Resident Remediation, Probation, and Dismissal
Basic Considerations for Program Directors

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ABSTRACT

Objectives: To suggest a basic new approach for pathology training programs to consider when a resident requires remediation, probation, or dismissal.

Methods: Remediation, probation, or dismissal of the poorly performing pathology resident is one of the most difficult and challenging aspects of any pathology training program. The poorly performing resident requires extra time and resources from the faculty and the program and can be disruptive for the entire program. Effective remediation requires faculty development, a well-constructed remediation or probation plan, and documentation.

Results: Despite best efforts, not all remediation plans are successful and dismissal of the resident will need to be seriously considered.

Conclusions: Approaches to dealing with resident performance issues can be variable and need to be tailored to the issue being addressed.

Upon completion of this activity you will be able to:
• describe important points to consider when a resident requires remediation, probation, or dismissal.
• describe the key elements of a resident remediation or probation plan.
• apply basic guidelines to analyze resident behaviors that warrant remediation, probation, or dismissal.

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One of the most difficult and important responsibilities of a pathology residency or fellowship program director is to ensure that upon graduation his or her residents or fellows are competent to enter practice without direct supervision. In addition, it is typically the program director who signs the various forms verifying competence and fulfillment of accredited training to allow the graduating resident or fellow to sit for his or her board examination, to obtain state licensure, and to obtain hospital credentialing and privileges. The program director may perform such verification procedures multiple times over years or decades for individual graduates.

To adequately assess and evaluate a resident’s performance, close observation by multiple observers using multiple evaluation tools is required at multiple points during the training period. With the recent requirement by the Accreditation Council for Graduate Medical Education (ACGME) for every
Transforming Incompetent Pathology Trainees Into Competent Physicians

It may seem intuitive that the purpose of residency training is to turn enthusiasts, incompetent medical school graduates into fully competent pathologists. But there are many known and unknown parts that make up the whole. As Steinberg noted, “We [teachers/faculty] nurture, mature, grow, and transform by multimodal communication in every venue in which we do communicate, and by professionalism—not only as rigid laws and commandments, but professionalism as a verb: the hidden acculturation, socialization, and action—ethics that are yet ill-defined and underacknowledged by our profession and that must be synonymous with trust and security. We must mirror back to the trainee the best empathy model they contain and are developing, and that we must possess.” Thus, we as teachers and faculty, as we impart and pass on our knowledge and mirror back the work of the pathologist, are truly acting as role models (positive or negative) and mentors to our residents during their formative and transformative years of becoming pathologists.

This transformative process of incompetence to competence also requires that faculty be given the tools and education to function in the roles of mentor, evaluator, and effective teacher. To adequately and appropriately assess and evaluate residents, faculty will, of necessity, need to learn these skills. The ability to be an effective mentor has also been shown to be tremendously important to the educational process. In this regard, training programs will not only need to develop their faculty but will also need to develop and promote a culture of professionalism that demonstrates and upholds ethical behavior, empathy, respect, truthfulness, and justice.

Ultimately, faculty development in assessing the core competencies and milestones in their trainees is a key component to ensure that residents are given the support and encouragement they need to best effect their success and competence upon graduation. Faculty development also helps to ensure that resident performance and professionalism issues are identified early and dealt with appropriately. However, a review of the extensive literature on this topic is beyond the scope of this article.

Identification of Resident Performance Problems

Timely and truthful evaluation and feedback of resident performance is critical to identifying problems early and at a stage where they can, hopefully, be corrected. There will always be issues or behavior that will demand immediate dismissal of a trainee (eg, criminal behavior, sexual harassment, patient abuse, etc) and institutions should already have these defined for their training programs and employees. However, the majority of performance concerns that program directors and CCCs will have to address will be related to deficiencies in medical knowledge, technical expertise, or professionalism. Figure 1 outlines an algorithmic approach to dealing with most performance issues.

Performance and professionalism concerns can be identified at any point in the evaluation process and not necessarily only from a faculty’s global evaluation at the end of a rotation. A 360-degree evaluation that comes from a laboratory technologist or an apheresis nurse, for example, may raise concerns about a resident’s interactions with allied health staff or patients. Incident reports or hallway “spur of the moment” conversations with the program director may trigger a concern that warrants further investigation. For example, a resident who is observed verbally abusing a secretary for some perceived shortcoming or a resident who does not meet the program’s expectations for attendance at educational conferences may come to the attention of the program director outside of the normal evaluation processes and should prompt a counseling session that may (or may not) lead to placement on a remediation plan.

