Postgraduate Education Policy and Procedures for the Assessment of Resident Performance – Competence by Design, RCPSC

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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 – Competence by Design, RCPSC					Class: B
Approved By:	Postgraduate Education Committee				
Approval Date:	2018 12 31	**Effective Date:**	2018 12 31	**Review Date:**	2021 12 31
Responsible Portfolio/Unit/ Committee:	Postgraduate Education (PGE)				
Responsible Officer(s):	Associate Dean, PGE				

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, residents achieve the program goals and objectives, all milestones are met, and residents are competent in all Entrustable Professional Activities (EPAs), in order 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 who are in Competence by Design postgraduate programs at NOSM.

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 registered in Competence by Design RCPSC programs. All matters fall within the jurisdiction of the Postgraduate Education Office and the Academic Council of the Northern Ontario School of Medicine (NOSM). A companion policy governs residents who remain in traditional time-based RCPSC and in CFPC programs. 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.

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 *Academic Advisor*
Academic Advising is a decision-making process by which residents realize their maximum educational potential through communication and information exchanges with an advisor. It is ongoing, multifaceted, and the responsibility of both the resident and the advisor. The advisor reviews and provides feedback to residents on individualized learning plans. This role could also take on the role of remediation coach should that be necessary.

3.3 *Appellant*
The postgraduate resident who appeals a decision.

3.4 *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.

3.5 *Block/module*
Timed intervals within the academic year for the purpose of scheduling clinical activities for residents to have the opportunity to program requirements

3.6 *Certification*
The formal recognition of completion of all necessary components of training.

3.7 *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. The coach is focused on the enhancement of learning and development through increasing self-awareness and a sense of personal responsibility, where the coach facilitates the self-directed learning of the resident through questioning, active listening, and appropriate challenge in a supportive and encouraging climate.

3.8 *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]

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

3.10 *Competence Committee*
The committee responsible for assessing the progress of residents in achieving program-specific requirements based on each stage of training. Their goal is to ensure all learners achieve the requirements through synthesis and review of qualitative and quantitative assessment data. The committee reports to the Residency Program Committee.

3.11 *Competence Continuum*
Developmental stages of professional practice each with its own set of milestones that programs determine. The stages are:

1. Transition to discipline
2. Foundations of discipline
3. Core of discipline
4. Transition to practice

3.12 *Conflict of Interest*
Impartiality during Appeals is considered crucial. Examples of conflict of interest that may arise but are not limited to:

1. where a member has any emotional or financial interest in the outcome of the appeal hearing,
2. where a member has any affiliation with either party of such as nature or proximity as to give rise a reasonable apprehension of bias, and
3. where a member has been privy to information about an appeal obtained by means other than through the presentation of evidence at the appeal hearing or in documents filed by the parties.

3.13 *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]

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

[1] [2] Takahashi et al; 2015 CanMEDS Teaching and Assessment Tools Guide

3.15 *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.

3.16 *Entrustable Professional Activities (EPA)*
The statements describing an essential activity or task embracing multiple competencies a professional has been entrusted to perform independently in context in their discipline (e.g. lead a team meeting, give an epidural to a labouring woman, perform a cholecystectomy in an otherwise healthy patient).

3.17 *Individualized Learning Plan*
The resident will maintain an individualized learning plan with faculty guidance. This opportunity is intended to guide a resident towards successful attainment of competencies and will be forwarded to the competence committee for review and discussion

3.18 *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.

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

3.20 *Milestone*
Is a defined, observable marker of a trainee's ability along the developmental continuum of training. Residency-specific EPAs are comprised of multiple milestones. They are used for teaching and assessment.

3.21 *Narrative Feedback*
Written descriptions of a resident's performance, organized in logical order, to illustrate the "story" or account of a resident's progress and performance, including strengths and areas for improvement to guide future efforts.

3.22 *Natural Justice*
The basic components of natural justice include: a duty to act fairly where individuals receive notice of decisions and rationale for such decisions, are provided with specific aspects of the case under consideration to provide opportunity for responses. Decision-makers will be unbiased, understand what bias is, will be free to make own decisions, and can be objective and impartial about the matter under consideration. A well-informed decision make-maker with access to information on the matter is not biased if she or he has an open mind and is open to persuasion by the information provided during the decision making process.

Natural Justice is also the requirement to duly follow processes and policies fairly and consistently. It also entails that individuals need have clearly defined competencies to achieve and be given feedback and opportunity to improve.

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

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

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

3.26 *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.

3.27 *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.

