Postgraduate Education Policy and Procedures for the Assessment of Resident Performance

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Northern Ontario School of Medicine
École de médecine du Nord de l'Ontario

Policy

	Postgraduate Education Policy and Procedures for the Assessment of Resident Performance				Class:	B
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1.0 Purpose

The Northern Ontario School of Medicine has a responsibility to the public at large and particularly to the people and communities of Northern Ontario to ensure that all residents graduating from NOSM residency programs have demonstrated competence in their discipline to provide safe and effective patient care. Residents are observed frequently and given specific timely feedback to ensure that their trajectory of developing competence is appropriate and residents achieve the program goals and objectives, all milestones and Entrustable Professional Activities (EPA's) to certify that physicians entering the work force are competent and safe to practice medicine.

This document outlines the principles of In-Training assessment and promotion of residents in all postgraduate programs at NOSM. Each individual residency program may have additional program- specific criteria for resident assessment and promotion. All residents must have access to this document, as well as any program specific criteria, and be advised of these documents and how to access them when they enter postgraduate training.

Assessment of residents should occur in an open, collegial atmosphere that supports and encourages self-reflection on the part of the learner. Staff physicians should model self-reflection, encourage feedback from others on their own decisions and approaches, and foster a spirit of scholarship and inquiry.

2.0 Scope

This policy and its associated procedures apply to all postgraduate residents. All matters fall within the jurisdiction of the Postgraduate Education Office and the Academic Council of the Northern Ontario School of Medicine (NOSM).

3.0 Definitions

3.1 Academic Council Appeals Committee (ACAC)
The committee that hears appeals based on an academic decision rendered by any Program Director or committee under the purview of the Academic Council of NOSM. This is the highest body of appeal for a postgraduate resident.

3.2 Appellant
The postgraduate resident who appeals a decision.

3.3 Associate Dean Postgraduate Education (AD PGE)
The senior faculty officer responsible for the overall conduct and supervision of postgraduate education at NOSM. The AD PGE reports to the Dean.

3.4 Coaching
The process by which one individual, the coach, creates a supportive relationship with the other that makes it easier to learn. This process occurs in such a way that it creates stronger physicians who have an appreciation for themselves and their capacity to couple their personal competence with effort and produce good results.

3.5 Competence
The collection of attributes across multiple domains or aspects of a physician's performance in a given context. Competence is multi-dimensional, dynamic and changes with time, experience and context.[1]

3.6 Competencies
The observable abilities of a health professional and include knowledge, skills, and attitudes. [2]

3.7 Context
The "who" (types of patients, groups, populations) the "what" (areas of practice, types of service), the "where" (setting, community,) and the "how" (e.g. professional role, funding models) of an individual's practice or education milieu.[3]

3.8 Dismissal
The permanent termination of a resident from their residency program.

[1] Takahashi et al; 2015 *CanMEDS Teaching and Assessment Tools Guide*

[2] Takahashi et al; 2015 *CanMEDS Teaching and Assessment Tools Guide*

3.9 Education Advisory Board (EAB)
The Board who provides advice, resources, and support to any Residency Program, Program Director, or Resident requesting guidance with creating and implementing effective individual educational/learning plans particularly where there have been concerns about a resident's progress. Remediation plans are reviewed by the EAB and feedback given to the Program.

3.10 Entrustable Professional Activities
The statements describing an activity or task embracing multiple competencies a professional has been entrusted to perform (e.g. lead a team meeting, give an epidural to a laboring woman, perform a cholecystectomy in an otherwise healthy patient).

3.11 Faculty Advisor
A confidential, resource person/mentor who meets regularly with a resident to support their academic progress and who does not have an assessment role. If acceptable to both resident and the program, a Faculty Advisor could take on the role of remediation coach.

3.12 Four-zone Model
A model used to guide the need for remediation where each residency program is responsible to define minimal and unacceptable standards of performance.

3.13 ITER/ITAR
The acronym for In-Training Evaluation Report/In-Training Assessment Report.

3.14 Mini-CEX
The acronym for Mini-Clinical Evaluation Exercise.

3.15 Milestones
The expected ability of a health professional at a particular stage of development.

3.16 Natural Justice
The basic components of natural justice are that appellants and respondents will receive notice of case consideration, be provided with specific aspects of the case under consideration so that an explanation or response can be prepared, and be provided with the opportunity to make submissions (written or oral) relating to the case. Decision-makers will be unbiased and be objective and impartial about the matter under consideration.

3.17 OSCE
The acronym for Observed Structured Clinical Exam.

3.18 POCCE
The acronym for Point of Care Clinical Encounter.

3.19 Postgraduate Education Appeals Subcommittee (PGEAC)
An ad hoc subcommittee of PGEC convened for level two PGE appeals. The PGEC governs the subcommittee.

3.20 Postgraduate Education Committee (PGEC)
The committee responsible for the conduct of postgraduate medical education at NOSM.

3.21 Postgraduate Education Office
The administrative office responsible for the admission, registration, policy and operational support of all postgraduate residency programs.

3.22 Probation
A temporary status for a resident and an indication that the resident is in serious academic difficulty**.** An unsuccessful probation will result in dismissal from the residency program.

3.23 Probation Period
An educational program of defined length (typically twelve weeks) during which the resident must correct identified weaknesses or deficiencies. The probation period may be extended once only for an additional twelve weeks in exceptional circumstances on the recommendation of the Residency Program Committee.

3.24 Program Director
The faculty member most responsible for the overall conduct of the residency program in a given discipline. The Program Director is responsible to the AD PGE.

3.25 360 Reviews
A process used to solicit information from a variety of workplace sources on a resident’s work-related behavior and/or performance; also known as multi-rater or multi-source feedback.

3.26 Remediation
A period of additional individualized structured training and monitoring initiated when resident performance is below minimal standards but above unacceptable standards with the goal of ensuring that resident performance moves to and stays above those minimal standards.

3.27 Remediation Coach
A physician, or other qualified person, who enters into a formal, structured, and confidential relationship with a resident as a longitudinal partnership. The resident and coach meet regularly, outside of the resident’s clinical setting, to focus on

developing identified knowledge, skills, and competencies as outlined in the remediation plan. The coach will work with the resident until such time that the resident can demonstrate that they have been able to integrate the competencies into the clinical setting. A coach provides formative feedback to the resident but does not normally provide summative assessment. It is expected that the summative assessment of the identified competencies occurs in the clinical setting.

3.28 Remediation Supervisor
A physician who is directly responsible for supervising a resident in a clinical setting during a remedial period. The goal of this relationship is to provide extra support, focused learning strategies, and enhanced assessment to support the resident to develop the knowledge, skills, and competencies as outlined in the remediation plan.

3.29 Residency Program Committee (RPC)
The Committee that oversees the planning and overall operation of the residency program to ensure all requirements as defined by the national certifying colleges are met.

3.30 SCAR
The acronym for Surgical Competency Assessment of the Resident.

3.31 Suspension
The temporary interruption of a resident's participation in all program activities including clinical, educational and research.

3.32 Working Days
The days on which NOSM offices are open for business from Monday to Friday, excluding statutory holidays or any other day that NOSM is closed.

4.0 Procedures

4.1 Assessment Process, Requirements and Promotion

4.1.1 Educational Requirements

Building from accreditation requirements for resident assessment, the in-training assessment system at NOSM must include multiple methods of assessment such as written and oral exams, OSCES, multisource feedback, direct observation and feedback, and self-reflection exercises, as appropriate for the experience and performance being evaluated.

Royal College residency programs must include assessment of all seven CanMEDS roles, and in-training assessment in Family Medicine

residencies must be structured to allow for monitoring of resident progress through training towards the achievement of the competence expected for the start of independent practice.

Assessment must be based on the goals and objectives of the program, and must use tools compatible with the characteristic being assessed. Methods of assessment of resident performance must be clearly communicated to residents and faculty, and the level of performance expected of residents in the achievement of program objectives must be clearly outlined.

Clinical skills including communication skills must be assessed by direct observation of patient interactions, physical exam, procedures, and must be documented by such methods as daily/weekly assessment forms, Mini CEX, etc. Written communication skills (chart notes, consult/referral letters,) must be formally assessed.

Attitudes and professionalism must be assessed by such means as interviews with peers, multisource feedback, supervisors, other health care professionals, patients and their families, and administrative personnel.

Collaborating abilities, including interpersonal skills in working with all members of the interprofessional team, including other physicians and health care professionals, must be assessed.

Teaching abilities must be assessed in multiple settings, including written student assessments and by direct observation of the resident in seminars, lectures or case presentations.

In-training assessments must include an understanding of issues related to age, gender, culture and ethnicity.

There must be honest, helpful and timely feedback provided to each resident. Feedback and assessment must not be limited to the end of an activity or clinical experience. They must occur frequently, at least by the middle of a placement, in time for behavior change to occur, and ideally on a daily basis or immediately after an activity, whenever pertinent.

Feedback sessions to residents must include face-to-face meetings as an essential part of resident assessment. The assessment system should permit very early identification (i.e. well before any summative assessment), or self-identification of residents in difficulty. Residents must be informed when serious concerns exist and given opportunity to correct their performance.

4.1.2 Administrative Requirements

Face-to-face meetings with residents must occur at least twice during a 4-week rotation, three (3) times during a longer rotation:

- **First meeting** near the beginning, to review both the resident's personal objectives and the program objectives for the rotation,
- **Second meeting** to provide a formal mid rotation assessment for rotations longer than four (4) weeks and/or if the resident's performance is not meeting expectations,
- **Final meeting** before the end of the rotation to review and discuss the ITER/ITAR.

As stated above, a variety of methods must be used in assessment and should be used to complete the ITER/ITAR.

Both the preceptor and resident must confirm that they have seen the assessment before it is considered complete. Confirmation by the resident that they have seen the assessment form does not mean agreement with the content or the conclusion of the assessment.

The Program must receive the completed and signed assessment within ten (10) working days of completion of the rotation/educational experience. Residents must ensure the timely receipt of all completed rotation assessments. Assessments are reviewed by the Program Director or designate.

All NOSM resident assessments are confidential and retained indefinitely.

4.1.3 Summative Assessments and Decisions Regarding Process

Program Directors or designated faculty advisors/competency coaches must have one-to-one meetings with each resident at least every six (6) months to review the resident's overall progress and:

- Discuss with the resident the program objectives, the resident's own learning objectives, and design an appropriate educational plan
- Review this plan regularly and assist the resident in finding the resources within the program necessary to meet his or her unique learning needs
- Help the resident:
    - Reflect on program choices to be made
    - Understand assessment feedback

- Set and revise learning objectives
- Define career plans

These meetings must be documented, and should include any suggested alterations to the resident's education program.

When the summative assessment of resident performance on a rotation is unsatisfactory, the rotation is viewed as not successfully completed. In addition, a resident may be deemed to have failed to meet the criteria for successful completion of a rotation when any of the following circumstances prevail:

1) An unsatisfactory assessment in any domain of the rotational ITER/ITAR
2) Documentation that a resident, regardless of their clinical performance during the rotation, has not satisfied accepted standards of ethical and professional behaviour (see Related Documents).

The RPC or designated subcommittee, will make final decisions regarding successful completion of all rotations based upon all available documentation. Rotations not successfully completed based on the above criteria will require remediation, or other appropriate modifications to a resident's education, supervision, and assessment, which may include a requirement for the successful completion of a repeat of the rotation at some point in the future. The Program Director or designate must contact the resident and advise the resident regarding the need for remediation or other alteration in the education program within four (4) weeks of the completion of the rotation.

Notwithstanding the above, when a rotation assessment or the assessment of another learning experience identifies areas of concern but is not designated as overall unsatisfactory, the Program Director or designate can outline plans to remedy such areas especially in domains where performance is felt to be below expectations and competencies have not yet been achieved, or where the overall summative assessment is below expectations. These include, but are not limited to:

- Close monitoring of resident performance on subsequent rotations
- Repetition of the rotation using elective or selective time
- Specific skills training

Although not a formal remediation, The Program Director or designate must still contact the resident and make the resident aware of any recommendations to improve subsequent performance within four (4) weeks of the completion of the rotation and complete the "PGE Enhanced

Learning Plan Form". Use of this learning plan form is not considered a formal remediation period/plan.

Two or more ITERs/ITARs which are unsatisfactory or below expectations in a twelve (12) month period will trigger a formal review by the RPC or designated subcommittee with regard to whether or not the resident is to be placed on remediation.

4.1.3.1 This is an option, which may be considered by the program, when a resident requires more time to achieve certain objectives/competencies but in the opinion of the Residency Program Committee does not require formal remediation. Recommendations for extension of training must be brought to the Program's Residency Program Committee by the Program Director. A decision regarding an extension of training will only approved by the Residency Program Committee.

The nature and length of the extension of training period will be determined by the Residency Program Committee with resident opportunity to comment.

A " PGE Extension of Training Form" must be completed by the Program and must include the following:

- details the reasons for an Extension of Training,
- duration of the extended period of training,
- activities to be undertaken by the resident during the extension of training period,
- potential outcomes of the extension of training period.

The extension of training details must be discussed in person or by teleconference/ videoconference with the resident. The discussion must include all the steps described above.