Unprofessional behavior has been identified as probably the single most common cause for disciplinary action against medical students, residents, and fellows. In pathology, one study found that professionalism issues such as honesty, reporting/recognizing medical errors, collegial and interpersonal interactions, and conflict of interest were recognized as important ethical and professionalism issues in our profession.
Other professionalism issues that might warrant remediation include attitudinal problems (laziness, mood swings, rudeness to coworkers or peers, no-show for important/expected conferences, excessive/inappropriate cell phone usage during duty hours, etc); excessive staff or patient complaints; interpersonal conflicts (abusive behavior toward others, confrontational style with support staff, peers, or faculty, etc); or other inappropriate behaviors toward staff, peers, or faculty.6-9

Every instance of subpar or borderline performance does not necessarily rise to a level that demands immediate remediation or probation. For example, a resident who is normally prepared for an unknown surgical case conference but who falls short on one or two occasions may not warrant more than a verbal inquiry as to why he or she was not prepared. The program director and/or the resident’s mentor will need to make fine distinctions based on defined and written

![Figure 1](https://academic.oup.com/ajcp/article-abstract/141/6/784/1766491) Suggested approach to handling resident performance problems.
expectations for all trainees. Most programs—typically at
the quarterly or semiannual formal evaluation—will provide
needed feedback to the resident on areas that he or she could
improve on going forward. This is a normal part of the evalu-
ation and feedback process (eg, some program directors make
it a point to always give each resident one area in which he
or she can improve—ie, the “no one is perfect and all of us
can find room for improvement” approach). Thus, caution is
warranted to not use the terms “remediation” or “probation”
lightly unless you truly mean it as such with defined goals, a
defined timeline, and defined consequences if the goals and
timeline are not met. Most of us can find areas for improve-
ment, but it does not necessarily rise to the level of remedia-
tion. Perhaps a better term in situations where remediation or
probation is not warranted, but where improvement could be
made, might be “on-going self-improvement,” “area(s) for
educational improvement,” “area(s) for self-enhancement of
the core competencies,” “performance improvement or
enhancement discussion (or evaluation),” “informal interven-
tion” (ie, a “cup of coffee conversation”), “effective milestone
achievement,” or “continuous competency improvement.”
Terms like “remediation” and “probation” are frequently used
by credentialing agencies but can sometimes have different
meanings for different groups.

Many state licensing boards and hospital credential-
ing entities are increasingly crafting language to ferret out
every possible performance issue in a person’s training, no
matter how insignificant (they are no longer simply asking
if the applicant has been on probation or dismissed). For
example, one state licensing board asks this question of
both the applicant and of the program director: “Has any
academic program, health care entity or professional orga-

nization ever taken against you [the resident], through either
oral or written communication, any of the following public
or private actions: warning, censure, reprimand, or formal
admonishment; limitation, reduction, suspension, revocation
or denial of privileges; additional limitations or requirements
placed on you based on your clinical performance, academic
performance, discipline, or for any other reason; placement
on academic or disciplinary probation; acceptance of vol-
untary resignation in lieu of further investigations or other
action; are any such actions listed [above] pending; are you
currently under investigation by any academic program,
health care entity or professional organization?”11 Another
state medical board asks the resident and program director:
“Was the applicant ever placed on probation... disciplined
or placed under investigation; were any incident reports
regarding this applicant ever filed by instructors; were any
limitations or special requirements placed upon the applicant
for clinical performance, professionalism, medical knowl-
edge, discipline, or for any other reason; was the applicant
ever terminated, dismissed or expelled?”12 Broad statements
like these have the potential of being broadly interpreted by
the resident or the program director so it is important for all
concerned to be clear about the level of concern or severity of
the performance issue when it is discussed with the resident.
For residents who have had documented performance issues,
the program director should consider discussing the long-term
implications (if any) with the resident and how such licensing
or credentialing statements noted before will be answered by
the program director so that there are no misunderstandings
on how future paperwork will be completed. For example,
a program director and I met with a resident concerned a
professionalism incident. After the meeting, documentation
was placed in the resident’s file detailing the incident, the
meeting, and the consequences if the behavior recurred. No
formal remediation plan was instituted (other than “don’t ever
do this again”). No further performance issues occurred and
the resident graduated in good standing and moved to another
state for fellowship training. In applying for a state license, the
resident indicated a “no” response to the question related to a
written warning or admonishment while the program director
answered “yes.” As might be expected, the confusion caused
a delay in the graduate obtaining state licensure and in starting
fellowship training. Thus, both the program director and the
resident need to be clear as to the meaning of the particular
intervention and any future ramifications related to probation,
a remediation plan, an adverse incident report, or any written
or verbal warnings or admonishments.