3.28 *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.

3.29 *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.

3.30 *Remediation*
A period of formal increased 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.

3.31 *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.

3.32 *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.

3.33 *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.

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

3.35 *Workplace Based Assessments*
The assessment of a resident's professional skills and attitudes and should provide evidence of appropriate everyday clinical competencies. Multiple-source assessment tools such as Observed Structural Clinical Exams (OSCEs) Surgical Competency Assessment of the Residents (SCARs) & Point of Care Clinical Exams (POCCE's), Structured Assessments of a Clinical Encounter (STACER's) etc.

3.36 *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.

Competence by Design residencies must be structured to allow for monitoring of resident achievement of EPAs through competence continuum stages.

Learning experiences will be organized with a hybrid model of competence-based and timed rotation blocks.

Assessment must be based on the goals and objectives of the program, individual block and/or module descriptions, 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.

Preceptors must document milestones and EPAs regularly. Narrative, actionable and timely feedback on EPA's is required. Residents are responsible to ensure form distribution, observation, and documentation is happening in real time. The milestones and EPAs to be completed and number of observations required must be clearly outlined to residents and faculty for every clinical block and/or module description.

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 competencies related to the resident's ability to consider age, gender, culture and ethnicity when treating and managing patients.

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

Feedback sessions with 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 by the Competence Committee), or self-identification of residents in difficulty. Residents must be informed when serious concerns exist and given opportunity to correct their performance before Remediation occurs.

Decisions regarding promotion and progression of residents are determined by a Competence Committee responsible for regular review of integrated date from multiple EPAs and observations as well as other assessment data.

4.1.2 *Administrative Requirements of EPAs*

Programs must have a clear assessment strategy for each EPA. These expectations must be clearly communicated to the residents and preceptors for the block/module.

- EPAS are marked as 'achieved' when all of the key milestones related to that EPA are considered complete by the competence committee.
- When an EPA has not been achieved, it is listed as "in progress" and individual milestones must be reviewed to identify particular challenges and develop feedback and learning activities to assist the resident to complete more WBAs if required.
- Competence Committees can both award an EPA as achieved with less than the defined number of successful WBAs or they may determine an EPA incomplete despite more than the suggested number of WBAs being performed, based on feedback evidence and exceptional circumstances.

4.1.3 *Administrative Requirements of Blocks/Modules*

Face-to-face meetings between the resident and supervising preceptor must occur at minimum:

- **First meeting:** near the beginning of the block/module, to review EPAs and associated milestones associated with the clinical learning experience and there must be a learning plan for the block/module.
- Preceptors are required to have multiple meetings and observations with residents throughout the assessment period. Assessments must be immediately documented by observers in the resident's electronic portfolio
- **Final meeting:** before the end of the clinical block and/or module to review and discuss progress.

The programs must employ a variety of methods to assess resident performance (e.g. ITARs, OSCEs, etc.). The Competence Committeee must review the resident twice yearly and synthesize all assessment data.

Both the preceptor and resident must confirm that they have seen the end of block/module summary 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 block/module. Residents must ensure the timely submission of all assessments once they are completed by faculty. Assessments are reviewed by the Program Director or designate.

All NOSM resident assessments are confidential and retained indefinitely.

Academic Advisor/Competency Coach Requirements

The program must ensure an academic advisor/competence coach or other dedicated faculty provide academic guidance to residents at least semi-annually. During these meetings the faculty and resident must review individual resident assessments and portfolios.

The advisor/coach must meet formally with the resident semi-annually, either face-to-face or virtually to:

- Conduct a comprehensive review of progress in their portfolio.
- Review the residents Individualized Learning Plan to ensure it aligns with the training schedule and EPAs.

More frequent meetings may be scheduled as required. The resident must formally document details of the meeting and send them to the advisor/coach for review and approval. The advisor/coach liaises directly with the Program Director or Competence Committee to help inform progress decisions and may be required to attend meetings or submit reports as determined by the Program.

4.1.4 *Assessments and Competence Committee Decisions Regarding Progress*

Each residency program has its own Competence Committee, which is responsible for group decisions on learner achievement of EPAs and progression through the Competence Continuum stages. The Competence Committee reports to the Residency Program Committee, which is the body that ratifies all progress decisions. Competence Committee Procedures are Outlined in Appendix A.

The Competence Committee must discuss each resident at least semi-annually and trainees may be selected for review based on the following:

1. Regularly timed review
2. Concerns flagged on assessments

3. Completion of stage of training and eligible for promotion
4. Determine readiness for RCPSC examination
5. Significant concerns about academic performance, or delay in attainment of progress.

