

# Remediation of the Struggling Clinical Educator

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**F**or high-performing clinical educators, there is an abundance of opportunities to participate in regional or national faculty development programs.<sup>1-4</sup> These comprehensive programs emphasize teaching, research, and administrative skills.<sup>3-5</sup> However, they may not be relevant (or even available) for the struggling clinical educator. Medical educators are left to deal with underperforming clinical educators, usually without the benefit of standard processes or formal programs. In this article, we review strategies to identify and remediate clinical educators whose educator skills fail to meet expectations. These strategies are based on expert advice,<sup>1-10</sup> published studies,<sup>11-14</sup> and our experience working with struggling educators. For clarity, we use the terms *clinical educator* to refer to the faculty member or attending physician who is the focus of the remediation effort, and *medical educator* to refer to the educational program leader who leads the improvement effort or the nonphysician educator who serves as a resource for the remediation.

## Making the Diagnosis

We have observed that early identification of the struggling clinical educator facilitates timely remediation. Medical educators should regularly review faculty educational performance data (ie, evaluations from rotations and teaching sessions, timeliness of evaluations, and participation in educational activities). This information should be reviewed with the clinical educator and departmental leadership at least annually.<sup>15</sup> Because grade inflation is common, faculty evaluation scores are typically above the middle score on the scale.<sup>11</sup> Faculty evaluation scores can be compared to peers' scores to identify outliers. Written comments are particularly insightful,<sup>11,12</sup> as is verbal feedback solicited from trainees. For the clinical educator whose educational deficits are part of a larger pattern of disruptive behavior, it is valuable to get feedback from additional sources, such as hospital adverse event reporting systems, hospital leadership, or clinic staff. Causes of the deficiencies can be organized into

4 categories: knowledge, attitudes/behaviors, skills, and system problems.<sup>6,7</sup>

When making a diagnosis, we consider system factors that may contribute to poor clinical educator performance, such as increased research time, clinical demands, or administrative responsibilities. Increased workload may be temporary (eg, colleague on leave, unfilled faculty position) or longer term (eg, new administrative position, research grant). Educational responsibilities may need to be adjusted to account for changing work demands. Time pressure outside of work such as family commitments can affect performance. Finally, there may be a mismatch between educational expectations and educator expertise. For example, some clinical educators' skills are more suited to working with senior residents or fellows, while others prefer to work with medical students or junior residents. Identifying and modifying these contributing factors can help to improve outcomes.

Poor clinical educator performance also can be a manifestation of a more global problem. Disruptive physicians often exhibit unprofessional behavior in their teaching as well as clinical practice. Physical ailments, mental illness, substance abuse, burnout, or personal issues such as marital problems or family illness can also negatively affect performance. The presence of underlying issues should be assessed in order to address the resulting educational concerns.

## The Initial Intervention

Once the educational deficit has been identified, we recommend holding an informal "cup of coffee conversation" with the clinical educator.<sup>10</sup> We start with data including evaluations, blinded comparison with peers, and specific examples of substandard practices. The clinical educator is given an opportunity to self-reflect and make recommendations for improvement. After reviewing the data and discussing the underlying issues, clinical educators will predictably commit to addressing their deficiencies. With this initial intervention, we find that most clinicians improved their performance.<sup>12,13</sup> This should be

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**BOX 1** Questions That Can Be Included in a Self-Reflection Exercise

- Why do I teach?
- When are my teaching skills most effective?
- What prevents me from being a better educator?
- When are my most enjoyable moments as a medical educator?
- When are my least enjoyable moments as a medical educator?

confirmed with a follow-up meeting that includes a review of updated evaluation data.

### **What If the Clinical Educator Continues to Struggle?**

When the clinical educator's performance remains deficient, we recommend developing a formal plan for improvement.<sup>10,14</sup> We begin by confirming the clinical educator's commitment to medical education because career interests and goals can change over time. The clinical educator may want to change teaching commitments, or even stop teaching altogether. Without dedication, it is unrealistic to expect that the educator will improve. Self-reflection from the clinical educator is critical,<sup>6</sup> and we note that some benefit from a "self-reflection" assignment (BOX 1).

For the struggling educator who is committed to change, we developed a focused remediation plan to address the educational deficiencies.<sup>9,13</sup> The key to a successful outcome is the correct diagnosis, and the diagnosed deficiency forms the basis for the remediation plan (length of remediation, interventions, metrics to determine success/failure). We prefer a team-based approach, and may include a faculty mentor, nonmedical coach, medical leaders (division chief, chair, nonclinical educators), and peers (within or outside the educator's division or department). We develop the plan with input from the clinical educator as well as the remediation team. Depending on the experience and seniority of those involved, the process is overseen by the program director, chair, or graduate medical education dean. Finally, it is important to clarify the outcomes if the remediation is unsuccessful (BOX 2).