Development and Monitoring of the Remediation Plan

Remediation and its more serious and ominous coun-
terpart, probation, is a process with defined goals, timeline,
and consequences if the goals and timeline are not met.13,14
Remediation is often the first step before probation,
which is usually followed by termination if the resident fails to
improve. However, depending on the severity of the issue(s),
a failed remediation could also end in dismissal or nonrenewal
of contract if the resident fails to achieve the defined goals, and
probation may be the first step rather than remediation.

As noted before, not all subpar performance issues rise
to the level of remediation or probation. For example, a one-
time observed issue related to professionalism may be just
that—a one-time event—and a 5-minute discussion between
the resident and the program director is all that it takes to keep
the resident on the right track. Such informal or “let’s have a
cup of coffee” type of discussions should be documented in
writing (and their informal, unofficial status noted) and placed
in the resident’s file but may not mandate further, more severe
scrutiny as long as the issue does not recur.

Other specialty groups outside pathology have offered
their approaches to resident remediation and the approach...
Development of a Remediation or Probation Plan

1. Identify the specific concern(s) or issue(s) that need to be improved.
2. Define expectations to be achieved, along with clear goals and objectives.
3. Detail how the goals/objectives will be evaluated, assessed, or measured; and who will be involved in reviewing the resident’s performance and progress.
4. Establish a clear and reasonable timeline for completion of the remediation as well as the frequency (or specific dates) for any progress meetings with the program director.
5. Clearly detail the consequences for not successfully completing the remediation (including possible dismissal or nonrenewal of contract).
6. Assist the resident in identifying support networks (employee health assistance programs, faculty or resident mentor, resident ombudsperson, study aids or courses, etc).
7. Put the remediation plan in writing (signed by the resident and program director) and document (in writing) the initial and all subsequent progress meetings with the resident and maintain all documents and evaluations in the resident’s permanent file.
8. Discuss with the resident any future consequences of verbal or written warnings, incident reports, documentation of poor performance, remediation, probation, or dismissal.

Table 1

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outlined here incorporates these various principles. Before a remediation plan can be developed, every effort needs to be made to ensure that the correct underlying problem, deficiency, or performance issue is identified. Poor performance can have confounding or contributing factors such as stress at home, substance abuse, cognitive issues related to language or processing issues, etc. As noted later, the program director or CCC should not try to diagnose confounding problems but can help point the resident to resources to help him or her identify and treat any contributing factors. The remediation plan should only target and address the specific issue(s) identified, should have clearly defined goals with defined measures/assessments, a clearly defined and realistic timeline for achieving the goals, designated faculty or mentors (if necessary) to assist the resident, defined points along the timeline for the resident and program director to meet and assess progress to date, and clearly delineated consequences or next steps if the resident fails the remediation plan (Table 1). The remediation plan should be approved not only by the program director but also by a majority of the CCC members. The major details of the plan should be put in writing, signed by the resident and the program director, and placed in the resident’s file.

It is recommended that in addition to the program director at least one other faculty member (eg, a CCC member, the department chair, the resident’s faculty mentor, the institution’s associate dean for graduate medical education, etc) should be present when the remediation or probation plan is presented and discussed with the resident. This helps to ensure that all necessary and key issues are discussed and that the resident has no questions about what is expected of him or her. The third person also acts as a witness that the remediation plan, expectations, and consequences were discussed and understood. After the meeting, the program director should put a written summary of the meeting, along with a copy of the signed remediation plan, in the resident’s permanent file.

As a former designated institutional official, I always appreciated being informed earlier rather than later about at-risk residents who are placed on remediation or probation. Program directors should also familiarize themselves with any institutional policies about informing the graduate medical education committee or the institution’s legal counsel whenever a resident or fellow is placed on remediation or probation or is dismissed.