The Competence Committee will make decisions regarding successful completion of all requirements based upon all available documentation and aggregate evidence. EPAs not successfully completed by the end of Competence Continuum stage may require remediation, or other appropriate modifications to a resident's education, supervision, and assessment, and may require continued clinical educational experiences at the same stage of the competence continuum. The resident will receive notice regarding the need for remediation or other alteration in the education program within four (4) weeks or 20 NOSM working days of the RPC ratification of the CC decision.

Notwithstanding the above, when the Competence Committee outlines areas of concern but has not designated progress 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 modules and EPAs
- An enhanced individualized learning plan

Decisions of the Competence Committee regarding progress to the next stage are appealable however individual EPAs and end of block/module assessments are not eligible for appeal.

4.1.5 *Promotion*

A resident will be promoted to the next stage of the Competence Continuum when the stage specific milestones and EPAs have been met to the satisfaction of the Competence Committee, including any remedial training that may have been required. Residents may be reviewed more often than twice annually, should the Competence Committee deem this to be necessary. Promotion decisions shall be made by the RPC, based on the recommendation of the Competence Committee and communicated to the Associate Dean PGE.

4.2 **Remediation**

4.2.1 *Expectations and Decision Making*

- A resident may be placed on remediation when they are failing to progress in their training despite completion of enhanced learning plans to facilitate attainment of specific competencies or to improve professional conduct.
- Remediation may also be triggered by a single egregious event involving the resident or when there are serious concerns that performance is significantly below acceptable standards.
- The RPC is responsible for reviewing and ratifying decisions about successful completion of all educational experiences based upon all available documentation.
- Remediation plans will be developed and approved by the RPC in conjunction with the Program Director and based on the recommendations of the Competence Committee. 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 all available sources of data in the decision making process.
- 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 must ask for assistance from the EAB in the development of the remediation program.
- The length of the remediation will vary dependent upon the nature of the concerns and the proposed remediation strategy.
- 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*

- Remediation is a formal individualized plan intended to assist a resident towards successful attainment of clinical, academic or professional competencies.
- Remediation may be required for an entire stage or for an individual competency or series of competencies as deemed necessary for the observed deficiency.

4.2.2.1 The competence committee may propose to the RPC that a resident be placed on remediation in the following circumstances:

- The resident has not met the competencies by the suggested maximum amount of time allocated by the specialty committee for a given stage of training.
- The resident has not met the requirements of the modified/enhanced learning plan.
- Significant professionalism or patient safety concerns have arisen.
- Repeated pattern of concern about performance in a particular domain or CanMEDS role.

4.2.2.2 Documentation and Timing

- Remediation Status
  - The Program Director or designate must contact the resident within four (4) weeks of a Competence Committee Decision that determines that progress is not as expected or that competence for progression to the next Stage has not been achieved 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 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, based on recommendations of the Competence Committee 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 additional 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, EPAs 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 by the RPC or designated subcommittee to the resident 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. (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.
- 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 on 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 include:

- Unsatisfactory evaluations in a remedial program.
- Upon recommendation of the Competence Committee, the RPC and/or the Program Director may initiate probation 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 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 and 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 additional 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 supervisor, 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 by the RPC or designated subcommittee to the resident 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

iii. 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 (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 (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, directly (face-to-face, by web-conference or phone) as well as 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 a 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. A decision on resident's failure to progress through any stage of training including the final transition to independent practise ratified by the RPC.
ii. 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,
iii. A decision by the RPC and/or the AD PGE to dismiss a resident.

4.5.3 *Level of Appeal Bodies*

4.5.3.1 Appeals to Postgraduate Education Appeals Committee (PGEAC)

An appeal is made to an ad hoc PGEAC convened 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.
- Where a member of the PGEAC has a conflict of interest they will be replaced on the Committee per the specific case
- The Appellant has the right to appear before the PGEAC with or without legal counsel or other advisor at his or her own cost; 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.

4.5.3.2 Appeals to Academic Council – Decisions of Dismissal

An 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 appeal and has been communicated to the appellant.

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

The decision of the ACAC is final and there is no further right of appeal.

4.5.4 *Process*

Appeal Procedures – PGEAC

4.5.4.1 RPC Decisions on Competence Continuum Progression, Remedial Training and Probation

The following decisions of the RPC may be appealed to the PGEAC:

i. that remedial training is required,
ii. that progression is delayed,
iii. that probation is required,
iv. the terms or content of the remediation or probation, and
v. that remediation was unsuccessful.

