
Remediation of Learners Who Perform Poorly on an OSCE

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Data from well-designed OSCEs help educators identify trainees with gaps in their core clinical skills. Yet there is little consensus on effective remediation strategies for individuals who perform poorly. Experts stress that it is important to clearly delineate the implications and consequences of learner failure in any performance assessment (Cleland et al. 2005; Sayer et al. 2002; Segal et al. 1999; Schwartz et al. 1998) and assert that successful remediation requires approaches tailored to identified deficits (Hauer et al. 2009). By definition, learner remediation must have a reasonable chance of leading to an improvement in clinical competence. Table 3.1 breaks the remediation process down into manageable steps. Effective remediation first of all requires good data (see Chap. 2, Step 9 for an in-depth discussion of standard setting). Also crucial, to engage meaningfully in and gain life-long benefit from remediation, learners must have or develop the capacity to accurately self-assess and self-regulate learning.

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Initiating the Remediation Process

Not surprisingly, trainees are usually very upset upon hearing they have failed an OSCE. A structured first meeting between the student and faculty member responsible for remediation, which allows enough time for discussion of feelings, a student's self-assessment, and a careful review of data from the exam, is reassuring to the student and will most likely to lead to an effective remediation. Depending on the nature of the OSCE (low stakes/formative versus high stakes/summative), the remediation process can be more or less comprehensive. For a low-stakes exam, a brief individual feedback session, with videotape review if available, may be sufficient. Table 3.2 provides outline for a comprehensive intake meeting in a high-stakes situation. We schedule 1.5 h for this initial session.

Using detailed data from the OSCE in remediation is invaluable because it helps "break down" learner resistance to the process, builds accurate self-assessment skills, and if necessary provides the support for documentation for disciplinary actions. These data may include the various sources of information listed in Table 3.3.

Characterizing the Difficulty

There are a host of reasons learners fail an OSCE. The most common reasons for failure are summarized in Table 3.4¹ in order of frequency.

Once the faculty facilitator and the learner come to a negotiated agreement on one or more areas of difficulty, a contract or individualized remediation plan (IRP) should be drafted and follow-up plans made. This document (see Fig. 3.1 for an example) should evolve as the remediation process proceeds

¹Kalet A. et.al. (manuscript in progress). Our experience with clinical skills remediation for three consecutive classes of medical students, 2007–2009. During this time period, 53 of 500 students failed. Sample learning diagnoses are listed from most remediable to least.

Table 3.1 Steps in the remediation process

1. *Gather and carefully review objective data of performance*
2. *Obtain student self-assessment and provide feedback based on objective data*
3. *Assess for nonacademic issues*
4. *Make an educational diagnosis*
5. *Formulate an individualized learning plan with diagnosis specific remediation strategies (think creatively about available resources!)*
6. *Make a plan to follow-up on progress and measure*

Table 3.2 OSCE remediation initial diagnostic interview

- Statement of expectations*
- Learner self-assessment*
- Assessment of exam-specific performance issues*
- Educational history* Including screening for verbal and nonverbal learning disabilities, attention deficit disorders, language fluency
- Assessment of professionalism* e.g., learner attitudes toward the OSCE, accountability for performance
- Screening for situational stressors*
- Screening for common psychiatric illness* e.g., depression, anxiety, bipolar disorder, eating disorders, substance abuse

Table 3.3 Learner data useful for remediation

- Performance across OSCE cases compared to the group means*
- Performance by case*
- Post SP encounter notes*
- SP comments (after prescreening)*
- Videotape of the encounter*
- Other evaluation data available* e.g., academic record, clerkship comments

and new light is shed on the student's strengths and weaknesses. Keeping the IRP updated provides an efficient communication tool among the members of the remediation team and keeps the student actively engaged in the process.

