developed the Milestone Project, which includes specialty-specific subcompetencies and milestones under each of the 6 competencies.[1–3] The milestones allow programs to determine the progression of each resident's knowledge, skills, and attitudes during the course of training.[4] With the understanding that subcompetencies and milestones for competencies, such as patient care and medical knowledge, might vary significantly among specialties, we posed the question as to whether or not those for ICS and professionalism share common content themes. If unifying standards for the house of medicine for these competencies did exist, it should follow that suggested approaches to remediation could be applicable across specialties.

It is the authors' hope that the best practice recommendations to follow will allow a program director to expand his or her toolbox for remediation of these competencies, while also developing a broader understanding of approaches to successful remediation. In addition, a remediation approach using targeted strategies mapped to subcompetency proficiency levels is presented for the authors' specialty of emergency medicine (provided as online supplemental material).

The Problem

Despite the importance of professionalism and ICS to the training of future physicians, residency programs often struggle with educating residents in these areas, as well as providing effective remediation for those who fail to meet expectations.[5–7] In a survey, pediatrics program directors reported that residents terminated after failed remediation were significantly more likely to have deficiencies in ICS and professionalism,[8] while neurology program directors noted that the most prevalent issue for "problem neurology residents" was professionalism, as demonstrated by inappropriate interactions with colleagues and staff.[9] Among program directors in emergency medicine, 80% noted that deficiencies in professionalism were harder to remediate than deficiencies in other core competencies.[10] Clinical skills examination scores for Canadian medical students showed a predictive relationship between students who scored poorly on communication and future complaints in their medical practice, with students in the bottom quartile accounting for a significantly higher percentage of patient complaints.[11]

Program directors face multiple challenges in striving to effect successful remediation of residents failing to meet milestone achievements.[12] While some specialties (such as emergency medicine, radiology, pathology, and ophthalmology)[1,3] list suggested assessment methods for the competencies, many provide no guidance to program directors with

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Editor's Note: The online version of this article contains vignettes in emergency medicine, family medicine, obstetrics and gynecology, and psychiatry, as well as remediation approaches by proficiency level for Emergency Medicine Interpersonal and Communication Skills and Professionalism Milestones.

BOX 1 Professionalism Milestone Themes With Suggested Remediation Strategies

Professional Values and Conduct (Maintains honesty, integrity, ethical behavior, respect, empathy, and trustworthiness)

- Pick a mentor role model of professionalism to shadow and/or meet with periodically.[13]
- Solicit specific feedback from faculty that addresses areas of professionalism through evaluations.
- Read specific journal articles regarding professionalism; facilitate mentored small group discussion and reflection.[14]
- Review dangers of social media, discuss infractions, and develop a plan for removal of certain online material.[15]
- Participate in wellness education, including development and presentation of content during a didactic session.[16,17]
- Review current policies of department, institution, or state and develop a plan for an impaired physician.
- Review policies or literature for disclosing errors and help develop an educational session for residents.[18]

Accountability (Upholds commitment to patients and society through timeliness, pursuit of professional development, and practice with a sense of duty)

- Review with program leadership monthly adherence to requirements (eg, reporting duty hours, procedure log, assignments).[19]
- Meet with program leadership to discuss professional appearance, punctuality, and wellness techniques; identify barriers to success.[20]

Responsiveness to Unique Characteristics and Needs of Patients (Embraces cultural competency, humanism, and compassion)

- Meet with a set number of patients and summarize reflections of the experience with regards to patients' perspectives, and the physician role in the patient experience as part of a "patient advocate shift."
- Shadow a social worker or patient representative to learn how to advocate for patients and gain patient perspectives; write a reflection.
- Participate in written/simulated case scenarios with emphasis on the impact of physician's beliefs on patient care and experience.[21]
- Perform a self-reflection analysis regarding perceived difficult patients; develop a plan to care for these patients in an unbiased manner.[21]

Self-Awareness and Betterment (Utilizes knowledge of one's strengths and limitations; practices reflection; and is open to receive feedback)

- Perform a monthly self-assessment of professionalism with examples of cases handled effectively and those in need of improvement.[22]
- Participate in patient case scenarios (standardized patients, simulation, or oral cases); debrief performance using a checklist and develop a performance improvement plan. Follow up with role modeling or self-remediated example.[21,23]
- Obtain and discuss frequent multisource feedback (faculty, nursing, peer, self).[24]

Adaptability (Accepts ambiguity and utilizes resources when dealing with uncertainty)