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

i. 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
ii. 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:

i. a copy of relevant assessment data and decisions, remedial plan and the RPC decision,
ii. the grounds for appeal and desired outcome, and
iii. 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:

i. state that there are no grounds for altering the decision of the RPC and that the decision of the RPC shall stand, or
ii. approve the appeal if it is found that the RPC's decision was made without complete and thorough/relevant information and in the case of an appeal against a decision where remediation was unsuccessful, it may direct the program to engage in another evaluation process of the Appellant under such terms as RPC may require (including directing that appropriate accommodation be provided to the Appellant), or
iii. approve 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 where remediation was unsuccessful, it may direct the program to engage in another evaluation process of the Appellant under

such terms as RPC may require (including directing that appropriate accommodation be provided to the Appellant), or

iv. approve the appeal if it was found that the Appellant was able to establish that:
    a. there is evidence of a factual error or procedural irregularity in the consideration of a previous decision; and/or
    b. 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.

4.5.4.2 Decision of Dismissal

Dismissal 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:

i. 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),
ii. 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
iii. 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:

i. a copy of the relevant Competence Committee documentation and assessments (as applicable),
ii. a copy of the Residency Program Director, the RPC or the AD PGE's decision,
iii. the grounds for appeal and outcome sought, and

iv. 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:

i. 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
ii. approve 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
iii. approve the appeal if it is found that the Appellant is able to establish that:
    a. there is evidence of a factual error or procedural irregularity in the consideration of a previous decision; and
    b. that the previous body did not adhere to the principles of natural justice during the process.
iv. In the case of dismissal based on an unsuccessful probation**,** it may direct the program to engage in another evaluation process of the Appellant under such terms as RPC may require (including directing that appropriate accommodation be provided to the Appellant)
v. 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.

Academic Council Appeal Procedures – Dismissal Decisions

As outlined in section 4.5.4.2, 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 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 appeal.

With regard to an 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-in-Practice/CPGs-Other-Guidelines/Guidelines-for-College-Directed-Supervision
- http://www.cpso.on.ca/Physicians/Policies-Guidance/Policies
- https://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/
- http://www.royalcollege.ca/rcsite/cbd/assessment/committees/competence-committees-status-recommendations-e
- http://www.royalcollege.ca/rcsite/cbd/assessment/competence-committees-e

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.
3.0	2018 06 18	Procedure created for first review.
4.0	2018 06 27	Postgraduate Competency Based Education Subcommittee (PCAS) Edits

APPENDIX A

COMPETENCE COMMITTEE PROCEDURES – PROGRESSION/PROMOTION

Purpose: This procedure document was created to ensure the procedures of Competence Committees across all of the Northern Ontario School of Medicine Postgraduate Medical Education (PGME) programs are consistent, fair and equitable.

1.0 Residents are selected for a planned Competence Committee meeting by the Chair, the Program Director or their delegate

1.1 Each resident **must** be discussed at least semi-annually
1.2 Residents may be selected for review based on any one of the following criteria:
- Regularly timed review
- A concern has been flagged on completed assessment(s)
- Completion of stage requirements and eligible for promotion or completion of training
- Requirement to determine readiness for the RCPSC examination
- Concern regarding a significant delay in the resident's progress or academic performance
- Decision required regarding possible significant acceleration of the resident's progress

2.0 Each resident selected for the discussion at the Competence Committee meeting is assigned to a designated **primary reviewer** who completes a detailed summary review of each active EPA, program defined expectations, and of overall resident performance based on observations and other assessments or reflections included within the resident's portfolio.

2.1 Program defined expectations may include:
- Periodic performance assessments or other summary assessment of resident performance
- Examinations
- Research project completions
- Residents as Teacher requirements
- Other as deemed required by program and clearly articulated to residents

3.0 The primary reviewer **must** consider the resident's recent numerical data, comments and any other valid sources of information (OSCE; in-training examination performance; other).

4.0 The primary reviewer will prepare and provide a succinct synthesis and impression of the resident's progress to the Competence Committee

5.0 The primary reviewer proposes a resolution on the resident's status going forward during the Competence Committee meetings, the following apply for each active resident:

5.1 The primary reviewer presents relevant synthesis of information pertaining to each EPA and program defined expectation, including reports from the electronic portfolio, important quotes from any observational comments about the resident and concludes by proposing the following:

- Recommended action on each active EPA
- Recommended action on each program defined expectation
- **Global assessment** of the resident's status with respect to the current stage/phase of training and recommended action for the resident going forward in the Residency Program.