In Table 3.5 we list remediation strategies we use regularly. Relevant references include Pinsky and Wipf (2000) for videotape review, Bowen (2006) and Croskerry (2003) for clinical reasoning and critical thinking, and Kogan et al. (2009) for direct observation with feedback. The primary purpose of any strategy is to enhance the learner's awareness of deficits and enabling them to improve their clinical performance. Strategies used will depend on the issues, available resources, and the learner's willingness to explore difficult issues.

Who Should Participate in Learner Remediation?

The most effective facilitators of clinical competence remediation are likely to be, but not restricted to, experienced

Table 3.4 Areas of difficulty leading to poor OSCE performance

1. *Preexisting academic issues*
 - Learning disabilities
 - Poor academic track-record especially on stressful clinical rotations
 - Nontraditional educational paths such as learners with discontinuous training (e.g., MD-PhD programs) or transfer from other programs (e.g., accelerated BS-MD programs)
2. *Isolated clinical skills deficit* i.e., specific area(s) of weakness such as knowledge base, communication, reasoning, or problem-solving skills
3. *Metacognitive or specific testing issues*
 - Time management or organizational difficulties
 - Insufficient preparation or poor understanding of the exam
 - Performance anxiety
4. *Extenuating psychological factors*
 - Anxiety
 - Depression
 - Situation-specific duress
5. *Nonverbal learning disorders* e.g., long-standing social awkwardness, autism spectrum disorders
6. *Professionalism issues* i.e., learner does not know or agree with health professional tenets and values; paranoid, combative, or defiant personality style or frank personality disorder

clinician educators. Table 3.6 lists examples of the experts and specialists who we have found are invaluable to the effort.

Faculty Development for Remediation

The institutional capacity to remediate learners who fail a high-stakes OSCE is entirely dependent on the number, commitment, and expertise of the faculty members available to participate. Faculty members who enjoy working with learners one-on-one, are good listeners, skillful at giving effective feedback, knowledgeable about learning disorders and psychiatric diagnoses and who are interested in the development of clinical competence are ideally suited for this work but may need additional training to maximize their effectiveness. Table 3.7 lists learning objectives for faculty development in clinical skills remediation. Educators specifically interested in reading more about defining behavioral measures of clinical competence are referred to Quirk (2006).

Make-Up OSCE

A remediation program, to be effective, must culminate in a measure of learner performance. In remediation for high-stakes exams, we require students to participate in and pass a four-station OSCE, which is a mix of cases repeated from the

Fig. 3.1 Example individualized remediation plan

| | Learning Goals | Strategies | Evidence of Improvement |
|----|-----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|
| 1. | Improve my rapport-building skills, especially non-verbal expressions of attention and concern . | Practice with an SP until I can do this consistently (2-3 sessions). | Perform adequately on Remediation OSCE. |
| 2. | Improve my clinical reasoning so that I can include more pertinent negative historical and physical exam facts in a patient note. | Write up 10 practice cases and review these with Dr. X. Respond to feedback by demonstrating commitment to learning. | Perform above the threshold on Remediation OSCE. |
| 3. | Explore my attitudes about patients who are seeking pain medication. | Write and discuss 3 brief essays: Physicians' attitudes toward pain management in terminally ill patients; Barriers to adequate pain relief in chronic pain syndromes; Ethical issues when treating pain. | By the Remediation OSCE, Dr. X will be satisfied that I have explored my own attitudes and beliefs in this area. |

Table 3.5 Selected remediation strategies

1. *Self-directed videotape review (VTR)* Using a blank OSCE checklist the learner rates his/her performance on one or two videotaped encounters from the actual OSCE, summarizes his/her findings from the VTR, and reviews these documents with a faculty adviser
2. *Faculty-facilitated videotape review* In learners who demonstrate poor self-awareness of their difficulties a structured, faculty-facilitated VTR can help the student recognize areas of difficulty
3. *SP practice with feedback* A learner with very specific communication difficulties can benefit from scheduled sessions with an SP experienced in giving feedback, to practice the skills
4. *Clinical reasoning practice* Learners are assigned reading about the clinical reasoning/critical thinking process to enhance metacognitive awareness and then practice with paper or Web-based cases
5. *Direct observation with real patients*
6. *Physical exam workshops* Can be done in groups with a faculty or resident facilitator; active practice and discussion about findings is critical to success
7. *Reflective writing* Brief assignments asking learner to reflect on attitudes and beliefs expressed or demonstrated which do not align with medical professionalism or effective patient care
8. *Directed readings* Relevant when there is an isolated knowledge deficit or lack of understanding of specific principles such as the tenets of medical professionalism or standards of treatment (e.g., substance abuse)
9. *Work with a specialist* e.g., referrals for psychiatric assessment, interpersonal skills coaching, performance anxiety strategies, learning/organization support, and career advice