We find that many departments have experienced clinical educators with an academic educational focus who can assist with remediation.<sup>8</sup> These individuals can serve as mentors to offer advice, encourage reflection, or participate more actively (such as

coteaching in the classroom or the clinic and observation of clinical teaching, large group sessions, or small group teaching). We discourage dual roles where the medical educator also serves as a mentor, as this combination makes it difficult to objectively assess outcomes, especially when clinicians continue to struggle.

Implementation of the remediation plan can have significant costs for the clinical educator. The time spent improving educational performance may reduce clinical or research productivity. The clinical educator's colleagues may need to provide coverage, or spend time observing performance and giving feedback. It is expensive to hire a nonmedical coach. The financial impact may be more significant for a volunteer clinical educator.

Once initiated, we have frequent follow-up meetings to confirm the diagnosis and adherence with the plan, assess performance, and identify ongoing issues (at least every 3 months, and often more frequently at first). Rarely, a clinical educator's performance will remain deficient despite remediation—the physician is unable or unwilling to be an effective educator. In this case, the clinical educator's privileges may be revoked. This can be straightforward or complex, depending on his or her educational role, faculty appointment and associated expectations for job performance (tenured/tenure track versus volunteer), and practice site (availability of advanced practice providers and/or "nonteaching" services). Another response is to accept the clinical educator's weaknesses and make systemic changes to try and limit the damage from the educator's deficiencies. Although this can be an easy short-term solution, ignoring the issue will almost assuredly lead to recurring problems.

### **Conclusion**

In our experience, it is not unusual to encounter a struggling clinical educator. Regular review of educational data for all faculty members is important to promote high-level performance, clarify expectations, and maintain a culture that values educational excellence. Most clinicians can improve their teaching performance once they are made aware of the problem. Rarely, the educational deficits persist, and a more focused intervention may help the educator improve his or her performance. Finally, it is important to remember that the educational deficit may be a symptom of a larger problem such as illness, disruptive behavior, or substance abuse.

**BOX 2** Developing an Individualized Learning Plan for a Struggling Clinician Educator**1. Diagnose the educational deficiency**

- Quantitative evaluation data are useful starting points<sup>10,12</sup>
- Written evaluation comments provide more “actionable” information
- Meet with learners to obtain verbal feedback (often more candid and nuanced than written comments)
- Meet with the struggling faculty member to review evaluations and hear his or her assessment
- Self-reflection from the faculty member after review of the data (see BOX 1)
- Consider system issues that contribute to poor faculty performance<sup>7</sup>
- Diagnosis is made in concert with the faculty member—the remediation will not be successful if the faculty member does not concur with the diagnosis
- It is difficult to diagnose a faculty member who is unreflective or uncooperative
- Review the diagnosis at follow-up meetings; occasionally the diagnosis is incorrect or changes over time

**2. Develop a plan in collaboration with the struggling educator and remediation team****3. Potential learning activities for a clinician with a clinical knowledge or skills deficit<sup>9,13</sup>**

- Focused reassessment and certification of competence
  - Clinical assignments
  - Readings
  - Skills training
  - Videos of operations or procedures

**4. Potential learning activities for a clinician with educational knowledge or skills deficit**

- Participation in a medical educator faculty development program (if available)
- Deliberate practice with feedback and reflection
- Standardized learners with video and review
- Simulation or direct clinical care
- Observation of or by a faculty mentor or colleague in small group/large group teaching sessions
- Observation of or by a faculty mentor or colleague performing clinical care (ward rounds, clinic, procedures)
- Videos of small group/large group teaching sessions
- Coteaching with scheduled debriefing

**5. Potential learning activities for the struggling educator with unprofessional behavior**

- Directed readings based on deficit
- Observed teaching (simulation or direct clinical care) with feedback
- Reflective writing with feedback
- Observation and interaction with role models

**6. Time frame/deadlines/plan duration****7. Planning for feedback and evaluation**

- Roles of supervising/evaluating educational leader, faculty mentor, and coach
- Possible components of successful remediation
  - Task completion (meeting with coach, reflective writing, etc)
  - Improved teaching evaluations
- Frequency of formal progress reviews
- Method to determine success or failure of remediation
- Potential outcomes for successful and unsuccessful remediation

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