5.2 All Competence Committee members provide a secondary review of the data presented by the file primary file reviewer at the time of the Competence Committee meeting and discuss the resident's performance. Members must have access to the raw data in the resident's portfolio for ad hoc review.

5.3 Deliberations of the Competence Committee for each active EPA, including the summary assessment by the primary reviewer and Committee recommendations will be documented in the resident's electronic portfolio and might include the following:

5.3.1 Resident has "*completed the EPA"*
- Recommendation is for removal from the active EPA list

5.3.2 Resident's *"progress is accelerated"*. Possible recommendations for action might include the following:
- Modify Learning Plan

- Continue without modification

5.3.3 Resident is *"progressing as expected"*. Possible recommendations for action might include the following:
- Monitor learning
- Modify Learning Plan
- Continue learning the EPA without modification

5.3.4 Resident is *"not progressing as expected"*. Possible recommendations for action might include the following:
- Modify Learning Plan
- Remediation of EPA

5.3.5 Resident has demonstrated *"failure to progress"*. Possible recommendations for action might include the following:
- Remediation of EPA
- Probation of EPA
- Dismissal/Withdrawal from the Residency Program

5.4 Deliberations of the Competence Committee for each active program defined expectation, including the summary assessment by the primary reviewer and Committee recommendations will be documented in the resident's electronic portfolio and might include the following wording. Note the Competency Committee may identify other specific wording provided it clearly identifies progress as per program defined expectations:

5.4.1 Resident has "*completed program defined expectation"*
- Recommendation is for program defined expectation to be marked as complete in resident record

5.4.2 Resident's *"progress is accelerated"*. Possible recommendations for action might include the following:
- Modify Learning Plan
- Continue without modification

5.4.3 Resident is *"progressing as expected"*. Possible recommendations for action might include the following:
- Monitor learning
- Modify Learning Plan
- Continue working toward program defined expectation without modification

5.4.4 Resident is *"not progressing as expected"*. Possible recommendations for action might include the following:
- Modify Learning Plan
- Remediation of program defined expectation

5.4.5 Resident has demonstrated *"failure to progress"*. Possible recommendations for action might include the following:
- Remediation of program defined expectation

- Probation of program defined expectation
- Dismissal/Withdrawal from the Residency Program

5.5 Deliberations of the Competence Committee for **global assessment** of the resident's status with respect to the current stage/phase of training and recommended action going forward in the Residency Program, including the summary assessment by the primary reviewer, the resolution of the Committee on the resident's status and associated progress recommendations are documented in the resident's electronic portfolio and might include the following:

5.5.1 Resident has *"completed the current stage/phase"*
- Recommendation is for advancement to the next stage/phase at the earliest appropriate opportunity

5.5.2 Resident's *"progress is accelerated"*. Possible recommendations for action might include the following:
- Modify Learning Plan
- Continue in current stage/phase without modification

5.5.3 Resident is *"progressing as expected"*. Possible recommendation for action might include the following:
- Monitor learning
- Modify Learning Plan
- Continue in the stage/phase without modification

5.5.4 Resident is *"not progressing as expected"*. Possible recommendations for action might include the following:
- Modify Learning Plan
- Remediation

5.5.5 Resident has demonstrated *"failure to progress"*. Possible recommendations for action might include the following:
- Remediation
- Probation
- Dismissal/Withdrawal from the Residency Program

6.0 The Competence Committee members vote on the recommendations of the primary reviewer

7.0 The competence committee's decisions must be transparent and defensible. In that regard, the chair must emphasize the consideration of available data and seek documentation if issues seem to be missing.

7.1 Decisions can be deferred if additional information is required, but the deferred decision **must** be revisited within four weeks or 20 NOSM business days.

7.2 Suggestions on retrieving additional information from faculty that have not been documenting concerns:

7.2.1 Encourage faculty to provide feedback using the narrative form without an entrustment rating

7.2.2 Meet with faculty and learner together to facilitate a conversation then enter a summary of the meeting as a narrative form without an entrustment rating

7.2.3 Email paraphrasing feedback from faculty and ask for confirmation that interpretations are correct, then add to resident file

8.0 A status decision on the resident is recorded in the Competence Committee's archives stored in the Residency program files

9.0 As soon as possible after the Competence Committee decision, the Academic Advisor, Residency Program Director or other appropriate delegate will discuss the decision of the Competence Committee with the resident

10.0 Changes to the resident's Learning Plan, assessments or clinical and academic schedule are developed and implemented as soon as feasible

11.0 The resident or Primary Reviewer may approach the Competence Committee Chair, Program Ombudsman (where identified), or Program Director if he/she feels a faculty member has included inappropriate commentary regarding resident's personal character or performance.