If rotation(s) are required outside the resident's program, these will be discussed and arranged with the respective program director(s) prior to finalizing the extension of training.

The Program's plan for the Extension of Training period must be ratified by the Associate Dean, PGE prior to its implementation.

At the end of the Extension of Training period, the RPC will review the resident's performance and make a final decision regarding outcome.

4.1.4 Promotion

A resident will be promoted to the next academic year level when all program requirements have been met for the level of training, including any remedial training, and all assessments have been completed with ratings of "satisfactory" (or equivalent) or higher. This determination shall be made by the RPC and communicated to the Associate Dean PGE by the Program Director.

4.2 Remediation

4.2.1 Expectations and Decision Making

- A four-zone model is used to guide the need for remediation and each residency program is responsible to define minimal and unacceptable standards of performance.
- The RPC, or designated subcommittee, is responsible for making decisions about successful completion of all rotations/educational experiences based upon all available documentation.
- A formal remediation must be approved by the RPC. The RPC or designated subcommittee reviews the concerns and will make a decision regarding the implementation of a remedial program.
- The RPC or designated subcommittee must consider multi source data in the decision making process. Examples include: ITER/ITAR, Field Notes, POCCE, SCAR, Mini-CEX, OSCE, 360 reviews and other feedback from members of the health team, as well as written examinations.
- Remediation may include a requirement for the successful completion of a repeat of the unsuccessful rotation/educational experience.
- As part of developing the remediation plan, the Program Director or designate must offer the resident a meeting with the Wellness Lead and/or a member of the EAB to ensure a comprehensive understanding of any potential contributing factors to the resident's academic difficulties, such as system problems, personal, health, family, learning issues.
- The Program Director or designate and/or the resident may ask for assistance from the EAB in the development of the remediation program.
- All Remediation Plans must be referred to the EAB for review and comment before finalized. The resident can request that resident EAB members not be involved in the review of their remediation plan.

- The length of the remediation will, in most instances, approximate the time on the rotation where performance was considered unsatisfactory, but this may vary dependent upon the nature of the concerns and remediation strategy.
- Extension of training is usually required following successful remediation. It may be possible for a Resident, with the approval of the Program Director or designate, to use elective time or other scheduled rotations/educational experiences for remedial activities and still fulfill the requirements of the current PGY level. The maximum amount of elective time that may be used for remediation is as follows:
    - Family Medicine – 1 block of elective time per 2 year program
    - Family Medicine PGY3 – 1 block of elective time per 1 year program
    - Royal College programs – 3 blocks of elective time per 4 or 5 year program

- Any change in promotion date implies an extension of training and therefore must be approved by the Associate Dean of PGE.
- During a remedial rotation/learning experience, any leaves of absence must be approved by the Program Director or Site Director.
- The resident must comply with the remedial plan. Failure to comply will result in an unsuccessful remediation period and implementation of probation

4.2.2 Remediation Implementation Procedures

4.2.2.1 Reasons for which a resident will be placed on remediation:

- Rotations/Educational Experiences, if not successfully completed will require remediation, or other appropriate modifications to a resident's education program, supervision, and assessment. Rotations/Educational Experiences are not considered successfully completed:
    - If the summative assessment of resident performance is unsatisfactory or the goals and objectives, milestones, level of competence, or EPA is not achieved.
    - Additionally, a resident may be deemed to have failed to meet the criteria for successful completion of a rotation/educational experience when any of the following circumstances prevail:

        - An unsatisfactory assessment in any domain of the ITER/ITAR
        - Documentation that a resident, regardless of their performance in the Medical Expert role, during the rotation/educational experience, has not satisfied accepted standards in one or more of the Intrinsic CanMEDS Roles
    - If there is a repeated pattern of concerns in a given domain or CanMEDS Role even if no individual rotation/educational experience is designated as overall unsatisfactory
    - When a resident is on probation

4.2.2.2 Documentation and Timing

- Remediation Status
    - The Program Director or designate must contact the resident within four (4) weeks of the completion of a rotation/educational experience that has been assessed at below expectations and/or when a repeated pattern of concerns is brought forward to the program's attention, and bring any concerns to the next scheduled RPC to decide if remediation is warranted.
    - Once the RPC has made the decision to place the resident on remediation, the Program Director must advise the resident within ten (10) working days of the RPC decision, at a face-to-face or videoconference/web-conference or teleconference meeting. The resident and the Associate Dean of PGE must also receive written documentation of his or her remediation status at this time.
    - After informing the resident, the program has fifteen (15) working days to finalize the Remediation Plan inclusive of EAB review, and obtain RPC or designated subcommittee approval and present it to the resident.

- Remediation Plan
  All periods of remediation must have an explicit, written plan completed using the "PGE Remediation Plan Form" (RPF). The plan must be developed under the authority of the Program Director or designate in consultation with the resident. The plan must be reviewed by the EAB. The plan must be signed by the Program Director, the Resident, and the Associate Dean of PGE. The plan must be approved by the RPC or designated subcommittee.

  During the remediation period, the Remediation Supervisor or Coach may identify a competency that was not identified in the

Remediation Plan and that is deemed significant to address for the purpose of this remediation. The Remediation Supervisor or Coach must discuss this competency with the resident and identify it as an objective for the period of remediation. This should be documented and appended to the original document with resident and supervisor signatures.

The plan must include the following information and steps:

- Resident information,
- Time frame including start date for the remediation and projected end date,
- Coach and/or Supervisor information,
- Reasons for the remediation,
- Goals, objectives, and competencies that must be achieved to constitute a successful remediation,
- Clear learning strategies for each of the goals, objectives, and competencies,
- Measures, tools, and resources that will be used to ensure that the goals, objectives, and competencies have been met at each stage as well as at the end point,
- Monitoring processes, including frequency and form of the meetings and feedback given to the resident,
- A clear statement as to the consequences of either successfully achieving the goals, objectives and competencies of the remediation (i.e. reinstated into the program with or without an extension of residency) or an unsuccessful remediation (ie. the RPC may recommend a further period or extension of remediation or that the resident be placed on probation)
- A record of the approvals and oversight by the RPC.

- Final Outcome
  The outcome of the remediation must be communicated in writing within fifteen (15) working days of the conclusion of the remediation and include the following information:
  - The dates of the remediation period
  - Final outcome and consequences of the remediation period

4.2.2.3 Remediation Outcomes and Consequences

The RPC or designated subcommittee will review the assessments from the remedial program and document in writing its decision to the resident outlining successful completion or further remediation or probation actions.

4.3 Probation

4.3.1 Expectations and Restrictions

- The resident is relieved from the regular duties of their rotation schedule in order to complete the probation plan. (Note: a Resident's salary continues during this time period).
- No vacation or other time off will be allowed during a probation period, except in exceptional circumstances.
- Any approved time away for exceptional circumstances must be made up but it is strongly advised that the entire probation period be completed as a single intensive educational experience.
- The resident will not participate in elective rotations.
- Probation will generally result in extension of the residency program.
- Probation periods are reported to the College of Physicians and Surgeons of Ontario (CPSO) and hospital administration as part of credentialing and educational licensing requirements. In rare, exceptional cases, there may be academic credit granted for probation time at the discretion of the Program Director.
- The Resident probation must receive remediation and close monitoring of their progress (at a minimum, weekly face-to-face and written feedback on progress towards defined objectives and competencies).
- If the resident indicates that personal factors, such as family or health issues, are contributing to the academic difficulties, these must be brought, in confidence, to the attention of the Program Director within ten (10) working days of being placed on probation. The resident will be encouraged to seek assistance through available confidential resources.

4.3.2 Probation Implementation Procedures

4.3.2.1 Reasons for which a resident will be placed on probation

- Unsatisfactory evaluations in a remedial rotation.
- Upon recommendation of the RPC and/or the Program Director for any of the following reasons:
    i. an unsuccessful remediation program;
    ii. two remediation periods in a twelve (12) month time frame, regardless of whether the first has been successful;

iii. any serious issue related to lack of professionalism, collaboration and/or communication skills;
iv. a continued pattern of unsubstantiated absence from the program

4.3.2.2 Documentation and Timing

- Probationary Status
  - Once the RPC has made the decision to place the resident on probation, the Program Director must advise the resident within fifteen (15) working days of the RPC decision, at a face-to-face or videoconference/web-conference or teleconference meeting. The resident must receive written documentation of his or her probationary status, including an explanation of why the resident is on probation. At this time, the resident must also be presented with a DRAFT probation plan which has been reviewed by the EAB.
  - The resident has five (5) working days to review the DRAFT probation plan and provide written input. This is not an appeal.
  - RPC will meet within twenty-five (25) days of the original meeting, during which time the resident is invited to make an oral presentation regarding the probation plan. The RPC will consider the resident's input and render a decision as to final content of the plan, which will be communicated to the resident within five (5) working days of the RPC meeting. All probation plans must be approved by the RPC and the Associate Dean of PGE before implementation.

- Probation Plan
  All periods of probation must have a Probation Plan. This plan must be reviewed by the EAB, be signed by both the resident and the Program Director, and a copy must be sent to the Associate Dean of PGE. All documents will be kept in the confidential resident file.

  During the probation period, the Probation Supervisor or Coach may identify a competency that was not identified in the Probation Plan and that is deemed significant to address for the purpose of this probation. The Probation Supervisor or Coach must discuss this competency with the resident and identify it as an objective for the period of probation. This should be documented and appended to the original document with resident and supervisor signatures.

The plan must include the following information and steps:

i. The location and duration of the probationary period. NOTE: The location of the probationary period will be based on availability and remains at the discretion of the Program Director though consideration may be given to special requests by residents,
ii. Reasons for the probation and identified areas of weakness or deficiency requiring probation,
iii. Educational objectives/competencies to be achieved during the probationary period and expected outcomes,
iv. Methods and frequency of assessment of progress towards achievement of the objectives/competencies of the probationary period. The resident must be assessed, in writing, weekly, during the probation period by the preceptor(s) who are providing the training. Information verbal feedback should be provided daily and residents must receive copies of their assessments,
v. Probation supervisor identified and responsibilities outlined,
vi. An outline of all suspended program requirements. A resident who is on probation is expected to focus their learning on the identified objectives/competencies to be achieved during the probationary period. To that end, other program requirements will be suspended during the probationary period,
vii. Consequences of the successful or unsuccessful completion of the probationary program,
viii. Expected plans upon return to the program if the probationary program is successful.

- Meeting Documentation
  The resident must meet with the preceptor, or the program director (or delegate) to review each written evaluation. The meeting may be set up by video conference, web conference or teleconference when the parties are not located in the same city. The meeting must be documented.

- Final Outcome
  The outcome of the probation must be communicated in writing within ten (10) working days of the conclusion of the probation period and include the following information:

i. The dates of the probationary period
ii. A copy of the final summative evaluation
iv. Final outcome and consequences of the probationary program

4.3.3 Probation Outcomes and Consequences

The final outcome of the probation will be decided by the RPC and the Program Director based on the weekly assessments and the final summative assessment of the probation period.

Progress to the next level of training will depend upon successful completion of the entire probationary period.

If the probation is unsuccessful, the resident will be dismissed from the program. If the probation is successful, then the resident will return to the program as a resident in good standing.

4.4 Suspension and Dismissal

4.4.1 Suspension: Implementation and Process

4.4.1.1 Implementation

Residents are licensed physicians and as such are bound by a professional code of conduct and the policies of the licensing and credentialing bodies. Violation of any of these may constitute improper conduct. In cases of improper conduct, negligence, criminal activity or when the safety of patients, staff, colleagues or the public is jeopardized, a resident may be immediately suspended from the program.

4.4.1.2 Process

The Program Director or delegate may suspend a resident immediately in cases of improper conduct, negligence, criminal activity or safety risk and remove the resident from clinical care. A formal written letter must be sent (either hand-delivered or by registered mail) to the resident within two (2) working days outlining the reasons for the suspension, anticipated duration, next steps in the process and the right to appeal the decision outlined. The resident will continue to be paid during the suspension pending the formal review but may be denied access to hospital and/or educational facilities.

Once the resident has been suspended, the Program Director or delegate must notify the Associate Dean of PGE and relevant hospital/clinic administrators immediately and document in writing within two (2) working days of the incident. Such documentation must include the reasons for and recommended duration of the suspension.

A formal review by the RPC or designated subcommittee must be held within ten (10) working days of the suspension letter communication to determine the appropriate plan, which may consist of reinstatement, remediation, probation or dismissal. The RPC's decision must be communicated to the resident within five (5) working days of the RPC meeting. All documentation must be copied to the Associate Dean and the Postgraduate Office.

4.4.2 Dismissal: Implementation and Process

4.4.2.1 Implementation

Dismissal may occur:

- During a Probation period for lapses related to the reasons for probation
- Following Suspension
- For improper conduct

4.4.2.2 Process

The resident must be advised by the Program Director or Associate Dean Postgraduate Education, in person (face-to-face, by webconference or phone) and in writing of the decision to dismiss him or her from the program and the reasons for this decision. The following must occur:

- A copy of this letter must be sent to the Associate Dean of PGE.
- When a resident is dismissed, he or she must immediately surrender all Northern Ontario School of Medicine and hospital/clinic property such as ID badges, pagers, etc.
- The resident will be advised of his or her right to appeal this decision and the appeal process.