- Participate in patient case scenarios (standardized patient, simulation, or oral cases) with an emphasis on shared decision making.[25]
- Review graduated level of responsibility policies and discuss when to request assistance from senior residents or attending physicians.
- Review literature on medical uncertainty and help develop an educational session for residents.[26]
- Document a complex patient case log with analysis on care issues.

regard to how to assess trainees in their progression on milestone achievements, and there are few specific recommendations for remediation when residents fail to meet expectations. While the Milestone Project provides programs with concrete achievements that residents must meet for each core competency and may aid programs in identifying residents who are not meeting expectations,[1–4,27–29] the transition from identification to remediation requires knowledge of available resources and expertise in remediation and evaluating outcomes of remediation.[30–34]

A Remediation Task Force Was Born

A remediation task force was developed for the Council of Residency Directors in Emergency Medicine (CORD-EM) and was charged with developing

BOX 2 Interpersonal and Communication Milestone Themes With Suggested Remediation Strategies

Patient-Centered Communication With Patients and Families (Gathers information; collaborates with patients; negotiates complex situations; manages and resolves conflict; counsels and educates patients, including disclosure of errors; demonstrates empathy; maintains sensitivity to cultural and socioeconomic differences; and builds therapeutic patient-physician relationships that foster trust)

- Read material such as "Martin's Mind Map"; reflect on areas to incorporate into future patient encounters.[35]
- Complete patient evaluations, and reflect on strengths and areas for improvement.[36]
- Utilize a faculty mentor for scheduled meetings or shadowing to discuss patient interactions.
- Participate in simulated patient encounters to evaluate general communication skills via checklist and debrief after the interaction.[37]
- Participate in meetings with patient relations with focus on patient complaints related to communication and preventive strategies.
- Attend conflict resolution and communication courses, reflect on current practice, and develop a performance improvement plan.
- Participate in employee assistance programs and/or emotional intelligence testing.[38]
- Review literature to develop an educational session on aspects of communication, such as breaking bad news, disclosing errors, shared decision making, and against medical advice discharges.[39–42]
- Participate in simulated scenarios for breaking bad news, disclosing errors, and patient refusal/against medical advice with evaluation and debriefing.[39–42]

Health Care Team Communication (Demonstrates respect; effectively transitions care and relays information; exhibits responsiveness; and negotiates and resolves conflict)

- Utilize a faculty mentor for scheduled meetings or shadowing to discuss interactions with colleagues and staff.
- Work in other roles on the health care team (eg, nurse, social worker, physical therapist, pharmacist) to gain perspective on their roles.
- Receive feedback through standardized videotaped or simulation scenarios, direct observation, and 360° evaluations to identify specific areas of communication that need improvement.[43–46]
- Use a reflection exercise about perceived strengths and weaknesses with team communication to then comment on stressors that lead to conflict.
- Participate in an observed checklist of transition-of-care experience, both as an observer to offer feedback and a learner to receive feedback.[47]

Health Care Team Leadership (Understands and respects all members of the team; promotes collaboration; and directs teams while promoting safe patient care)

- Participate in a leadership training course or Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) training course.[48,49]
- Participate in mentored reading program (suggested books include *How to Win Friends and Influence People* or *Crucial Conversations*).[50,51]
- Evaluate teamwork climate using metrics such as the Care Process Self-Evaluation Tool; identify areas for improvement.[52]
- Present a didactic session regarding conflict resolution strategies, including vignettes as didactics.

Documentation in the Health Record (Demonstrates the ability to provide timely and accurate information in a concise format; practices within the boundaries of record-sharing polices)

- Perform monthly self-assessment of documentation and identify those needing improvement.
- Review the literature on acceptable documentation practices and develop and present a didactic.
- Participate in peer-review documentation audits.

activities and tools to assist programs with remediation of residents regarding each proficiency level specific to each subcompetency. Our group focused on professionalism and ICS; each member completed an independent literature review regarding methods to remediate professionalism and ICS, and collated relevant literature from all medical specialties. Participants suggested specific methods to address remediation based on (1) a literature review, and (2) previous experience with remediation in professionalism and ICS. When approaching proficiency levels within professionalism and ICS, the group agreed to focus the assessment on levels 1 through 4, as level 5 represented aspirational achievements that may not

be achieved during training, and thus did not require remediation. Consensus was obtained on specific methods to address substandard performance for proficiency levels 1 through 4 in each of the emergency medicine subcompetencies (references were used where available and are provided as online supplemental material).

Core Programs' Common Themes Identified for ICS and Professionalism

As the task force work was completed, it became clear that our approach could be easily translated across graduate medical education programs. We then reviewed the subcompetencies for professionalism and ICS for the specialties of anesthesiology, diagnostic radiology, emergency medicine, family medicine, internal medicine, pathology, pediatrics, psychiatry, obstetrics and gynecology, ophthalmology, orthopaedic surgery, and surgery.[1–3] While the specialties differed in the number of subcompetencies devoted to professionalism and ICS, certain fundamental themes were shared.

The task force utilized our previous approach to develop recommendations for these *shared* themes (BOXES 1 and 2). These suggested methods are intended for use as a guide, with the understanding that each remediation plan needs to be individualized for the specific specialty, appropriate for the remediation lapse, and tailored for the trainee. Residency training programs may map the themes and suggested remediation technique to their specialty-specific milestone proficiency levels.

In the following section, we continue the vignette with an example of how a program director might utilize this work to identify substandard performance, develop and implement a remediation plan, and assess the effect. Additional vignettes in emergency medicine, family medicine, obstetrics and gynecology, and psychiatry are available as online supplemental material.

Implementation

Now reconsider the following: a program director receives a complaint from 2 faculty members that a PGY-3 resident seems argumentative during handoffs and not receptive to discussion about faculty concerns. The program director then maps this issue to the specialty-specific milestone subcompetency ICS-2 (communication with other professionals), proficiency level 2: "effectively communicates relevant patient issues during transitions or transfers of care" and to subcompetency Prof-4 (receiving and giving feedback), proficiency level 2: "accepts feedback from faculty members and incorporates suggestions into practice."

For remediation, the program director chooses the following methods for ICS: (1) participate in an observed checklist of transition-of-care experience, both as an observer to offer feedback and as a learner to receive feedback, and (2) use a reflection exercise about perceived strengths and weaknesses with team communication to then comment on stressors that lead to conflict. For professionalism, the program director uses (1) a monthly self-assessment of professionalism with examples of cases handled effectively and those needing improvement, as well as (2) frequent multisource feedback (faculty, nursing, peer, self).

For monitoring, the program director alerts faculty members that their feedback will be solicited monthly for 2 to 3 months or until feedback is universally positive.

Next Steps

With the specific remediation activities and monitoring methods described, residency and fellowship programs can use our recommendations as a guide to remediate residents in professionalism and ICS. It is our hope that targeted remediation strategies will be developed for milestones under the remaining core subcompetencies. Collaboration within the graduate medical education community to develop both assessment tools and remediation strategies for the milestone subcompetencies should be the standard.

References

1. Accreditation Council for Graduate Medical Education. Program and institutional accreditation: hospital-based specialties. https://www.acgme.org/acgmeweb/tabid/367/ProgramandInstitutionalAccreditation/Hospital-BasedSpecialties.aspx. Accessed September 21, 2015.
2. Accreditation Council for Graduate Medical Education. Program and institutional accreditation: medical specialties. https://www.acgme.org/acgmeweb/tabid/368/ProgramandInstitutionalAccreditation/MedicalSpecialties.aspx. Accessed September 21, 2015.
3. Accreditation Council for Graduate Medical Education. Program and institutional accreditation: surgical specialties. https://www.acgme.org/acgmeweb/tabid/369/ProgramandInstitutionalAccreditation/SurgicalSpecialties.aspx. Accessed September 21, 2015.
4. Nasca TJ, Philibert I, Brigham T, Flynn TC. The next GME accreditation system—rationale and benefits. *N Engl J Med*. 2012;366(11):1051–1056.
5. Sullivan C, Murano T, Comes J, Smith JL, Katz ED. Emergency medicine directors' perceptions on professionalism: a Council of Emergency Medicine