11.1 Competence Committee discusses commentary at the next available meeting date

11.2 Competence Committee makes a recommendation to RPC as to whether or not it should be removed or amended from the resident record

11.3 The RPC makes final decision and ensures that decision is relayed to the resident in writing

12.0 In the event that a resident's performance on a previously attained EPA indicates that *"*EPA *entrustment is no longer appropriate"*, that EPA will be reactivated and added to the ongoing list of EPAs for assessment at the Competence Committee meetings. Possible progression recommendations would depend on the EPA and on the degree of lapse and might include the following:

12.1 Reactivation of the EPA with or without Remediation or Probation of the EPA and one of the following:

- Continue in the current stage/phase with a modified Learning Plan
- Continue in the current stage/phase on Remediation
- Continue in the current stage/phase on Probation

13.0 With respect to the resident whose status is *"inactive"* (Leave of Absence or Suspension), the Competence Committee will discuss the current status of the resident and will document the discussion and related recommendation to the Residency Program Committee in the resident's portfolio as required. Possible recommendations for action might include the following:

- Return to training (re-entry point and conditions will be specified)
- Monitor learning for expected return from Leave of Absence or Suspension
- Remediation

- Probation
- Dismissal/Withdrawal from the Residency Program

14.0 Major progression and promotion decisions, including the resident's final portfolio documenting achievement of competencies and promotion to certification **must** be forwarded by the Competence Committee to the Residency Program Director and on to the Associate Dean, PGME for verification and approval prior to submission to the RCPSC

15.0 All RPC decisions leading to Remediation, Probation, Suspension or Dismissal/Withdrawal **must** be forwarded to the Associate Dean for approval and copied to the PGE offices as per the processes outlined in the Postgraduate Education Policy and Procedures for the Assessment of Resident Performance.

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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:

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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?

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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.

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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

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 signed by the Program Director, Resident, and Associate Dean of PGE.
4. 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.

Northern Ontario School of Medicine
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

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 signed by the Program Director, Resident, and Associate Dean of PGE.
5. 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.

☐	An end of rotation/educational experience In-Training Evaluation/Assessment Report (ITER/ITAR) with flagged assessments of "below expectations" 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:

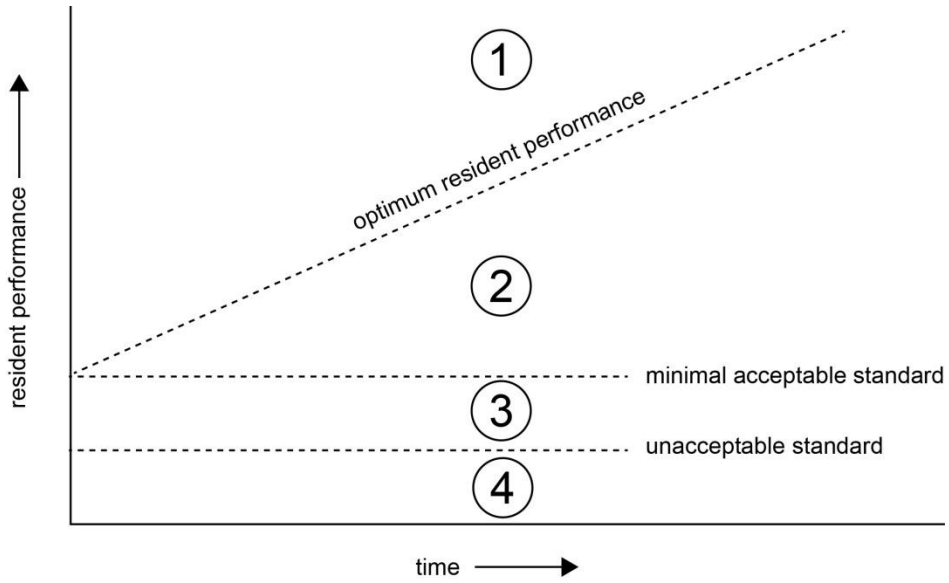
Director, PGE
Northern Ontario School of Medicine
955 Oliver Road, Thunder Bay P7G 1E3
Telephone 807-766-7503