4.5 Appeals

4.5.1 Pending Disposition of an Appeal

While an appeal is pending related to an ITER/ITAR, remediation or probation program, the RPC will determine if an Appellant will commence remediation, continue with regularly scheduled clinical rotation/education experiences, or if a leave will be arranged. The RPC will determine if academic credit will be granted for activities during the time of the remediation/probation.

In determining the outcome of any appeal, the decision maker(s) will take into consideration whether any action or omission affecting an Appellant was directly or indirectly related to a protected characteristic under the Ontario Human Rights Code and, if so, whether appropriate accommodation was provided.

4.5.2 Categories of Decisions Being Appealed

A resident may appeal the following:

i. Any aspect of an ITER/ITAR that clearly indicates progress is not as expected or that there are significant concerns with performance in any domain,
ii. An end of rotation/educational experience ITER/ITAR designated overall as a “Fail” or leading to remediation/extension on the basis of that assessment,
iii. An RPC decision that remedial training or probation is required; a decision about the content or terms of the remediation or probation; or that remediation was unsuccessful,
iv. A Program Director decision not to complete a Final In-Training Evaluation Report (FITER) or Core In-Training Evaluation Report (CITER) where the Program Director indicates that he/she cannot certify that the resident has acquired the competencies of the program, or
v. A decision by the RPC and/or the AD PGE to dismiss a resident.

4.5.3 Levels of an Appeal

This policy provides for three levels of appeal for resident assessments.

4.5.3.1 Level One PGE Appeal

Level one appeal (as described below) is generally made to the RPC and/or Evaluation/Assessment subcommittee of the RPC or the AD PGE.

4.5.3.2 Level Two PGE Appeal

Level two appeal is made to an ad hoc PGEAC convened as needed to hear an appeal with the following terms applicable in all scenarios:

- The subcommittee is governed by the PGEC and is comprised of three Program Directors and the AD PGE.
- The Appellant will be given the choice of having resident representation on the PGEAC; however, the Appellant cannot choose the specific individual. In this case, the PGEAC will choose a resident representative who has not worked with or assessed the Appellant.
- The Appellant's own Program Director and other Program Directors or faculty who have been directly involved in the RPC decision will be excluded from the PGEAC. The AD PGE will chair unless the appeal involves a review of his/her decision and in that case, an alternate chair will be selected.
- The Appellant has the right to appear before the PGEAC with or without legal counsel or other advisor; however, only the Appellant may present the case.
- All reports are submitted in confidence to the PGEAC.
- The PGEAC reaches decision by majority vote on a formal resolution in a closed session.
- A written report of the decision is supplied to the Appellant with five (5) working days of the conclusion of a hearing and must include:
    - the membership of the PGEAC,
    - the background of the appeal,
    - a summary of the case,
    - the findings of fact,
    - consideration of human rights issues, if applicable, the decision, recommendations (if any) and the reasons for the decision.

4.5.3.3 Level Three Appeal

A level three appeal may be made to the ACAC only after the RPC decision regarding dismissal has been ratified by the PGEAC and the Associate Dean PGE. An appeal of a decision of dismissal must be made to the ACAC only after a decision has been reached at the immediately preceding decision and/or level of appeal and communicated to the appellant.

All procedures and requirements for this procedure are found within the NOSM Policy Regarding Academic Appeals

With regards to a level three appeal, the decision of the ACAC is final and there is no further right of appeal.

4.5.4 Process

4.5.4.1 An ITER/ITAR that clearly indicates progress is not as expected or that there are significant concerns with performance in any domain

Level One Appeal Procedures – RPC and/or Evaluation/Assessment subcommittee of the RPC
An Appellant may submit in writing on the "PGE Request for Appeal Form" an appeal to the Postgraduate Office regarding any aspect of an ITER/ITAR that clearly indicates progress is not as expected or that there are significant concerns with performance in any domain

The PGE "Request for Appeal Form" must be received by the PGE Office via postgrad@nosm.ca within ten (10) working days from receipt of the assessment. The appeal request must outline:

a) the reasons the Appellant disagrees with the assessment,
b) the desired outcome,
c) the grounds for the appeal, and
d) any supporting documentation.

An Appellant may dispute process matters related to the accuracy of the rating, the fairness of the evaluation process, or raise compassionate or extenuating circumstances (including any circumstances related to a protected characteristic under the Ontario Human Rights Code).

If the rotation/educational experience occurred outside of the home discipline, the review will be conducted by the home Program Director and RPC and/or Evaluation/Assessment subcommittee of the RPC in consultation with the preceptor and potentially the NOSM Program Director of the relevant discipline.

The Program Director will table the request at the next RPC and/or Evaluation/Assessment subcommittee of the RPC meeting, giving the Appellant the opportunity to attend and provide an oral report. The Appellant may be accompanied by legal counsel or another advisor; however, only the Appellant may give the oral presentation.

The RPC and/or Evaluation/Assessment subcommittee of the RPC will review all relevant documentation and may request a follow up meeting with the clinical preceptor if deemed necessary before rendering a decision.

The RPC and/or Evaluation/Assessment subcommittee of the RPC will issue a decision in writing and copy the AD PGE within five (5) working days.

For a decision regarding 4.5.4.1: an ITER/ITAR that clearly indicates progress is not as expected or that there are significant concerns with performance in any domain, the decision of the RPC and/or Evaluation/Assessment subcommittee of the RPC is final and cannot be appealed to the next level two or three.

4.5.4.2 End of Rotation/Educational Experience ITER/ITAR with an Overall 'Fail' Designation or Leading to Remediation/Extension on the Basis of that Assessment

The Appellant shall first follow the level one appeal procedures to the RPC and/or Evaluation/Assessment subcommittee of the RPC as described in section 4.5.4.1.

Level Two Appeal Procedures – PGEAC
An appeal of an RPC and/or Evaluation/Assessment subcommittee of the RPC decision to uphold a failed ITER/ITAR decision to the PGEAC may be made on the following grounds:

a) the RPC and/or Evaluation/Assessment subcommittee of the RPC did not take into consideration relevant information when it reached a decision (including any information related to a

protected characteristic under the Ontario Human Rights Code), or

b) the Appellant was denied natural justice and/or the RPC failed to follow this policy and such failure could cast doubt on the validity of the decision.

The PGEAC cannot assess the accuracy of the clinical assessment but rather will judge whether the process followed by the RPC and/or Evaluation/Assessment subcommittee of the RPC was according to policy and supports the decision.

The Appellant must submit a PGE "Request for Appeal" form to the PGE Office via postgrad@nosm.ca within ten (10) working days of the issuance of the RPC's decision and include:

a) a copy of the ITER/ITAR and RPC decision,
b) the grounds for appeal and desired outcome, and
c) a statement supporting the grounds for appeal and any supporting documents.

The PGE Office shall forward the documentation to the Program Director who shall provide a written reply with relevant documentation within ten (10) working days of the filed appeal. A copy of the reply will be provided to the Appellant.

The Appellant and Program Director will be invited to attend the meeting of the PGEAC, along with any other appropriate individuals as determined by the PGEAC such as the preceptor who completed the ITER/ITAR.

The PGEAC will hear the appeal within ten (10) working days of the Program Director's reply to the Appellant.

The decision of the PGEAC shall:

a) state that there are no grounds for altering the decision of the RPC and/or Evaluation/Assessment subcommittee of the RPC and that the decision of the RPC and/or Evaluation/Assessment subcommittee of the RPC shall stand, or

b) grant the appeal if it is found that the RPC and/or Evaluation/Assessment subcommittee of the RPC 's decision cannot be supported by the information that was before the RPC and/or Evaluation/Assessment subcommittee of the RPC and direct that the ITER/ITAR be corrected, removed from file, or that there may be another evaluation of the Appellant

under such terms as the RPC and/or Evaluation/Assessment subcommittee of the RPC may require, or

c) grant the appeal if it is found that the RPC and/or Evaluation/Assessment subcommittee of the RPC 's decision did not take into account relevant information related to a protected characteristic under the Ontario Human Rights Code, and direct that the ITER/ITAR be corrected, removed from file, or that there may be another evaluation of the Appellant under such terms as the RPC and/or Evaluation/Assessment subcommittee of the RPC may require (including directing that appropriate accommodation be provided to the Appellant), or

d) grant the appeal if it was found that the Appellant was able to establish that:

i. there is evidence of a factual error or procedural irregularity in the consideration of the appeal at a previous level of decision; and/or

ii. that the previous body did not adhere to the principles of natural justice during the process.

Within five (5) working days of the conclusion of the hearing, the Chair of the PGEAC shall supply a written report of its decision to the Appellant, the Respondent, the AD PGE, the Dean of NOSM and to other individuals as the PGEAC deems appropriate and/or necessary.

4.5.4.3 RPC Decisions on Remedial Training and Probation
Appeals of these decisions are first heard at level two.

Level Two Appeal Procedures – PGEAC
The following decisions of the RPC may be appealed to the PGEAC:

a) that remedial training is required,
b) that probation is required,
c) the terms or content of the remediation or probation, and
d) that remediation was unsuccessful.

An Appellant may appeal the decision of the RPC to the PGEAC on the following grounds:

a) the RPC did not take into consideration relevant information when it reached a decision (including any information related to a protected characteristic under the Ontario Human Rights Code), or
b) the Appellant was denied natural justice and/or the RPC failed to follow this policy and such failure could cast doubt on the validity of the decision.

The Appellant must submit a PGE "Request for Appeal Form" to the PGE Office within (10) working days of the issuance of the RPC's decision and include:

a) a copy of relevant evaluations, remedial plan and the RPC decision,
b) the grounds for appeal and desired outcome, and
c) a statement supporting the grounds for appeal and any supporting documents.

The PGE Office shall forward the documentation to the Program Director who shall provide a written reply with relevant documentation within ten (10) working days of filing the appeal. A copy of the reply will be provided to the Appellant.

The Appellant and Program Director will be invited to attend the meeting of the PGEAC, along with any other appropriate individuals as determined by PGEAC.

The PGEAC will hear the appeal within ten (10) working days of the Program Director's reply to the Appellant.

The decision of the PGEAC shall:

a) state that there are no grounds for altering the decision of the RPC and that the decision of the RPC shall stand, or
b) grant the appeal if it is found that the RPC's decision cannot be supported by the information that was before the RPC and in the case of an appeal against a decision that remediation was unsuccessful, it may direct that an evaluation be corrected, removed from the file or that another evaluation of the Appellant be undertaken under such terms as RPC may require, or

c) grant the appeal if it is found that the RPC's decision did not take into account relevant information related to a protected characteristic under the Ontario Human Rights Code, and in the case of an appeal against a decision that remediation was unsuccessful, it may direct that an evaluation be corrected, removed from the file or that another evaluation of the Appellant be undertaken under such terms as RPC may require (including directing that appropriate accommodation be provided to the Appellant), or

d) grant the appeal if it was found that the Appellant was able to establish that:

   i. there is evidence of a factual error or procedural irregularity in the consideration of the appeal at a previous level of decision; and/or
   ii. that the previous body did not adhere to the principles of natural justice during the process

Within five (5) working days of the conclusion of the hearing the Chair of the PGEAC shall supply a written report of its decision to the Appellant, the Respondent, the AD PGE, the Dean of NOSM and to other individuals as the PGEAC deems appropriate and/or necessary.

4.5.4.4 Decision Not to Complete a FITER/CITER

Level One Appeal Procedures – AD PGE

If the Program Director refuses to complete a FITER or CITER certifying that an Appellant has acquired the competencies of the specialty, the Appellant may request a review of that decision by the AD PGE. Given the time-sensitive nature of completing a FITER or CITER, every effort is made to handle this in a timely fashion.

The Appellant must file a PGE "Request for an Appeal" form with the PGE Office via postgrad@nosm.ca within ten (10) working days of the issuance of the RPC's decision.

The AD PGE will meet with the Appellant to hear an oral submission and any additional documentation. The AD PGE will review all of the relevant documentation and may meet with the Program Director or other individuals as he/she deems necessary before making a decision.

The AD PGE will issue a decision in writing with reasons. If the AD PGE determines that the RPC decision was incorrect, he/she will refer the matter back to the RPC for reconsideration with recommendations.

If the AD PGE confirms the RPC decision, the Appellant may appeal the decision to the PGEAC on the following grounds:

a) the AD PGE did not take into consideration relevant information when he/she reached a decision (including any information related to a protected characteristic under the Ontario Human Rights Code),
b) the AD PGE's decision cannot be supported on the information before him/her at the time of the decision,
c) the Appellant was denied natural justice and/or the AD PGE failed to follow this policy and such failure could cast doubt on the validity of the decision.

Level Two Appeal Procedures – PGEAC

The Appellant must submit an appeal of the AD PGE's decision to the PGE Office via postgrad@nosm.ca on the PGE "Request for Appeal" form within ten (10) working days of the issuance of his/her decision and include:

a) a copy of the AD PGE's decision,
b) the grounds for appeal and desired outcome, and
c) a statement supporting the grounds for appeal and any supporting documents.

The PGE Office shall forward the documentation to the AD PGE who shall provide a written reply with relevant documentation within ten (10) working days of the filing the appeal. A copy of the reply will be provided to the Appellant.

The PGEAC will hear the appeal within ten (10) working days of the written reply to the Appellant.

The decision of the PGEAC shall:

a) state that there are no grounds for altering the decision of the AD PGE and that the decision of the AD PGE shall stand, or

b) grant the appeal if it is found that the AD PGE decision did not take into account relevant information related to a protected characteristic under the Ontario Human Rights Code, or
c) grant the appeal if it was found that the Appellant was able to establish that:

i. there is evidence of a factual error or procedural irregularity in the consideration of the appeal at a previous level of decision; and/or
ii. that the previous body did not adhere to the principles of natural justice during the process.

Within five (5) working days of the conclusion of the hearing the Chair of the PGEAC shall supply a written report of the decision to the Appellant, the Respondent, the AD PGE, the Dean of NOSM and to other individuals as the PGEAC deems appropriate and/or necessary.

4.5.4.5 Decision of Dismissal

Appeals of these decisions are first heard at level two.

Level Two Appeal Procedures – PGEAC

An Appellant may appeal a dismissal arising from an unsuccessful probation or decision made by the Residency Program Director, the RPC or the AD PGE to dismiss the Appellant to the PGEAC on the following grounds:

a) the Residency Program Director, the RPC or the AD PGE did not take into consideration relevant information when he/she reached a decision (including any information related to a protected characteristic under the Ontario Human Rights Code),
b) the Residency Program Director, the RPC or the AD PGE's decision cannot be supported on the information before him/her at the time of the decision, or
c) the Appellant was denied natural justice and/or the Residency Program Director, the RPC or the AD

PGE failed to follow this policy and such failure could cast doubt on the validity of the decision.

The Appellant must submit an appeal on the PGE "Request for Appeal" form within ten (10) working days of the issuance of the decision and include the following:

a) a copy of the relevant evaluations (as applicable),
b) a copy of the Residency Program Director, the RPC or the AD PGE's decision,
c) the grounds for appeal and outcome sought, and
d) a full statement supporting the grounds for appeal and any relevant documentation.

The PGE Office will forward copies of the appeal documentation to the AD PGE who will file a reply with relevant documentation within ten (10) working days of the filed appeal. A copy will be provided to the Appellant.

The Appellant, AD PGE and Program Director will be invited to attend the meeting of the PGEAC, along with any other appropriate individuals as determined by the PGEAC. The Appellant may be accompanied by a colleague or other individual of his/her choice.

The PGEAC will hear the appeal within ten (10) working days of the AD PGE's reply to the Appellant. An alternate chair to the AD PGE will be selected.

The decision of the PGEAC shall:

a) state that there are no grounds for altering the decision of the Residency Program Director, the RPC or the AD PGE and that the decision shall stand, or
b) grant the appeal if it is found that the Residency Program Director, the RPC or the AD PGE did not take into account relevant information related to a protected characteristic under the Ontario Human Rights Code, or
c) grant the appeal if it was found that the Appellant was able to establish that:

    i. there is evidence of a factual error or procedural irregularity in the consideration of the appeal at a previous level of decision; and

ii. that the previous body did not adhere to the principles of natural justice during the process.

d) In the case of dismissal based on an unsuccessful probation, it may direct that an evaluation(s) be removed, and/or that there be another evaluation(s) under such terms that the RPC may require.

e) In the case of dismissal by the Residency Program Director, the RPC or the AD PGE, it may reinstate the Appellant in the Program or reinstate with recommendation to the RPC for remediation or probation under such terms as the RPC may require (including directing that appropriate accommodation be provided to the Appellant).

Within five (5) working days of the conclusion of the hearing the Chair of the PGEAC shall supply a written report of the decision to the Appellant, the Respondent, the AD PGE, the Dean of NOSM and to other individuals as the PGEAC deems appropriate and/or necessary.

Level Three Appeal Procedures – ACAC

As outlined in section 4.5.3.3, an appeal of a decision of dismissal may be made to the ACAC only after a decision has been reached at the immediately preceding decision and/or level of appeal and communicated to the appellant. The preceding decision must be included in any appeal to the ACAC.

Pursuant to the NOSM Policy Regarding Academic Appeals, the Appellant must make a written submission requesting a hearing by the ACAC on the ACAC “Request for Appeal Form” to the Chair of the ACAC c/o the Secretary of the Academic Council within ten (10) working days of the Appellant’s receipt of the notice of decision at the previous level.

With regards to a level three appeal, the decision of the ACAC is final and there is no further right of appeal.

5.0 Related Documents

In support of this policy, the following [related policies/documents/companion/forms] are included:

- http://www.cpso.on.ca/Physicians/Your-Practice/Quality-in-Practice/CPGs-Other-Guidelines/Guidelines-for-College-Directed-Supervision
- http://www.cpso.on.ca/Physicians/Policies-Guidance/Policies
- https://www.policybase.cma/ca/documents/policypdf/PD06-02.pdf
- http://www.canera.ca/canrac/canrac/documents/general-standards-accreditation-for-residency-programs-e.pdf
- http://www.cfpc.ca/red_book_TOC/

6.0 Getting Help

Queries regarding interpretations of this document should be directed to:

Northern Ontario School of Medicine, Director of Postgraduate Education. (807) 766-7503.

DO NOT REMOVE THIS VERSION RECORD FROM THIS DOCUMENT		
Version	**Date**	**Authors/Comments**
1.0	2016 05 10	PGE Evaluation, Remediation, Probation, Suspension & Dismissal, and Appeals Policies amalgamated into one sequential policy document entitled Postgraduate Education Policy and Procedures for the Evaluation of Resident Performance.
2.0	2017 07 13	Full review and revision of policy. Approved by PGEC.

Northern Ontario School of Medicine
Postgraduate Education (PGE)
ENHANCED LEARNING PLAN

Resident Name:

PGY Level:

Preceptor/Mentor Name:

Please provide details on the areas of weaknesses that will be focused on during the enhanced learning plan:

MEDICAL EXPERT:

Detailed Plan to Address Weaknesses: (must include competencies to be achieved, learning strategies and assessment strategies including timing)

COMMUNICATOR:

Detailed Plan to Address Weaknesses: (must include competencies to be achieved, learning strategies and assessment strategies including timing)

COLLABORATOR:

Detailed Plan to Address Weaknesses: (must include competencies to be achieved, learning strategies and assessment strategies including timing)

LEADER:

Detailed Plan to Address Weaknesses: (must include competencies to be achieved, learning strategies and assessment strategies including timing)

HEALTH ADVOCATE:

Detailed Plan to Address Weaknesses: (must include competencies to be achieved, learning strategies and assessment strategies including timing)

SCHOLAR:

Detailed Plan to Address Weaknesses: (must include competencies to be achieved, learning strategies and assessment strategies including timing)

PROFESSIONAL:

Detailed Plan to Address Weaknesses: (must include competencies to be achieved, learning strategies and assessment strategies including timing)

Please provide meeting details to ensure follow-up is occurring:

DATE	TIME	PRECEPTOR/MENTOR	LOCATION

Once each meeting has occurred, please complete the Meeting Log (provided).

Resident Signature: _____ Date: _____

Preceptor/Mentor Signature: _____ Date: _____

Northern Ontario School of Medicine
Postgraduate Education (PGE)
ENHANCED LEARNING PLAN
MEETING LOG

Date	Time	Preceptor/Mentor	Location	Comments	Preceptor Initials

TO BE COMPLETED ONCE THE LEARNING PLAN HAS ENDED

The residents has successfully completed the Enhanced Learning plan: ☐ YES ☐ NO

*If no, please provide additional details and plan of action:

Comments :

Resident Signature: Date:

Preceptor/Mentor Signature: Date:

Northern Ontario School of Medicine
Postgraduate Education (PGE)
Plan for Extension of Training

This extension has been recommended by the Residency Program Committee (RPC) and the decision to extend has been ratified by the Associate Dean, PGE. The plan for the period is described below; it has been proposed by the RPC and discussed with the resident.

Section A: RESIDENT INFORMATION

Resident Name	
Program	
PG Level	

Section B: DETAILS DELINEATING THE REASONS FOR THIS EXTENSION OF TRAINING

The decision was based on the following sources of information: (check all that apply and include copies or a summary of all documents with the exception of ITERs available in One45)

ITERs/ITARs	
OSCE's	
Multi-source Feedback	
Standardized Exams	
Direct Observation	
Other (please specify): _____	

The resident's strengths include:	

Northern Ontario School of Medicine
Postgraduate Education (PGE) Plan for Extension of Training

The resident's weaknesses include:	

Please provide details of how the RPC came to the decision for the need for an extension of training:

Were there any issues involving the educational environment (including but not limited to workload, complexity of cases, level of responsibility, lack of orientation) and/or teaching faculty (including but not limited to inappropriate or unclear expectations, supervision, lack of feedback or personal perceptions) that may have affected the resident's performance?

Yes	
No	

If yes, describe how these will be addressed during this period:

Were there any issues involving the resident's personal wellbeing that may have affected the resident's performance?

Yes	
No	

If yes, describe how these will be addressed during this period:

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Postgraduate Education (PGE) Plan for Extension of Training

Section C: DURATION OF THE EXTENDED PERIOD OF TRAINING and SUPERVISION

Proposed start date	
Proposed end date	
Primary Supervisor	
Contact Information	

The primary supervisor will ensure that the activities and assessments are carried out as planned, and is responsible for submitting the results of those assessments to the Residency Program Committee. The RPC will decide the results and outcome of the period.

Section D: ACTIVITIES TO BE UNDERTAKEN BY THE RESIDENT DURING THE EXTENSION OF TRAINING PERIOD

Complete the table below linking a specified area for improvement (learning issue) with a learning objective. Document the method by which the trainee will achieve the objective (the learning strategy) along with the assessment methods, frequency, timing and expectations that will be used to evaluate whether the resident has achieved the objectives (the expected outcome). The learning strategy and expected outcomes should be SMART (example provided in italics)

Specific – are there specific steps and plans on how to accomplish each step?
Measurable – are there measureable outcomes?
Accountable – is the plan linked to the issues that were identified?
Realistic – is it realistic for the resident and program to carry out this plan? Timeline – does the plan outline a timeline?

Northern Ontario School of Medicine
Postgraduate Education (PGE) Plan for Extension of Training

Identified Learning Issues List specific performance issue, include CanMEDs role and/or personal issue	**Learning Objective**	**Learning Strategies** Include strategy, frequency, individual responsible	**Outcome Expected** State planned assessment method(s), frequency, timing and performance standard to be used to evaluate outcome
EXAMPLE: Completion of Dictations (Communicator/Manager)	*EXAMPLE: To complete dictations for all patients seen in clinic and on the ward in a timely manner.*	*EXAMPLE : Dr. R should expect to spend time after a clinic completing dictations. All faculty members will keep track of patients seen by Dr. R Has a dictation been completed? Y / N*	*EXAMPLE: Dictations must be completed within 48 hours of the patient encounter/discharge. It is expected that this objective be met at the beginning of the period and continue to be met throughout.*

Northern Ontario School of Medicine
Postgraduate Education (PGE) Plan for Extension of Training

Based on the above, the trainee's activities during the period, including the location and identified supervisor(s), are listed below:

(examples provided in italics)

Block #	Activity (eg. rotation or specific reason)	Location	Supervisor
3	*General Pediatrics*	*TBRHSC*	*Dr Renal*
3-6	*Weekly Professionalism sessions*	*NOSM West Campus*	*Ms English*
4	*Cardiology ward*	*General*	*Dr Heart*

If this plan requires rotations outside of the resident's program, please indicate that it was discussed with the respective program's Program Director by checking here: ☐

****Additional charts available at the end of this form if more space needed**

Northern Ontario School of Medicine
Postgraduate Education (PGE) Plan for Extension of Training

Section E: "POTENTIAL OUTCOMES OF THIS EXTENSION OF TRAINING PERIOD"

Upon completion of this extension of training period, the Residency Program Committee will review the resident's performance and complete Final Outcome: Extension of Training Period form. Potential outcomes of this period are guided by the PGE Policy and Procedures for the Evaluation of Residents and include:

Successful achievement of expected outcomes	☐
A further period of extra education activities	☐
An additional extension of training	☐
A period of remediation	☐
Other (please specify): _____	☐

The Residency Program Committee's decision will be based on the achievement of the expected outcomes stated in the table above.

Northern Ontario School of Medicine
Postgraduate Education (PGE) Plan for Extension of Training

Section F: SIGNATURES

These concerns were discussed with the resident at a meeting held with him/her on _____

Program Director

Signature of Program Director	Print Name	Date (on behalf of the RPC)

Resident

I acknowledge that these concerns about my performance have been discussed with me. By signing this document, I am still able to disagree with or appeal this decision.

Signature of Resident	Print Name	Date

Check this box if resident refused to sign: ☐

Primary Supervisor

In signing this document, I am indicating that I understand the nature and structure of this period of extra educational activities and am agreeing to provide and/or oversee the described supervision and assessment.

Signature of Primary Supervisor	Print Name	Date

Associate Dean, PGE

This document has been reviewed and ratified by the Associate Dean, PGE

Signature of Associate Dean, Postgraduate Education Northern Ontario School of Medicine	Print Name	Date

Comments	

Northern Ontario School of Medicine
Postgraduate Education (PGE) Plan for Extension of Training

Identified Learning Issues List specific performance issue, include CanMEDs role and/or personal issue	**Learning Objective**	**Learning Strategies** Include strategy, frequency, individual responsible	**Outcome Expected** State planned assessment method(s), frequency, timing and performance standard to be used to evaluate outcome

Northern Ontario School of Medicine
Postgraduate Education (PGE) Plan for Extension of Training

Block #	Activity (eg. rotation or specific reason)	Location	Supervisor

Northern Ontario School of Medicine Postgraduate Education (PGE) Resident Remediation Plan

This remediation plan **must** be completed for every resident on remediation at NOSM, prior to the start of each period of remediation. The arrangements described in this plan are subject to the policy entitled: Postgraduate Education Policy and Procedures for the Evaluation of Residents. It is recommended that any resident needing remediation should have access to a mentor who is not involved in the resident's direct assessment, and that all needed support be provided to the resident.

By signing this document (last page), the resident indicates that he/she understands the nature and structure of the remedial period. This does not in any way preclude the resident from pursuing an appeal of the decision for remediation, according to the Postgraduate Appeals Process.

Remediation cannot begin prior to Associate Dean's approval of the Remediation Plan

☐ As part of developing the remediation plan, the Program Director or designate has offered the resident a meeting with the Wellness Lead and/or a member of the EAB board to ensure a comprehensive understanding of all potential contributing factors

☐ The plan was reviewed by the EAB before finalized

1. The plan **must** be developed under the authority of the Program Director or designate in consultation with the resident.
2. All sections of the plan **must** be completed.
3. The plan **must** be reviewed by the EAB.
4. The plan **must** be signed by the Program Director, Resident, and Associate Dean of PGE.
5. The plan **must** be approved by the RPC or designated subcommittee.

Section A: RESIDENT INFORMATION & PROJECTED TIMEFRAME

The following resident requires a remedial rotation/educational experience:

Resident Name	
Program	
PG Level	
Remediation start date	
Projected remediation end date *Note: Remediation period may be extended if progress is being made but competencies have not been fully achieved*	

Northern Ontario School of Medicine
Postgraduate Education (PGE) Resident Remediation Plan

Section B: REMEDIATION COACH AND/OR SUPERVISOR INFORMATION (with timelines)

Remediation Coach

The physician, or other qualified person, who enters into a formal, structured, and confidential relationship with a resident as a longitudinal partnership. A coach provides formative feedback to the resident.

Name	

Contact Information	

During the remedial period, the remedial coach agrees to meet with the resident regularly to focus on developing the identified knowledge, skills, and competencies as outlined in this remediation plan.

Brief outline of coaching plan	

Number of sessions	

Duration of sessions	

Other details	

Northern Ontario School of Medicine
Postgraduate Education (PGE) Resident Remediation Plan

Remediation Supervisor

The physician who is directly responsible for supervising a resident in a clinical setting during the remedial period.

Name	

Contact Information	

Format of remediation period:

Block	
Longitudinal	

During the remedial period, the Remedial Supervisor agrees to:

1. Provide supervision of the resident during the remedial period from:

Start date	
End date	

2. On a ◯ weekly ◯ bi-weekly basis:

   a) Meet with the resident to review and discuss progress in attaining the objectives of the remedial rotation

   b) Keep record of the meetings and submit a weekly report to the resident's program director

   c) Send an email summary to the resident following each session, outlining:

      i) the goals and objectives for the meeting

      ii) areas that still require ongoing work

      iii) the plan that was discussed for the next meeting

3. Help the resident in achieving the objectives of remediation by (*check all that apply*):

Clarifying the difficulties the resident is having with knowledge base	
Providing extra teaching in clinical matters	
Providing supervision and training in procedural skills	
Coaching to address unprofessional behaviour and address issues related to negative attitude and lack of insight	

Directing the resident to other specific sources of information on teaching	
Assessing the resident by means of: _____	
Other: _____	

4. Attest at the end of the remedial period whether the resident has or has not met the objectives of the period of remediation and achieved the required competencies.

Section C: REASONS FOR THE REMEDIATION

Please indicate which CanMEDS roles are being remediated:

Medical Expert	
Communicator	
Collaborator	
Leader	
Health Advocate	
Scholar	
Professional	

Please outline all background information and describe in details the aspects of the Resident's performance or behaviour that requires remedial attention (e.g. knowledge, skills, attitudes).

Please include a copy of any comprehensive assessments completed by the Program Director and the letter form the RPC recommending a remedial program.

Northern Ontario School of Medicine
Postgraduate Education (PGE) Resident Remediation Plan

Section D: GOALS AND OBJECTIVES

For each area of concern please list and describe specific goals and objectives, expected behaviours or performance changes that **must** be achieved by the end ofthe remediation period). During the remediation period, the Remediation Supervisor may identify a competency that was not identified in the Remediation Program Plan and that is deemed significant to address for the purpose of this Remediation. The Remediation Supervisor must discuss this competency with the resident and identify it as an objective for the Period of Remediation. This should be documented and appended to the original document.

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Postgraduate Education (PGE) Resident Remediation Plan

Section E: LEARNING STRATEGIES

List and describe in detail the strategies that will be used to address each of the areas of concern e.g. simulation and direct observation, reflective exercises, role appreciation, journaling.

Section F: ASSESSMENT AND EVALUATION

Describe what measures, tools and resources will be used to ensure that the goals, objectives and competencies have been met.

Northern Ontario School of Medicine
Postgraduate Education (PGE) Resident Remediation Plan

Section G: MONITORING OF PROGRESS DURING REMEDIATION

Describe how progress towards achieving the necessary competencies will be assessed and documented - the frequency and form of the meetings and feedback given to the resident; provide a meeting schedule.

Section H: STATEMENT AS TO THE CONSEQUENCES OF REMEDIATION

Upon completion of the remediation period, the following outcomes may occur, as determined by the Residency Program Director, in consultation with the Residency Program Committee, depending on the resident's performance: (*Check all possible outcomes*)

Reinstatement as a resident in the program with no loss of time or extension of training	
Reinstatement as a resident, with training extended as recommended by the Program Director and the Residency Program Committee based on time lost due to unsatisfactory performance	
An additional period of remediation	
Placed on probation	
Other: _____	

Northern Ontario School of Medicine
Postgraduate Education (PGE) Resident Remediation Plan

Section I: SIGNATURES

By signing this document, the resident indicates that he/she understands the nature and structure of the remedial period. This does not in any way, preclude the resident from pursuing an appeal of the decision for remediation, according to the Postgraduate Appeals Process. An appeal must be submitted in writing to the Postgraduate Education Director.

Please note: residents who have completed or are now completing, any post graduate remedial training in Ontario for deficiencies or issues relating to professionalism, professional conduct, professional attitudes, interpersonal skills or communication skills are required to self-disclose this information during the annual CPSO re-application process.

Resident

Signature of Resident	Print Name	Date

Remedial Supervisor

Signature of Remedial Supervisor	Print Name	Date

Remedial Coach

Signature of Remedial Coach	Print Name	Date

Remedial Program Director

Signature of Program Director	Print Name	Date

Associate Dean, PGE

This document has been reviewed and ratified by the Associate Dean, PGE

Signature of Associate Dean, Postgraduate Education Northern Ontario School of Medicine	Print Name	Date

Northern Ontario School of Medicine
Postgraduate Education (PGE)
Resident Probation Plan

This probation plan **must** be completed for every resident on probation at NOSM, prior to the start of the probation period. The arrangements described in this plan are subject to the policy entitled: Postgraduate Education Policy and Procedures for the Evaluation of Residents and the Probation Policy. It is recommended that any resident needing probation should have access to a mentor who is not involved in the resident's direct assessment, and that all needed support be provided to the resident.

By signing this document (last page), the resident indicates that he/she understands the nature and structure of the probation period. This does not in any way preclude the resident from pursuing an appeal of the decision for remediation, according to the Postgraduate Appeals Process. An appeal must be submitted in writing to the Program Director.

Probation cannot begin prior to Associate Dean's approval of the Probation Plan

☐ The plan was reviewed by the EAB before finalized

General Instructions:

1. The Program Director or designate **must** meet with the resident and conduct a structured comprehensive assessment prior to completing the form.
2. The plan **must** be completed by the Program Director or designate in collaboration with the resident.
3. All sections of the plan **must** be completed.
4. The plan **must** be reviewed by the EAB.
5. The plan **must** be signed by the Program Director, Resident, and Associate Dean of PGE.
6. The plan **must** be approved by the RPC.

Section A: RESIDENT INFORMATION & PROJECTED TIMEFRAME

The following resident requires a remedial rotation/educational experience:

Resident Name	
Program	
PG Level	
Probation start date	
Projected probation end date	
Probation Location	

Northern Ontario School of Medicine
Postgraduate Education (PGE) Resident Probation Plan

Section B: PROBATION COACH AND/OR SUPERVISOR INFORMATION (with timelines)

Probation Coach

The physician, or other qualified person, who enters into a formal, structured, and confidential relationship with a resident as a longitudinal partnership. A coach provides formative feedback to the resident.

Name	

Contact Information	

During the probation period, the coach agrees to meet with the resident regularly to focus on developing the identified knowledge, skills, and competencies as outlined in this probation plan.

Brief outline of coaching plan	

Number of sessions	

Duration of sessions	

Other details	

Northern Ontario School of Medicine
Postgraduate Education (PGE) Resident Probation Plan

Probation Supervisor

The physician who is directly responsible for supervising a resident in a clinical setting during the probation period.

Name	

Contact Information	

Format of probation period:

Block	
Other	

During the probation period, the Probation Supervisor agrees to:

1. Provide supervision of the resident during the probation period from:

Start date	
End date	

2. On a [] weekly [] bi-weekly basis:

   a) Meet with the resident to review and discuss progress in attaining the objectives of the probation period

   b) Keep record of the meetings and submit a weekly/bi-weekly report to the resident's program director

   c) Send an email summary to the resident following each session, outlining:

      i) the goals and objectives for the meeting

      ii) areas that still require ongoing work

      iii) the plan that was discussed for the next meeting

3. Help the resident in achieving the objectives of probation by (*check all that apply*):

Clarifying the difficulties the resident is having with knowledge base		
Providing extra teaching in clinical matters		
Providing supervision and training in procedural skills		
Coaching to address unprofessional behaviour and address issues related to negative attitude and lack of insight		

Directing the resident to other specific sources of information on teaching		
Assessing the resident by means of: _____		
Other: _____		

4. Attest at the end of the probation period whether the resident has or has not met the objectives of the period of probation and achieved the required competencies.

Section C: REASONS FOR THE PROBATION

The reasons for being placed on probation are (check off all applicable points):

Unsatisfactory evaluations in a remedial rotation	
An unsuccessful remediation program	
Two remediation periods in a twelve month time frame, regardless of whether the first has been successful	
Issues related to lack of professionalism, collaboration and/or communication skills	
A continued pattern of unsubstantiated absence from the program	

Please indicate which CanMEDS roles are being remediated:

Medical Expert	
Communicator	
Collaborator	
Leader	
Health Advocate	
Scholar	
Professional	

Northern Ontario School of Medicine
Postgraduate Education (PGE) Resident Probation Plan

Please outline all background information and describe in details the aspects of the Resident's performance or behaviour that have led to the decision to place the resident on probation (e.g. knowledge, skills, attitudes).

Please include a copy of any comprehensive assessments completed by the Program Director and the letter form the RPC recommending a probation program.

Section D: GOALS AND OBJECTIVES

For each area of concern please list and describe specific goals and objectives, expected behaviours or performance changes that **must** be achieved by the end ofthe probation period). During the probation period, the Probation Supervisor may identify a competency that was not identified in the Probation Program Plan and that is deemed significant to address for the purpose of this Remediation. The Probation Supervisor must discuss this competency with the resident and identify it as an objective for the Period of Remediation. This should be documented and appended to the original document.

Northern Ontario School of Medicine
Postgraduate Education (PGE) Resident Probation Plan

Section E: LEARNING STRATEGIES

List and describe in detail the strategies that will be used to address each of the areas of concern e.g. simulation and direct observation, reflective exercises, role appreciation, journaling.

Section F: ASSESSMENT AND EVALUATION

Describe what measures, tools and resources will be used to ensure that the goals, objectives and competencies have been met. Please note that the resident must be assessed, in writing, weekly during the probation period.

Northern Ontario School of Medicine
Postgraduate Education (PGE) Resident Probation Plan

Section G: MONITORING OF PROGRESS DURING PROBATION

Describe how progress towards achieving the necessary competencies will be assessed and documented - the frequency and form of the meetings and feedback given to the resident; provide a meeting schedule.

Section H: OUTLINE OF ALL SUSPENDED PROGRAM REQUIRMENTS

A resident who is on probation is expected to focus their learning on the identified objectives/competencies to be achieved during the probation period. To that end, other program requirements will be suspended during the probation period, as listed below:

Northern Ontario School of Medicine
Postgraduate Education (PGE) Resident Probation Plan

Section I: STATEMENT AS TO THE CONSEQUENCES OF PROBATION

Upon completion of the probation period, the following outcomes may occur, as determined by the Residency Program Director, in consultation with the Residency Program Committee, depending on the resident's performance: (*Check all possible outcomes*)

Reinstatement as a resident, with training extended as recommended by the Program Director and the Residency Program Committee based on time lost due to unsatisfactory performance	
Dismissal from the program	
Other: _____	

Section J: EXPECTED PLAN UPON RETURN IF PROBATION SUCCESSFUL

Northern Ontario School of Medicine
Postgraduate Education (PGE) Resident Probation Plan

Section K: SIGNATURES

By signing this document, the resident indicates that he/she understands the nature and structure of the probation period. This does not in any way, preclude the resident from pursuing an appeal of the decision for probation, according to the Postgraduate Appeals Process. An appeal must be submitted in writing to the Postgraduate Education Director.

Please note: residents who have completed or are now completing, any post graduate remedial training in Ontario for deficiencies or issues relating to professionalism, professional conduct, professional attitudes, interpersonal skills or communication skills are required to self-disclose this information during the annual CPSO re-application process.

Resident

Signature of Resident	Print Name	Date

Remedial Supervisor

Signature of Remedial Supervisor	Print Name	Date

Remedial Coach

Signature of Remedial Coach	Print Name	Date

Remedial Program Director

Signature of Program Director	Print Name	Date

Associate Dean, PGE

This document has been reviewed and ratified by the Associate Dean, PGE

Signature of Associate Dean, Postgraduate Education Northern Ontario School of Medicine	Print Name	Date

Northern Ontario School of Medicine
Postgraduate Education (PGE)
Request For Appeal Form

A request for an appeal must be made on the "PGE Request for Appeal Form" to the Postgraduate Education Office of the Northern Ontario School of Medicine (NOSM) in accordance to the procedures in the Postgraduate Education Policy and Procedures for the Evaluation of Resident Performance. All communication to the resident (appellant) related to the appeal shall only be sent to his/her NOSM email account.

Section A: Resident Information

Name	
Program	
NOSM email account	
Local Address	
Telephone Number	
Permanent Address	
Cell phone number	

I have read and understood the NOSM Postgraduate Education Appeals Policy.

Printed Name	
Signature	
Date	

The appeal will only be heard for the reasons stated below and if the resident has followed the levels and steps of the appeal process.

Please ensure that you provide all the information requested below as part of your appeal.

Northern Ontario School of Medicine
Postgraduate Education (PGE) Request For Appeal Form

The Chair of the PGEAC may in his/her discretion request and introduce any evidence he/she deems relevant.

Section B: Categories for an appeal

Please check below the category of decision being appealed.

☐	Any aspect of an ITER/ITAR that clearly indicates progress is not as expected or that there are significant concerns with performance in any domain.
☐	An end of rotation/educational experience ITER/ITAR designated overall as a "Fail" or leading to remediation/extension on the basis of that assessment.
☐	An RPC decision that remedial training or probation is required, the content or terms of the remediation or probation, or that remediation was unsuccessful.
☐	A Program Director decision not to complete a Final In-Training Evaluation Report (FITER) or Core In-Training Evaluation Report (CITER) where the Program Director indicates that he/she **cannot** certify that the resident has acquired the competencies of the program.
☐	A decision by the Residency Program Director and/or the AD PGE to dismiss a resident.

Section C: Reasons for the appeal

Please identify your reasons for disagreeing with the assessment:

Section D: Desired Outcome

Please state briefly the desired outcome of the appeal:

Northern Ontario School of Medicine
Postgraduate Education (PGE) Request For Appeal Form

Section E: Grounds for Appeal

Please check below the appropriate grounds for appeal:

	Relevant information was not considered.
	Evidence of a factual error or procedural irregularity in the consideration of the appeal at a previous level of appeal.
	Evidence that one or more of the principles of natural justice has been violated at a previous level of appeal.

Please provide a brief, reasoned argument in support of each of the grounds that you are claiming for your appeal (copy below or attach to this form).

Section F: Supporting Argument/Documentation

1. Summarize the evidence which you are prepared to offer in support of your grounds for appeal. You may attach any documents that you feel would support your appeal (examples may include copies of ITERs/ITARs, RPC decision, PGE Office correspondence, medical documentation etc):

2. The Appellant must present his/her own appeal. In addition, the Appellant may have one support person or legal counsel present during the appeal. Only the Appellant can present the appeal. Please list below the individual who you will be calling upon or who will be present during the appeal.

Name	Title

Northern Ontario School of Medicine
Postgraduate Education (PGE) Request For Appeal Form

The PGE Director will contact the Appellant within 10 working days of receipt of the appeal to confirm receipt of the appeal and next steps and to provide a date for a PGEAC appeals meeting and any additional information at that time.

RETURN completed form to:

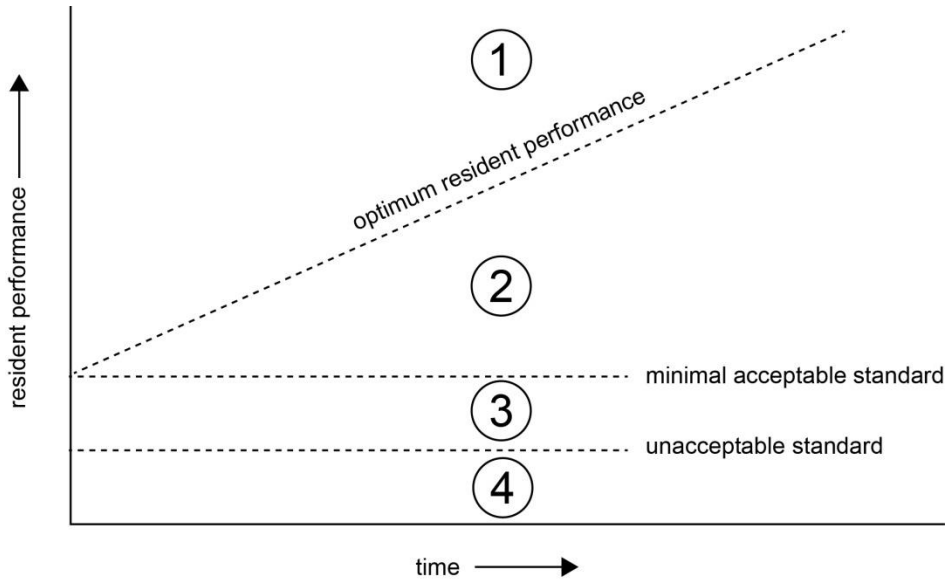
Director, PGE
Northern Ontario School of Medicine
955 Oliver Road, Thunder Bay P7G 1E3
Telephone 807-766-7503

Email: postgrad@nosm.ca

Appendix F- Four Zone Model

Structure when remediation is triggered

We can consider a four-zone model of resident performance (applying to whole programs and individual blocks within a program) and the different steps that are taken depending on how they perform over time:



Zone 1: resident performs at or above expected levels – **no additional action**

Zone 2: resident performs below expected levels but above minimal standards – **coaching required and instituted**

Zone 3: resident performs below minimal standards but above unacceptable standards – **remediation.** Note that failing one remediation will not normally lead to dismissal but there should be a cumulative threshold for the number of unsuccessful remediations that would lead to probation and dismissal.

Zone 4: resident performs below unacceptable standards – **dismissal**

We can further tabulate steps and actions related to this model as follows:

Zone	*Description*	*Moving down*	*Moving up*
1 On target	Performs/behaves and progresses at, around, or above expectations for stage of training	If below expectations but above minimal standard then to coaching	Successfully completes training
2 Coaching	Below expectations for stage of training but not below minimal acceptable standards	Falls below minimal standards for completing coaching	Successfully completes coaching
3 Remediation	Below minimal acceptable standards	Fails to successfully complete remediation	Successfully completes remediation
4 Exclusion	Failed to meet minimal	Dismissal from the	Once dismissed there is

	standards after remediation or in certain circumstances without a remediation step	program	no re-entry

Situating Remediation: Accommodating Success and Failure in Medical Education Systems

Rachel H. Ellaway, PhD, Calvin L. Chou, MD, PhD, and Adina L. Kalet, MD, MPH

Abstract

There has been a widespread shift to competency-based medical education (CBME) in the United States and Canada. Much of the CBME discourse has focused on the successful learner, with relatively little attention paid to what happens in CBME systems when learners stumble or fail. Emerging issues, such as the well-documented problem of "failure to fail" and concerns about litigious learners, have highlighted a need for well-defined and integrated frameworks to support and guide strategic approaches to the remediation of struggling medical learners.

This Perspective sets out a conceptual review of current practices and an argument for a holistic approach to remediation in the context of their parent medical education systems. The authors propose parameters for integrating remediation into CBME and describe a model based on five zones of practice along with the rules of engagement associated with each zone. The zones are "normal" curriculum, corrective action, remediation, probation, and exclusion.

The authors argue that, by linking and integrating theory and practice in remediation with CBME, a more integrated systems-level response to differing degrees of learner difficulty and failure can be developed. The proposed model demonstrates how educational practice in different zones is based on different rules, roles, responsibilities, and thresholds for moving between zones. A model such as this can help medical educators and medical education leaders take a more integrated approach to learners' failures as well as their successes by being more explicit about the rules of engagement that apply in different circumstances across the competency continuum.

There is growing attention being paid to the design and operations of medical education programs from a systems perspective. In the United States and Canada, this is reflected in the widespread shift to competency-based medical education (CBME), a system of methods and principles around which medical education programs can be constructed.[1] The adoption of CBME has focused on conducting more and higher-quality assessments, which has highlighted the need for integrated strategies to remediate struggling medical learners.[2] However, remediation practices appear to take place with little attention to broader consequences of the changes to medical education practice associated with CBME.

In this Perspective, we propose parameters for integrating remediation into CBME programs. We describe a model of zones of remediation, whose thresholds are defined by expected milestones of acceptable performance, and the potential rules of engagement for each zone. We present a manifesto for a systems-level approach to integrating emerging models of CBME and remediation. In doing so, we situate remediation as a critical connection between CBME and medical education's social contract, based on the principle that moral and effective medical education systems should encompass medical education's obligations to society, resist the argument that learners are entitled to graduate simply on the basis of their personal investment in training, and provide honorable and compassionate exit strategies for learners who are unable to complete their training. A glossary of terms used in this article is provided in Appendix 1.

Remediation in Medical Education

Remediation in medical education has been defined as "the act of facilitating a correction for trainees who started out on the journey toward becoming a physician but have moved off course."[3(p.xvii)] Medical learners underperform for a wide range of reasons,[4] which can prove challenging for all concerned. Remediation of struggling learners takes different forms according to the particular problems involved, as well as the learners, the faculty who act as their remediators, and the learning contexts in which this takes place. Generally, remediation involves (1) identifying the need or deficit to be addressed; (2) framing it in terms of required learning or performance goals; (3) developing and executing a series of defined and officially sanctioned episodes of additional training and monitoring; and (4) concluding with an assessment of whether the learner has met the predetermined remediation goals.[1,5,6]

Remediation is (or should be) a focused, time-limited, and highly structured

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series of episodes within which specific performance deficits must be addressed to the satisfaction of one or more supervisors. Remediation as an undertaking is therefore both reactive and adaptive; it is invoked only when individual learners are at risk of failing, with each instance focusing on the particular issues with which the learner is struggling. Remediation is also a liminal undertaking. It sits outside "mainstream" medical education because a learner's trajectory may be suspended while the learner is being remediated, or the remediation activity may continue in parallel with the learner's "normal" studies. Either way, remediation is not the same as regular training: It is more specific, intense, and focused, and the stakes are higher than usual. The learner must unambiguously and reliably demonstrate the required performance improvements to avoid further sanctions. To successfully complete remediation is to be rehabilitated back into "normal" training; to fail is to face probation or exclusion from the program.

Most learners undergo little or no remediation as they progress through their training, but those who do require a disproportionate amount of faculty and administrative time and resources.[7] Indeed, a common complaint amongst medical education program leaders is that they spend much of their time helping relatively small numbers of struggling learners. Despite this perception, remediation has been somewhat neglected in the medical education literature to date.[8] Existing work has tended to focus on what should happen within an episode of remediation, rather than on how remediation should or can interdigitate with the rest of medical education.[1,9]

Clearly, there are intersections between remediation and the rest of medical education. We therefore need to situate remediation in the broader context of medical education systems, not just to guide remediation practices but also to address issues of constructive alignment, the hidden curricula of remediation, the transparency and consistency of remediation rules and processes, and the impact of remediation on medical education as a whole.

As educators, we see the costs of failure for learners (time, fees, reputation, stress), their teachers (time, stress), and their programs (coverage, survivor guilt). The difficulties associated with failing learners have led to a chronic "failure to fail" phenomenon,[10] where substandard learners are allowed to progress through their training and even into practice because the effort not to allow them to do so is greater than most medical education systems are able to muster.[10,11] The failure of the medical education system in this regard becomes a health care system problem. Although "failure to fail" is a worldwide and multidisciplinary problem,[12] it seems particularly relevant to the more individualist cultures of Canada and the United States, which have low rates of attrition from medical training. The international rate of attrition for undergraduate medical education programs has been estimated at around 11%,[13] but the rate is far lower in the United States (3.4%)[14] and an order of magnitude lower still in Canada (0.4%).[15] The rapidly increasing cost of medical education to learners in the United States and Canada also seems to have encouraged a sense of entitlement to complete training, exacerbated by institutional concerns regarding the legal implications of dismissing a learner, the reality of heavy financial debt, and a lack of satisfying and reasonable alternatives to the medical profession for individuals who are unable to complete their training.

A Zone-Based Model of Remediation

We can describe normative medical education practice in terms of two intertwined subsystems: one focused on success and completion, the other focused on failure and exclusion. Each has different rules and practices, and each has its own literature and evidence base.[9,16–18] We can consider remediation as a bridge between these two subsystems: It functions as both an interface and a distinct rule-bound subsystem in its own right. Key differences between the three subsystems are set out in Table 1.

We propose reframing these differences in terms of five zones of practice. Zones 1 and 2 reflect the success subsystem. In Zone 1, the learner is performing at or above expected levels, and teaching is focused on supporting the learner's continued progression toward independent practice. In Zone 2, the learner is performing below expected levels (although not egregiously so), and teaching is intrinsically corrective to enable the learner to return to Zone 1. In Zone 3, the remediation subsystem, the learner is performing below an acceptable minimal standard and is undergoing active remediation; the learner must exit to either the success or failure subsystem. Finally, the failure subsystem is divided into Zones 4 and 5. In Zone 4, the learner has consistently been performing below an acceptable standard and is either suspended, placed on probation, or required to retake a component of the program. In Zone 5, the learner is excluded from the program. Compared with the rules in Zones 1–3, the rules in Zone 4 tend to be more austere, because the learner explicitly participates less in regular programmatic activities and there is a very real possibility of exclusion. Zone 4, like Zone 3, is temporary and must resolve up or down. The rules in Zone 5 are about how to exclude a learner from a program—this may be a brief phase if the exclusion is unchallenged, but it is often drawn out if appeals are involved. These zones along with exemplar learner trajectories are illustrated in Figure 1 and in the vignette in Box 1.

Although a model based on horizontal zone thresholds (as set out in Figure 1) will suffice for relatively short educational episodes, professional training clearly requires a progression toward practice with expected levels of performance rising over time. This reflects one of the core tenets of CBME,[16,19] where a learner's performance is assessed by comparing it with that expected of a generic learner at the same stage of training.[20] Extending this principle to our proposed model, we can remap the thresholds between zones as rising over time (Figure 2). A key consequence of this model is that a learner's performance need not fall in absolute terms for the learner to begin to struggle or fail: Nonprogression within expected parameters can lead to remediation or even exclusion.

We have presented our thesis in terms of an abstract model to demonstrate the principles it embodies. In practice, thresholds between zones would be marked by exams, assignments, clinical skills milestones, or equivalent reference points of expected performance. As such, definitions of the zones would need to be more detailed, the relative sizes of zones may differ, and the thresholds are unlikely to be as linear or parallel as we have

Table 1

General Principles of the Success, Remediation, and Failure Subsystems of Medical Education: Their Rules, Signature Practices, and Learner Entrances and Exits

Subsystem	Rules	Practices	Entrances and exits
Success	• Focus is on progression through or completion of phases of professional training and development. Stages and events are defined in terms of the default curriculum. • Assessment focuses on demonstrating progression within or completion of phases of training. • Most learners will succeed—those that do not are the exception.	Learners participate in the "normal" curriculum, typically as part of a class or cohort.	If learners fail, they are moved to the remediation subsystem.
Remediation	• Specific issues and corresponding goals are defined at the outset along with a timeline for completion. • No expectation that a learner will succeed or fail—each case is unique. • Remediated learners must satisfy their remediators that the goals have been met.	• Learners are in the program but not necessarily in the "normal" curriculum. • Individual learners interact with individual remediators. • Remediation is temporary.	Focus is on which subsystem learners move to following remediation: • If learners successfully complete remediation, they move to the success subsystem. • If learners fail to complete remediation, they move to the failure subsystem.
Failure	• Depending on the extent and nature of failure learners may: – Be allowed to redo a component (year, course, etc.); – Be suspended from the program pending some broader change in their suitability to continue; or – Be voluntarily or involuntarily dismissed from the program. • Focus is on due process, fairness, defensibility—a legal framework. • Expectation is that learners are likely to be unsuited to be doctors.	Individual learners interact with program leaders, deans, and committees.	Learners are out of the program (temporarily or permanently) or are sent back to redo parts of the program.

presented them. Assessment data, even for the most objective of competencies, are unlikely to ever reach absolute levels of measurement quality; in the case of less tangible aspects of competence, such as professionalism, assessment data are nearly always open to interpretation. Therefore, context will always matter, and clinically experienced experts will continue to need to make informed judgments about which learners should progress, remediate, or fail.

Implementing a zone-based model of a medical education system would involve (1) deciding what dimensions of practice to map (such as CanMEDS[19] or Accreditation Council for Graduate Medical Education[21] competencies); (2) selecting the threshold events (assignments, exams, observed practice, etc.) to use; (3) ensuring that performance measures can meaningfully map to an integrated model of different levels of performance; (4) anchoring performance thresholds as precisely as possible to differentiate between expected, acceptable, and unacceptable performance; (5) mapping these performance thresholds in terms of what constitutes borderline performance at each stage; and (6) defining the rules to apply in terms of faculty and learner roles and responsibilities when thresholds are approached (formative) or crossed (summative). We can consider the aggregate rules, roles, responsibilities, and thresholds for each zone as its "schema."

Implications

We have described a systems perspective on remediation that considers five zones of individual learner success and failure in contemporary medical education, and when and how learners move between these zones. Although these zones have different rules of engagement and different standards when crossing their borders, we have argued for a unified model for learner progression in medical education programs. Considering the system as a whole in this way allows for each zone to be adjusted relative to the others and that the zones can all align with the tenets of CBME (which has tended to focus almost exclusively on Zones 1 and 2). In doing so, we seek to shift the CBME discourse from one based on variable kinds of success to one that also acknowledges and responds to failure. This approach flags the importance of supporting learners who are unable, for whatever reason, to flourish in a medical training program, and it speaks to our social contract in terms of seeking to better manage our limited educational resources.

One key implication of our model is that, even in the most idealized competency-based program where time is all but ignored as a factor in learner progression, a learner can still eventually fail and be dismissed. Using specific milestones to define thresholds between all zones would make explicit the stage-specific requirements for all learners, something that we would argue is lacking in existing approaches to CBME implementation. By acknowledging intrinsic practical limits to the effort schools can invest in getting all of their learners through medical training, this model provides a systematic response to managing learner underperformance in the context of CBME.

This approach also allows us to consider more holistic questions regarding medical education systems. For instance, given the asymmetrical intensity of faculty

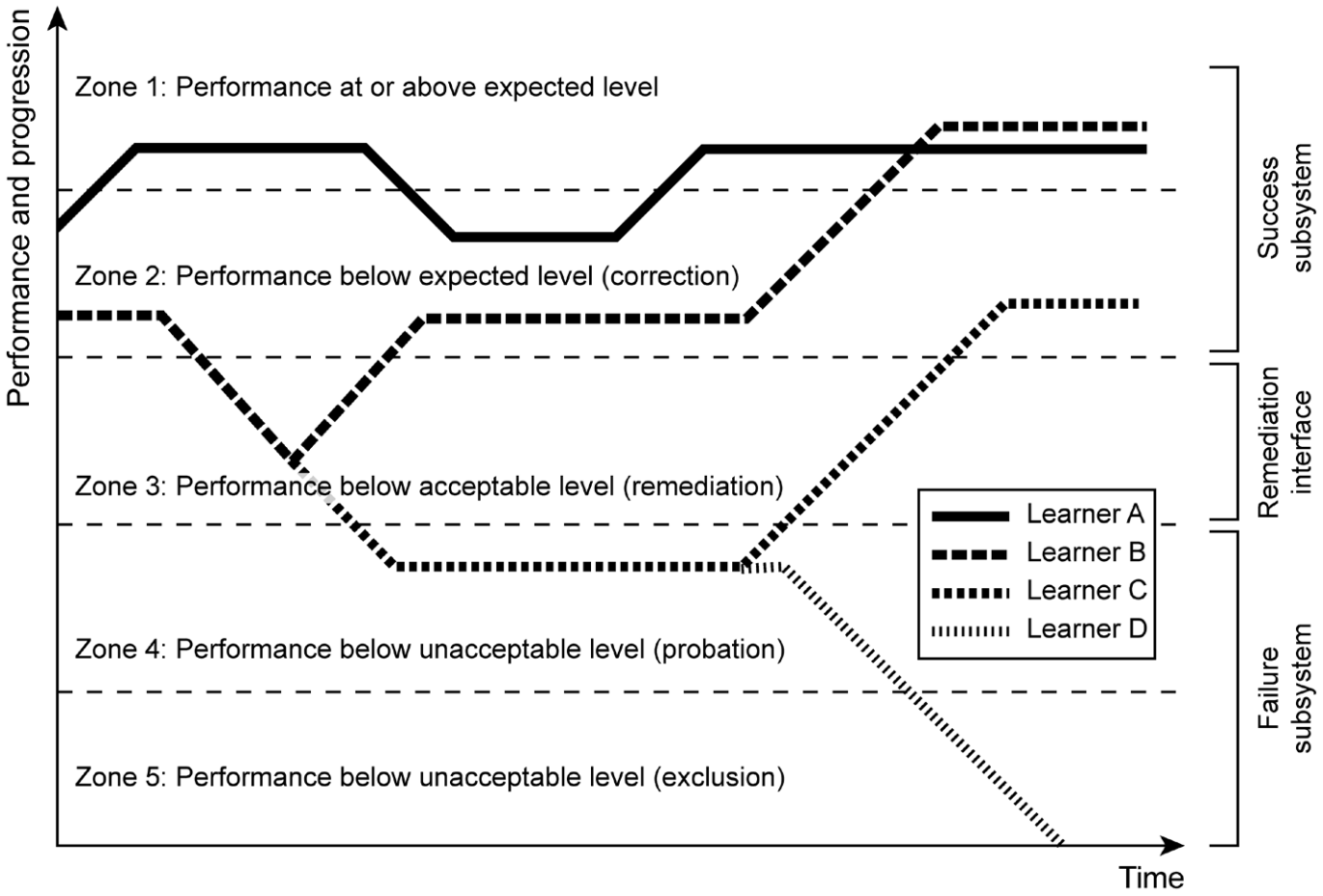

Figure 1 A five-zone model of rules and practices associated with different levels and subsystems of performance with exemplar learner pathways in a hypothetical medical education system. Learner A's performance varies over time but generally remains in the success subsystem (Zones 1 and 2). Learner B's performance dips below an acceptable level; this learner is remediated (Zone 3) and subsequently returns to the success subsystem. Learner C's performance falls below an unacceptable level; this learner is suspended (Zone 4), but performance improves thereafter. Learner D's performance is consistently below an unacceptable level, which leads to this learner being excluded from the program (Zone 5).

attention required by remediation compared with "normal" learning, most learners (i.e., those who are not remediated) receive less attention than the few learners who underperform. Should we focus more evenly on opportunities for every learner rather than on the acute needs of the less able few? Should we perhaps look to the admissions process to fix the problem of failing learners by selecting more academically or socially resilient learners? Or is it that our learners need better or different forms of nonacademic (pastoral) support or more adaptive and personalized teaching to reduce or reverse underperformance? These questions cannot be resolved purely on psychometric or equity grounds; their answers must also reflect what the medical education system can afford given its limited resources and increasing levels of accountability.

In advancing this argument, we should differentiate between remedial action and remediation. We define *remedial action* as largely supportive, informal, and short-term events in Zone 2 in which a preceptor facilitates a learner's progression toward professional mastery and independent practice. *Remediation* (Zone 3), on the other hand, is a formal response to sustained underperformance, with a different schema (its collected rules, roles, responsibilities, and thresholds) than the ones for the mainstream curriculum (Zones 1 and 2). For example, a learner who has a recurring problem mastering a particular procedural technique can benefit from formative remedial action to identify and "fix" the issues she has in achieving mastery. If the same student consistently underperforms across a broader range of issues (procedural or otherwise) that cannot be (or at least are not being) resolved, she is likely to enter a period of formal remediation, which may have serious consequences if not successfully completed. While both remedial action and remediation are course corrections, they differ in terms of the depth and duration of underperformance that triggers the event and the rules of engagement involved—in particular, the consequences of failure.

This difference is important because well-meaning remediators will too often keep trying to help a learner well beyond the point where improvement is likely to occur. This, in turn, contributes to the "failure to fail" phenomenon.[10] For instance, individuals who are unlikely to thrive as medical professionals may have fewer and fewer options and more financial debt the longer they languish unsuccessfully in medical training. Adopting a zone-based model would more clearly set out the rules of engagement and expectations for all

Box 1

A Practical Example of a Learner's Trajectory Through Different Zones: Mo's Story

Mo is an internal medicine trainee who intermittently struggles to meet the expected levels of performance set out in the program milestones. Sometimes her performance is acceptable and she receives minimal guidance (Zone 1); at other times, she needs more intensive help with diagnostic accuracy (Zone 2). However, she has been having increasing problems both with the quality of her diagnostic decisions and in her interactions with her interprofessional colleagues. In consultation with the residency program's competency committee, the program director decides that Mo needs remediation in both clinical reasoning and professionalism (Zone 3—see Figure 1).

Two preceptors are assigned to Mo to remediate these issues with her. The preceptor assigned to work with her on clinical reasoning is one of her existing preceptors, who is a highly respected clinician. He has Mo observe him and engage in extensive discussion of patient cases. While others notice Mo's improved clinical reasoning skills, she becomes consistently argumentative, defensive, and irritable with this remediating preceptor because of the formality of remediation; as a result, she is cited for professionalism issues (wrong schema).

The preceptor assigned to work with Mo on professionalism issues, on the other hand, is very explicit in his expectations for engagement in remediation. As part of providing a supportive, learner-centered coaching relationship, this preceptor negotiates a remediation plan with Mo involving written assignments and exercises to practice increasingly complex communication challenges (right schema). Mo successfully completes this side of her remediation.

However, because Mo failed one of the two remediation topics, she is placed on probation with significant scrutiny of her performance (Zone 4) and with an explicit expectation that she will make substantial improvements or face exclusion from the program (Zone 5). Finally realizing the seriousness of the situation, Mo addresses her performance problems, demonstrates significant improvement in her interprofessional communication in her daily interactions, and is then reinstated to normal participation within the program (Zones 1 and 2).

concerned (what the different schemas are and when they apply) and could thereby be used to reduce the punitive aspect of responses to failure.

In proposing this model, we argue that remediation should be explicitly structured as part of medical education systems, and not as an afterthought or an "outsider" activity as too often seems to be the case. Moreover, remediation should be a shared responsibility for a community of educators rather than being left to a select few.[22] When engaging with learners in the remediation zone, faculty typically need to take more time, expend more effort, and possess more advanced skills than when they teach in the routine curriculum. In addition, learners may have emotional issues, not least because remediation is conducted in that liminal space where dismissal from the program is a very real possibility. Institutions should therefore provide additional remediation resources, such as professionalism assessments that require scoring and interpretation by consultants, and standardized patients and other learning specialists able to give expert feedback.

Our model of zones is a systems-level response to integrating remediation with the rest of medical education, and as such it can be linked to a number of more tactical solutions. One example, proposed for medical learners with "moderate" professionalism lapses (e.g., see the trajectory of Learner B in Figures 1 and 2), involves a council that hears the learner's perspective and provides a guided reflection opportunity for that learner.[23] Another technique is to involve learners in designing and implementing their own remedial interventions—a low-cost model that can promote autonomy and self-regulated learning.[24] A more integrated approach may help to correct learners before full remediation is needed, which may in turn reduce stress and make better use of faculty resources.[18,25,26]

In advancing this model, we should also acknowledge that different problems in different competencies present different challenges in terms of both seriousness and remediability. For instance, professionalism problems tend to be more serious and less tractable than lapses or gaps in medical knowledge. Learners may also be failing in a number of areas but to different degrees. Indeed, rarely is a remediation plan focused narrowly on improving performance in a single competency. Learners requiring remediation often present several simultaneous struggles involving personal issues, problems with institutional cultures, extraprogram challenges (e.g., mental health), learning-related issues (e.g., learning disabilities), and/or professionalism-related issues. Because remediation requires attention to the unique needs of individual struggling learners, translating our model into practice will clearly need to accommodate the particular circumstances of different educational programs.

As medical educators, we should try to incorporate the same humanistic approach in remediation situations that we ideally bring to patient care. Fully understanding the multiple facets that bring a learner to remediation requires patience, active listening, and reflection. Yet, we cannot allow our acceptance and compassion to cloud our ultimate judgment when a learner enters the failure subsystem. A clinical analogy could be the consideration of and transition to palliative care. Initially, there are strong efforts to provide interventions that could bring learners to an acceptable level of academic function. At times, actively managed learners require repeated interventions, or remediation, over time. Those interventions may result in a learner's return to the success subsystem. However, with insufficient return on those investments, or with an acute decompensation in function, a decision to transition to a palliative approach (i.e., providing a dignified exit rather than fighting over whether the learner can remain in the program) may become necessary. Greater clarity regarding what zone we are working in with any given learner (and which schema should therefore be applied) should help to manage and align expectations, options, and actions, and thereby support a more compassionate stance in medical education as a whole.

We acknowledge a number of limitations in this article. First, we developed this model inductively from our own experiences and deductively from general principles of remediation and CBME, but we have not validated its use in practice, nor have we defined specific thresholds for the zones; these are beyond the scope of the current article. Further work is needed to explore how the model can inform the work of different stakeholders, such as program directors and

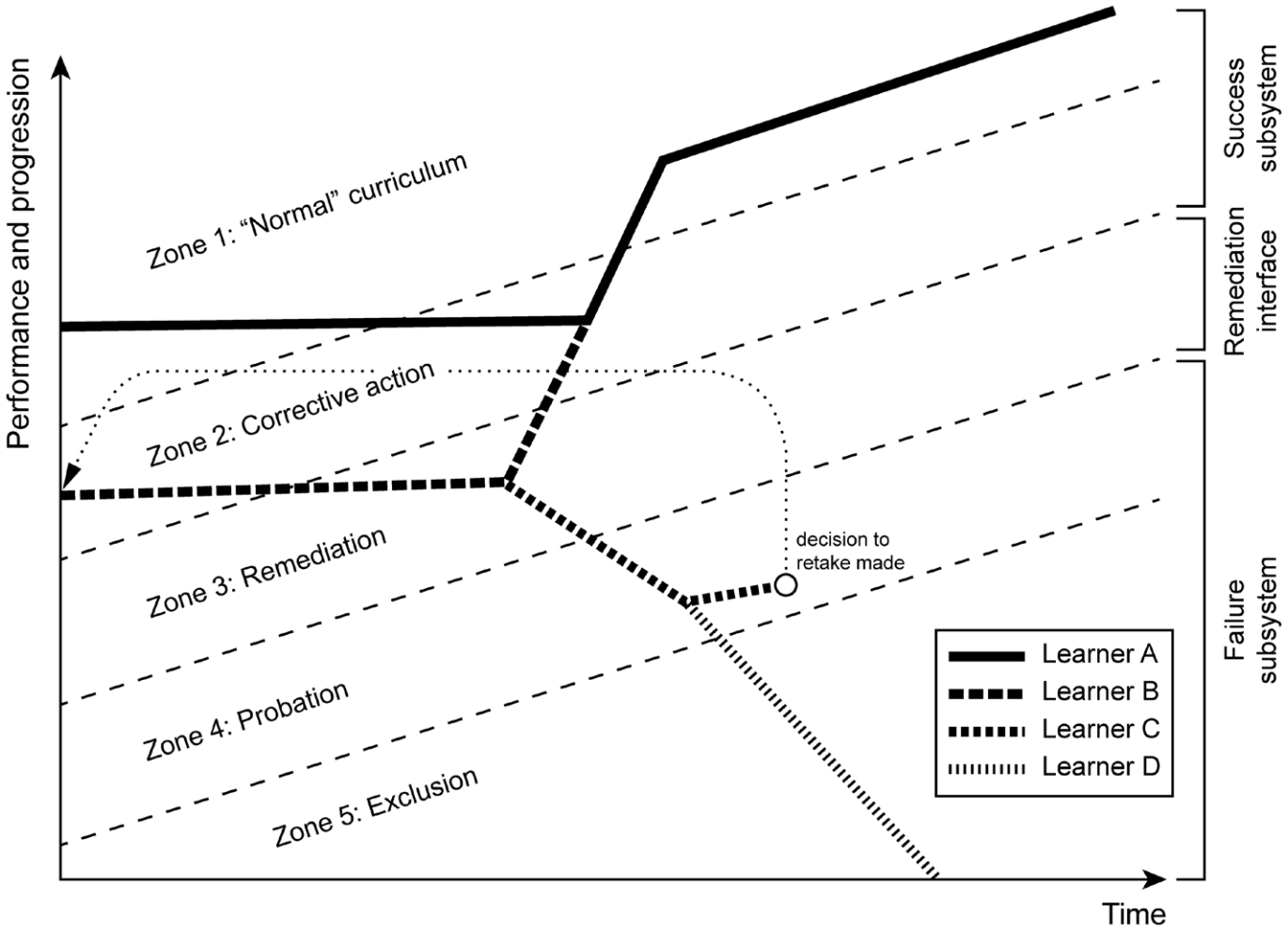

Figure 2 A five-zone model of rules and practices associated with different levels and subsystems of performance in a hypothetical medical education system, incorporating expected progress (reflected in higher levels of performance over time) with exemplar learner pathways equivalent to those depicted in Figure 1. While Learner A thrives (Zones 1 and 2), Learner B does not progress in performance. Learner B falls out of the success subsystem, undergoes remedial action (Zone 3), and returns to the success subsystem. Learner C's performance is also increasingly poor; the learner is suspended (Zone 4) and required to retake the episode of training with which the learner was struggling, after which Learner C's performance improves. Learner D is consistently unable to meet required levels of performance and is eventually excluded from the program (Zone 5).

competency committees. Second, we have concentrated on those medical education systems that prepare future physicians, but we acknowledge that there are likely to be applications in other medical education systems, such as continuing medical education. Although the zones, their schemas, and the rules for passing between zones may differ, the general principles would still seem to apply. However, future work must validate this assertion. Third, we did not focus on "best practices" in specific episodes of remediation, nor did we consider the specific assessment practices that identify whether learners may need to be remediated; this article is intrinsically strategic and system-wide in scope. Subsequent studies will be required to address these issues. Finally, we have presented an ideal model without factoring in issues such as difficulties in acquiring performance data, data gaps, and other process challenges.[27] We acknowledge that even the most carefully planned system will not function optimally, and that systems resilience and sustainability will also need to be considered in future work.

Although we present a simple model for these five zones, the schemas that define them, and possible phenotypes and educational responses for the learners who traverse them, we acknowledge that reality is more complex and that the model is perforce abstract and idealized. Most learners will likely take an uneven path in developing different competencies. In building on concepts of CBME, we inherit their common challenge: that measurements of competencies need to be practical and fit for purpose. Ultimately, medical school leaders must take responsibility for making high-stakes decisions in the face of uncertainty and complexity. We hope that, by using this model, they will be better able to do so both systematically and consistently.

Conclusions

The need for individualized remediation for learners who stumble along the way has been a relatively neglected aspect of CBME. By making theories of remediation explicit and integrating them into the emerging practices of CBME, we have sought to clarify systems-level responses to degrees of learner difficulty and failure. Much of the discourse around CBME has

emphasized a success-focused approach. In this Perspective, we have sought to expand this thinking to encompass the realities of suboptimal learning outcomes. This is an important development because of the burden struggling learners place on medical education systems, and because these learners deserve to be treated compassionately throughout the remediation process. We hope that this model may provide a framework for further research on developing medical competence, as well as helping to better define the expertise needed to conduct effective remediation, better manage educational resources, and better embody compassion for all our learners.

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Appendix 1

Glossary of Terms

Term	Meaning
Systems perspective	A consideration of a whole system, its interactions, and its dependencies.
Medical education system	A medical education program and its dependent components, both within and outside the program. A medical education program at a particular school will have its own policies and procedures but will also be shaped by institutional policies, accreditation, etc.; collectively these coincident factors form a medical education system.
Remediation	A practice-based interface between success and failure defined by time, rules of engagement, and potential consequences for completion (or failure to complete) for those learners with major flaws or gaps in their developing professional competence.
Remediator	An individual, usually a faculty member, responsible for conducting a remediation episode with a particular underperforming learner.
Remedial action	A largely supportive process by which an imposed course correction (which can occur at any point during training) facilitates a trainee's progression toward professional mastery and independent practice.
Probation	A marker for a learner's status within the program. Probation, like remediation, may end with a learner's return to the "normal" program. However, probation tends to be less corrective than remediation and is more akin to suspension pending a decision regarding the learner's future in the program.
Rules	The policies and procedures that apply in each zone, the boundaries of where and when they apply, and the expectations and assumptions about the roles and responsibilities of different participants in medical education systems.
Schema	The rules, participant roles and responsibilities, and performance thresholds for each zone.
Competency-based medical education	A model of medical education organized around competency principles.[1]
Zone	A distinct category of learner performance and medical education system responses to that performance defined by the rules that pertain within the category, and its upper and lower thresholds.
Zone threshold	The point at which the rules change between zones.