Table 3.6 Experts and specialists who can contribute to learner remediation

1. *Clinical educators* Best suited to conduct the initial assessment, work with learners on clinical reasoning or physical examination deficits, monitor remediation process, and make a final outcome determination
2. *Communication skills coach* Learners with isolated communication deficits or professionalism issues benefit from working with a coach familiar with the health care environment and skilled with behaviorally focused coaching approaches
3. *Drama therapist/SP trainer/experienced SP* Learners with communication skills deficits or performance anxiety benefit from practice with feedback and coaching
4. *Learning specialist/studying or executive function coach* Learners with a long-standing history of uneven academic performance, atypical organizational strategies, unusual study strategies, or who don't "read for pleasure" may have undiagnosed learning disabilities
5. *Psychiatrist/psychologist* (when a psychiatric diagnosis is suspected or already established)
6. *Role model* A respected member of the clinical field related to the learner's interests can be effective at encouraging the student to engage in the remediation enthusiastically

Table 3.7 Learning objectives for clinical skills remediation faculty development

Clinical educators conducting remediation with learners who fail an OSCE should be able to...

1. Interpret quantitative and qualitative data regarding the competence of individual medical trainees
2. Define clinical competence in a behaviorally specific, measurable manner
3. List common areas of difficulty for trainees struggling to pass an OSCE
4. Discuss the role of normal adult development in assessing clinical competence development
5. Describe the screening process needed to identify a learning disability or attention deficit disorder
6. Demonstrate the ability to screen for common psychiatric issues that may manifest as or coexist with clinical incompetence
7. Make defensible judgments regarding clinical competence
8. Conduct an effective, satisfying, and growth promoting remediation process
9. Document a remediation process that is meaningful and addresses legal and regulatory requirements
10. Explore personal attitudes and beliefs which inhibit effective identification and remediation of learners who struggle to achieve minimal competence
11. Understand that on rare occasions a student may fail the make-up exam

OSCE they failed and new cases. Because reliability of a four-station OSCE is predictably poorer than one with more cases we determine the outcome of this exam using standards established in the larger exam and take into account findings from a detailed review of the student's performance. Each case is videotaped or directly observed by a faculty familiar with the student.

Considerations When Documenting Remediation

Detailed documentation of the remediation process is important both to ensure communication among the remediation team and to provide evidence to support promotion decisions. At the minimum, programs should keep track of learner's data on OSCEs, standards for pass/fail decisions, IRPs, and

document date and time of meetings between learners and members of the remediation team. We have found it helpful to write a brief narrative summary of each session with a learner, documenting updates to the IRP, and agreed upon next steps. Depending on the local law and regulatory environment, schools and training programs have obligations and responsibilities to keep written records of the evidence that learners have demonstrated training stage appropriate competence. Remediation team leaders should familiarize themselves with the government, accreditation agency (ACGME, LCME), and institutional documentation requirements that may apply to the remediation process. In the United States, in addition to documentation requirements for the purposes of accreditation, there is relevant federal law that seeks to protect the privacy of students, patients, and employees by limiting access to records (the Family Educational Rights and Privacy Act of 1974 [FERPA]; see www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html) and personal health information (the Health Insurance Portability and Accountability Act of 1996 [HIPAA]; see www.hhs.gov/ocr/privacy/hipaa/understanding/index.html). