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AEM Education and Training

COMMENTARY AND PERSPECTIVE

Embracing our responsibility to ensure trainee competency

Sally A. Santen MD, PhD[1,2] | **Robin R. Hemphill MD, MPH**[3]

[1]Department of Emergency Medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio, USA

[2]Virginia Commonwealth University School of Medicine, Richmond, Virginia, USA

[3]Cincinnati Veterans Association Medical Center, Cincinnati, Ohio, USA

Correspondence
Sally A. Santen, Emergency Medicine and Medical Education, University of Cincinnati College of Medicine, Cincinnati, OH 45265, USA.
Email: sally.santen@vcuhealth.org

Every summer, emergency medicine (EM) residency educators graduate their residents, hand them a diploma, and certify that they have completed training and are ready for practice. Similarly, medical school deans hood, shake hands, award diplomas, and repeat the physicians' oath where they pledge with graduates, "the health and well-being of my patient will be my first consideration."[1]

The unfortunate secret is that faculty graduate trainees they know in their hearts they would not let care for their family.[2,3] They know the struggles and sometimes unprofessional behaviors of these trainees; yet, a small number are allowed to graduate. It is a significant issue and is unacceptable. We termed this "kicking the can down the road: when medical schools fail to self-regulate."[4]

The students enter residency becoming the responsibility of EM program directors, and as faculty, we find this process frustrating and unacceptable. Despite frustrations with medical schools, similarly residency programs graduate trainees they would not let take care of their families.[1,2] Fifty-two percent of internal medicine program directors acknowledged "I have graduated at least one person in the last three academic years (2014, 2015, 2016), about whom I have concerns regarding their ability to practice independently." Furthermore, 57% of them noted "every year I advance at least one resident about whom I have concerns regarding their ability to handle additional responsibility."[2] Yet, in over a decade only 65 of 51,882 EM residents were dismissed.[5] These concerning graduates become the problem of EM chairs, EM directors, quality and safety leads, and ultimately patients. We must remember that our penultimate responsibility is to the future patients of our graduates. In this perspective, we discuss some of the reasons for graduating these problematic trainees and propose solutions to improve medical education.

Performance in medical school and residency is associated with subsequent state medical board actions and may affect the future patient care and practice.[6–10] Students with professionalism concerns, students identified by medical schools' promotions committees, and residents with lower performance in internal medicine residency training are shown to have state medical board actions.[6–10] The goal of medical schools and residencies is to create physicians who can provide for the health and well-being of their patients. Yet, at times the profession allows residents to slip through, not upholding these fundamental principles,[11] and instead of ensuring competent graduates, they "kick the can down the road" passing the problematic trainee to the next phase of the profession.

To address these issues, we need to consider the incentives to graduate and barriers to dismissing trainees. First, EM is a helping profession. As educators, we have compassion for trainees. Placing them on remediation or dismissing them is upsetting.[12,13] Further, it can be difficult to disarticulate mental health issues such as depression and borderline personality and substance use disorder from performance. Programs cannot dismiss trainees due to mental health concerns due to disability laws; however, they have the responsibility to act on unprofessional behavior and problematic clinical performance. In addition, "helping" underserved, rural, and low-volume ED workforce needs with subpar trainees is another altruistic but misguided direction.

Second is concern for financial hardship since dismissal leaves trainees with limited employment options and many are deeply in debt.[14,15] Students extending training incur additional tuition costs with no guarantee they will graduate. If residents are dismissed, they also have medical school debt. If residents need to extend their

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training, then the department or institution must pay for the additional salary. While in the big picture of salary costs, this is not a significant amount of money, it is a barrier for extending training. These concerns of financial burden to trainees and program-related costs may prevent organizations from acting upon unacceptable behavior.

Third, the process of identification, remediation, and possible dismissal is challenging in EM.[16,17] Residents may spend many months on other services, making identification of problem residents more difficult. Once identified, trainees may be difficult to remediate due to lack of insight and other issues. Leadership may shy away from the difficult decision of dismissal due to legal and other concerns. Yet, educational institutions rarely lose lawsuits related to dismissal of trainees.[18–20] The courts have generally determined that professions can make these judgments if they follow organizational policies and ensure due process. In addition, programs choosing to extend training or dismiss trainees may be at risk for damaged reputation or issues with accreditation. Further, because the Medical Student Performance Evaluation (Dean's letter), residency letters of recommendation, and credentialing forms *should* include episodes of formal remediation,[10,21] there is a strong incentive to place trainees on *informal* remediation. Thus, the problematic behavior is not documented.

Finally, there is concern for the lack of precision measurement with the trainee's assessment data.[22–24] For high-stakes decisions, can we ensure the data are trustworthy and accurate enough to confidently dismiss or remediate the trainee? Programs examining milestones scoring must ask if there are sufficient numbers of observations? Are there educationally significant or meaningful differences in milestones' scoring to justify dismissal? Did faculty have private conversations with the program director and not document the problematic performance? These high-stakes decisions must be supported by complete documentation providing sound evidence, yet our assessment programs may not be adequately robust.

Recognizing these four strong incentives to not remediate or dismiss trainees, we present three solutions to help struggling trainees and assist programs. The first approach is measurement. Assessment serves two purposes. First, it drives learning by providing formative feedback for improvement. Second, assessment is the basis for summative judgment. While programs use various instruments to measure our trainees, they rarely explore the validity and reliability to know the accuracy of these instruments. Additionally, issues with rater training; stringency; frame of reference; shared mental model; and bias toward gender, race, and ethnicity also contribute to error in assessment.[25,26] These factors lead to important judgments of resident performance for the purpose of remediation and possible dismissal using potentially untrustworthy data.

Programs need to create a robust system of assessment. This includes being intentional about collecting reliability and validity evidence to assure accuracy and that the assessments serve the intended purpose. Further, since the goal in residency is to achieve competency, programs must map and adequately assess the milestones.[27] The use of programmatic assessment, using multiple methods including workplace-based, direct observation, end of shift/end of rotation, simulation, standardized patients, peer/nursing/patient/family assessments, and patient-oriented outcomes will provide a more robust view of the performance of the trainees. Through programmatic assessment we gain better understanding and ability to provide both formative and summative feedback to trainees. The process requires faculty to be responsible about completing trainee assessments regularly, while providing feedback to encourage growth mindset. In addition, learning analytic platforms may help with data collection, aggregation, and analysis better representing the performance of the trainee for the purpose of feedback and learning as well as competency committee assessment.[28]

Second, we need to move from trainees aimed at proving performance toward a growth mindset and the creation of master adaptive learners.[29–33] Based on the grading system, students' goal orientation is performance-driven and low performance is avoided so that they can get good grades.[34] This creates a fixed mindset and a limited approach to learning. Growth mindset, where trainees are challenged to learn, and fail, and try again, leads to improved learning and performance. Programs and faculty need to provide psychological safety to support and normalize failure, thereby accelerating growth. They need to become master adaptive learners, where they balance efficiency and new learning.[31–33] Trainees should work with individualized learning plans, coaching, and informed self-assessment. Through this process, trainees will learn and hopefully achieve the desired outcomes.

The third approach is that there should be a handover at each transition from medical school to residency[35–38] and residency to fellowship or practice. Standardized communication relaying medical student performance to residencies is a crucial first step. Information contained in residency applications is neither complete nor (at times) honest.[39] Further, information in the residency applications is not associated with intern performance.[40,41] Engaging students in the analysis of their medical school performance, then creating individualized learning plans with well-defined strengths and weakness, should create a roadmap to facilitate the transition as well as a growth mindset.[35–37] Moreover, when trainees enter practice there should be more robust "handover."

The need for these three reforms may seem insignificant given that most graduates are and will continue to be successful. Yet, the strategies we suggest are valuable to all learners including those that may not yet be achieving acceptable performance. Approaching performance through meaningful formative feedback and growth mindset will identify those struggling, but will also offer a valuable and different approach for all learners. Beyond these steps, efforts to develop trainee-engaged responsible handovers will provide information for the next phase to continue the growth trajectory. While these approaches will assist trainees and programs, medical educators also have the responsibility to patients to ensure safe and competent graduates. Thus, we call for medical educators to examine their consciences and work to ensure that every graduate is one that we would welcome to care for our families. We must support and remediate trainees, but also recognize when the trainee cannot live up to the professional

values and competencies required to practice independently. We call for all of us to commit to uphold our social compact as medical education professionals.

CONFLICT OF INTEREST STATEMENT

Dr. Santen—American Board of Emergency Medicine Oral Board Examiner, National Board of Medical Examiners committee volunteer, consultant American Medical Association. The opinions in this article are those of the authors and are not intended to represent the position of the Department of Veterans Affairs or the U.S. government.

ORCID

Sally A. Santen https://orcid.org/0000-0002-8327-8002

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