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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Acad Med. XXXX;XX:00–00.
First published online
doi: 10.1097/ACM.0000000000001855

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

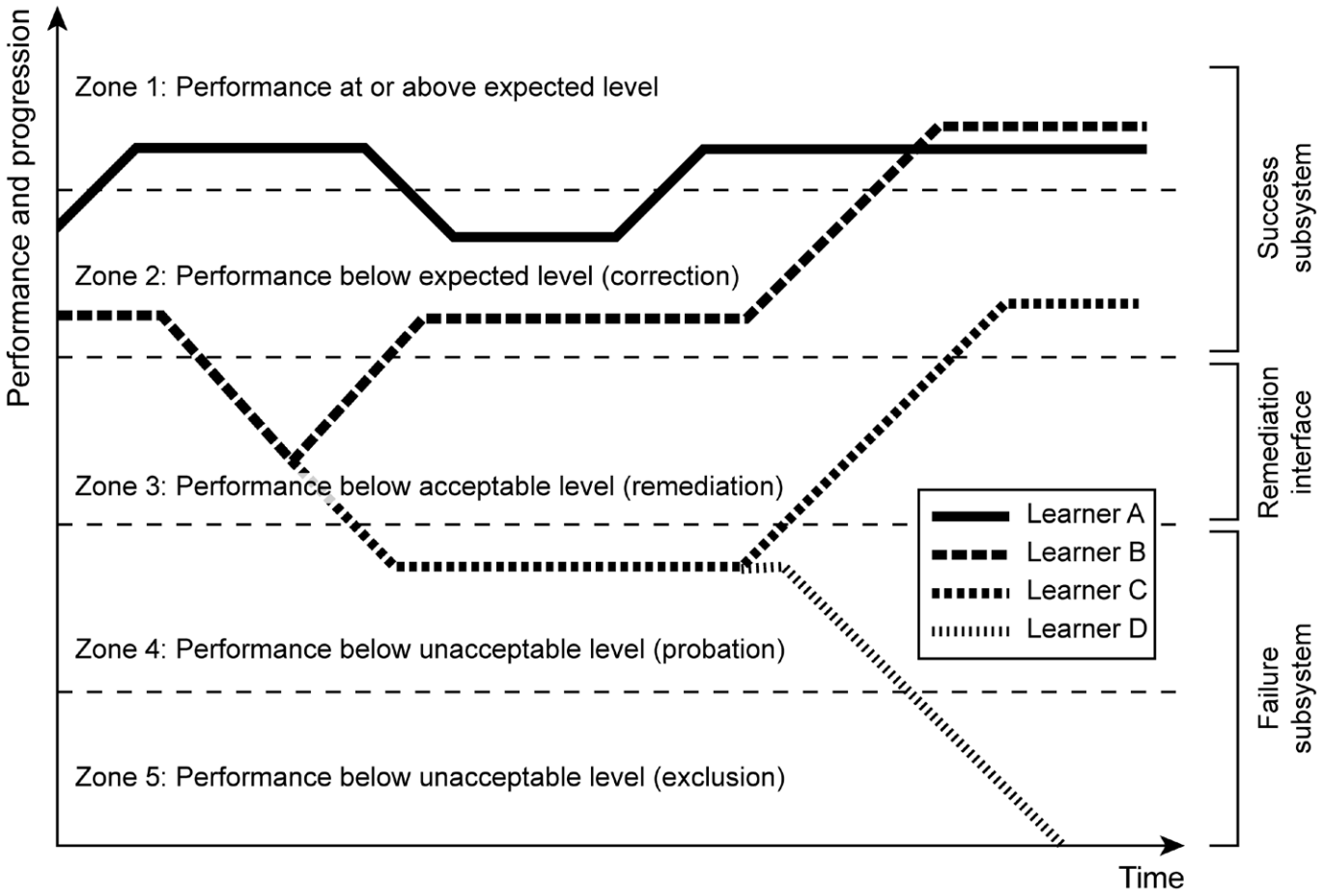

Figure 1 A five-zone model of rules and practices associated with different levels and subsystems of performance with exemplar learner pathways in a hypothetical medical education system. Learner A's performance varies over time but generally remains in the success subsystem (Zones 1 and 2). Learner 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