Medical or mental health issues that affect resident performance are also grounds for remediation, probation, or dismissal. A resident cannot be forced to seek counseling or therapy, and the program director should not attempt to diagnose the perceived medical or mental issue for the resident or insist that a resident seek specific therapy. However, the program can expect that a resident take any necessary steps to address medical or mental health issues and to produce a “fit for duty” letter/evaluation from the appropriate health care provider as part of a remediation plan before he or she will be allowed to continue. For example, if a resident has severe depression that affects his or her ability to perform as expected, then the program can require a “fit for duty” evaluation from a physician or other appropriate health care provider that states the resident is now (currently) able to effectively perform his or her duties (it would be the responsibility of the resident to initiate, maintain, and follow through on any necessary therapy, but if the resident asks for help or advice, then the program director is free to assist him or her). Likewise, if a resident had a medical issue that has or could affect performance (eg, poorly controlled type 1 diabetes that results in periodic cognitive impairment), a “fit for duty” letter from the treating physician indicating that the resident’s blood glucose is now well controlled may be required/requested before the resident can return to the program. Another example would be that of a resident whose poor performance was found to be secondary to substance abuse. After successful treatment in a rehabilitation facility (for example), the program could request/require “fit for duty” documentation that the resident has successfully completed the course of treatment and is able to return to duties.
Professionalism and interpersonal/communication issues are just as important in resident education as technical or medical knowledge or patient care issues and are also subject to remediation/probation/dismissal procedures if there are deficiencies in these areas. In my experience, in addition to medical knowledge and patient care issues, residents have undergone remediation, probation, or dismissal for behavior such as poor written or verbal communication skills; consistently canceling or calling off on clinic days; unprofessional behavior toward nurses, medical students, or other health care providers; not completing write-ups in the patient’s medical record in a timely manner; patient abuse; and poor attendance at required educational conferences or resident meetings.

Throughout the remediation process it is important for the discussion to openly include potential options if the remediation/probation plan fails. For example, a general surgery resident may be fulfilling all of the core competencies and milestones except those related to the technical aspects of performing surgery and may benefit from career counseling to consider another specialty of medicine. Likewise, the anatomic pathology resident who just does not have the morphologic “eye” for tissue diagnosis might be better suited to an area of clinical pathology or another area of medicine outside pathology.

**Dismissal**

Despite everyone’s best efforts, remediation and probation plans are not always successful and the difficult decision to terminate a resident must be made. Not all behaviors or deficits can be remediated, and as noted before, some residents may simply find themselves in a field of medicine in which it is beyond their ability to meet the milestones. Whatever the situation, dismissal is a decision that should not be made lightly and without general agreement between the program director and a majority of the CCC. Although it is a decision that may not come as a total surprise to the involved resident, some residents will be in a state of denial. In addition, the institution’s graduate medical education office and designated institutional official should not be surprised at the last minute but should have been kept informed, at least informally, in the event that legal counsel needs to be involved or other issues need to be addressed. In addition, as part of the dismissal meeting, it should be made clear to the resident what rotations and/or number of months of credit (if any) he or she will be given for the time spent in the program. How the program director will respond to requests from outside agencies concerning the resident’s performance in the program should also be made clear. The institution’s grievance and due process or appeal policy should also be presented to the resident during the dismissal meeting.

Depending on the performance issues being addressed in the remediation or probation plan, the resident could be dismissed immediately, at some future time during the contract year, or at the end of the current contract year (ie, nonrenewal of contract). If the resident is given additional paid time following a failed remediation plan, his or her clinical or patient care duties may need to be adjusted, limited, or curtailed until the departure date.

Again, documentation of the dismissal meeting is very important and a third party should be present in addition to the resident and the program director. Documentation is very important throughout the entire remediation/probation period and will minimize or neutralize any potential legal questions in the future. If the emotional stability of the resident is in doubt, it may be appropriate to station security personnel close by during the meeting.

Although the process leading up to the dismissal of an underperforming resident is time consuming and disruptive, failure to do so can have long-range negative ramifications for future patients and coworkers. It is imperative that programs plan ahead on how to deal with underachieving residents and fellows and give the faculty and staff the appropriate tools to help them make honest performance assessments.

**Summary**

The suggested guidelines or principles presented here should provide a basic framework for training program personnel to assess and establish their own approaches to the poorly performing resident. Documentation, ongoing assessment of performance, a defined timeline, and defined next steps are critical components to any remediation or probation plan. Faculty development in assessment, evaluation, teaching, and mentoring are also critical to the ongoing success of the training program and in helping residents to become competent. It is no longer appropriate for training programs to foster a “sink or swim” attitude toward residency training and to knowingly graduate poorly performing residents who have not fulfilled the core competencies or met the milestones. As Steinberg notes, “we must all walk down this path together.”

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**References**