Residency Directors survey. *Acad Emerg Med*. 2001;18(suppl 1):97–103.
6. Torbeck L, Canal DF. Remediation practices for surgery residents. *Am J Surg*. 2009;197(3):397–402.
7. Lurie SJ, Mooney CJ, Lyness JM. Measurement of the general competencies of the Accreditation Council for Graduate Medical Education: a systematic review. *Acad Med*. 2009;84(3):301–309.
8. Riebschleger MP, Haftel HM. Remediation in the context of the competencies: a survey of pediatrics residency program directors. *J Grad Med Educ*. 2013;5(1):60–63.
9. Tabby DS, Majeed MH, Schwartzman RJ. Problem neurology residents: a national survey. *Neurology*. 2011;76(24):2119–2123.
10. Sullivan C, Murano T, Comes J, Smith JL, Katz ED. Emergency medicine directors' perceptions on professionalism: a Council of Emergency Medicine Residency Directors survey. *Acad Emerg Med*. 2001;18(suppl 2):97–103.
11. Tamblyn R, Abrahamowicz M, Dauphinee D, Wenghofer E, Jacques A, Klass D, et al. Physician scores on a national clinical skills examination as predictors of complaints to medical regulatory authorities. *JAMA*. 2007;298(9):993–1001.
12. Goold SD, Stern DT. Ethics and professionalism: what does a resident need to learn? *Am J Bioethics*. 2006;6(4):9–17.
13. Park J, Woodrow SI, Reznick RK, Beales J, MacRae HM. Observation, reflection, and reinforcement: surgery faculty members' and residents' perceptions of how they learned professionalism. *Acad Med*. 2010;85(1):134–139.
14. Gaiser RR. The teaching of professionalism during residency: why it is failing and a suggestion to improve its success. *Anesth Analg*. 2009;108(3):948–954.
15. Farnan JM, Snyder Sulmasy L, Worster BK, Chaudhry HJ, Rhyne JA, Arora VM, et al. Online medical professionalism: patient and public relationships: policy statement from the American College of Physicians and the Federation of State Medical Boards. *Ann Intern Med*. 2013;158(8):620–627.
16. Schmitz GR, Clark M, Heron S, Sanson T, Kuhn G, Bourne C, et al. Strategies for coping with stress in emergency medicine: early education is vital. *J Emerg Trauma Shock*. 2012;5(1):64–69.
17. Lefebvre DC. Perspective: resident physician wellness: a new hope. *Acad Med*. 2012;87(5):598–602.
18. Gallagher TH, Waterman AD, Ebers AG, Fraser VJ, Levinson W. Patients' and physicians' attitudes regarding the disclosure of medical errors. *JAMA*. 2003;289(8):1001–1007.
19. Ogunyemi D, Eno M, Rad S, Fong A, Alexander C, Azziz R. Evaluating professionalism, practice-based learning and improvement, and systems-based practice: utilization of a compliance form and conflict behavior association. *J Grad Med Educ*. 2010;2(3):423–429.
20. Hickson GB, Picher JW, Webb LE, Gabbe SG. A complementary approach to promoting professionalism: identifying, measuring, and addressing unprofessional behaviors. *Acad Med*. 2007;82(11):1040–1048.
21. Hochberg MS, Kalet A, Zabar S, Kachur E, Gillespie C, Berman RS. Can professionalism be taught? Encouraging evidence. *Am J Surg*. 2010;199(1):86–93.
22. Wear D, Kuczewski MG. The professionalism movement: can we pause? *Am J Bioeth*. 2004;4(2):1–10.
23. Cruess R, McIlroy JH, Cruess S, Ginsburg S, Steinert Y. The Professionalism Mini-evaluation Exercise: a preliminary investigation. *Acad Med*. 2006;81(suppl 10):74–78.
24. Gauger PG, Gruppen LD, Minter RM, Colletti LM, Stern DT. Initial use of a novel instrument to measure professionalism in surgical residents. *Am J Surg*. 2005;189(4):479–487.
25. Towle A, Godolphin W. Framework for teaching and learning informed shared decision making. *BMJ*. 1999;319(7212):766–771.
26. Ghosh AK. Understanding medical uncertainty: a primer for physicians. *J Assoc Physicians India*. 2004;52:739–742.
27. Chan TM, Wallner C, Swoboda TK, Leone KA, Kessler C. Assessing interpersonal and communication skills in emergency medicine. *Acad Emerg Med*. 2012;19(12):1390–1402.
28. Beeson MS, Carter WA, Christopher TA, Heidt JW, Jones JH, Meyer LE, et al. The development of the emergency medicine milestones. *Acad Emerg Med*. 2013:20(7):724–729.
29. Philibert I, Brigham T, Edgar L, Swing S. Organization of the educational milestones for use in the assessment of educational outcomes. *J Grad Med Educ*. 2014;6(1):177–182.
30. Cruess RL, Cruess SR. Teaching professionalism: general principles. *Med Teach*. 2006;28(3):205–208.
31. Schwartz AC, Kotwicki RJ, McDonald WM. Developing a modern standard to define and assess professionalism in trainees. *Acad Psychiatry*. 2009;33(6):442–450.
32. Sullivan C, Arnold L. Assessment and remediation in programs of teaching professionalism. In: Cruess RL, Cruess SR, Steinert Y, eds. *Teaching Medical Professionalism*. Cambridge, UK: Cambridge University Press; 2009:124–49.
33. Hauer KE, Ciccone A, Henzel TR, Katsufrakis P, Miller SH, Norcross WA, et al. Remediation of the deficiencies of physicians across the continuum from medical school to practice: a thematic review of the literature. *Acad Med*. 2009;84(12):1822–1832.