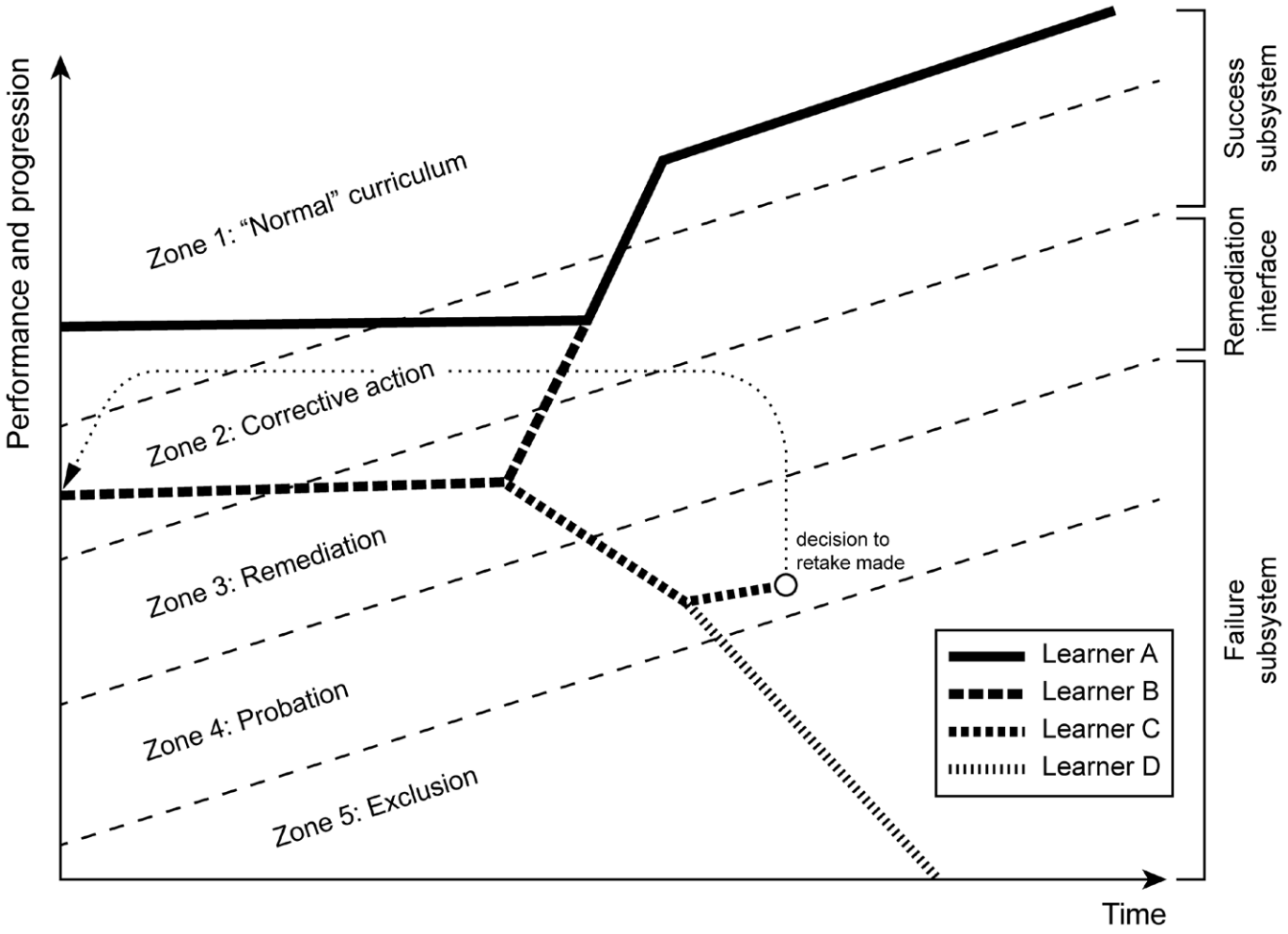

Figure 2 A five-zone model of rules and practices associated with different levels and subsystems of performance in a hypothetical medical education system, incorporating expected progress (reflected in higher levels of performance over time) with exemplar learner pathways equivalent to those depicted 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.

Acknowledgments: The authors wish to thank Dr. Muriel Bebeau and Dr. Catherine Cervin for their contributions to the initial stages of this work.

Funding/Support: None reported.

Other disclosures: C. Chou and A. Kalet edited the book *Remediation in Medical Education* (Springer, 2014). Neither receives royalties from sales of the book.

Ethical approval: Reported as not applicable.

Previous presentations: This article was developed from discussions arising from an Emerging Issues session that the authors led at the 2014 AAMC Medical Education Meeting in Chicago, Illinois, November 6–7, 2014. The material presented here has not been previously presented or published.

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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.