34. Rodriguez E, Siegelman J, Leone K, Kessler C. Assessing professionalism: summary of the working group on assessment of observable learner performance. *Acad Emerg Med*. 2012;19(12):1372–1378.
35. Martin D. Martin's Map: a conceptual framework for teaching and learning the medical interview using a patient centered approach. *Med Educ*. 2003;37(12):1145–1153.
36. Wen T, Huang, B, Mosley V, Afsar-Manesh N. Promoting patient-centered care through trainee feedback: assessing residents' C-I-CARE (ARC) program. *BMJ Qual Saf*. 2012;21(3):225–233.
37. Iramaneerat C, Myford CM, Yudkowsky R, Lowenstein T. Evaluating the effectiveness of rating instruments for a communication skills assessment of medical residents. *Adv Health Sci Educ*. 2009;14(4):575–594.
38. Taylor C, Farver C, Stoller JK. Can emotional intelligence training serve as an alternative approach to teaching professionalism to residents? *Acad Med*. 2011;86(12):1551–1554.
39. Park I, Gupta A, Mandani K, Haubner L, Peckler B. Breaking bad news education for emergency medicine residents: a novel training module using simulation with the SPIKES protocol. *J Emerg Trauma Shock*. 2010;3(4):385–388.
40. Bowyer MW, Hanson JL, Pimentel EA, Flanagan AK, Rawn LM, Rizzo AG, et al. Teaching breaking bad news using mixed reality simulation. *J Surg Res*. 2010;159(1):462–467.
41. Rosenbaum ME, Ferguson KJ, Lobas JG. Teaching medical students and residents skills for delivering bad news: a review of strategies. *Acad Med*. 2004;79(2):107–117.
42. Benenson RS, Pollack ML. Evaluation of emergency medicine resident death notification skills by direct observation. *Acad Emerg Med*. 2003;10(3):219–223.
43. Kemper PF, van Noord I, de Bruijne M, Knol DL, Wagner C, van Dyck C. Development and reliability of the explicit professional oral communication observation tool to quantify the use of non-technical skills in healthcare. *BMJ Qual Saf*. 2013;22(7):586–595.
44. Shapiro MJ, Morey JC, Small SD, Langford V, Kaylor CJ, Jagminas L, et al. Simulation based teamwork training for emergency department staff: does it improve clinical team performance when added to existing didactic teamwork curriculum? *Qual Saf Health Care*. 2004;13(6):417–421.
45. Rosen MA, Weaver SJ, Lazzara EH, Salas E, Wu T, Silvestri S, et al. Tools for evaluating team performance in simulation-based training. *J Emerg Trauma Shock*. 2010;3(4):353–359.
46. Rodgers KG, Manifold C. 360-degree feedback: possibilities for assessment of the ACGME core competencies for emergency medicine residents. *Acad Emerg Med*. 2002;9(11):1300–1304.
47. Starmer A, Landrigan C, Srivastava R, Wilson K, Allen A, Mahant S, et al. I-PASS Handoff Curriculum: Faculty Observation Tools. MedEdPORTAL Publications. 2013. https://www.mededportal.org/publication/9570. Accessed September 21, 2015.
48. Agency for Healthcare Research and Quality. TeamSTEPPS: national implementation. http://teamstepps.ahrq.gov. Accessed September 21, 2015.
49. Capella J, Smith S, Philp A, Putnam T, Gilbert C, Fry W, et al. Teamwork training improves the clinical care of trauma patients. *J Surg Educ*. 2010;67(6):439–443.
50. Carnegie D. *How to Win Friends and Influence People*. New York, NY: Pocket Books; 1981.
51. Patterson K, Grenny J, McMillan R, Switzler A. *Crucial Conversations: Tools for Talking When Stakes Are High*. New York, NY: McGraw Hill; 2002.
52. Seys D, Deneckere S, Sermeus W, Van Gerven E, Panella M, Bruyneel L, et al. The Care Process Self-Evaluation Tool: a valid and reliable instrument for measuring care process organization of health care teams. *BMC Health Serv Res*. 2013;13:325.

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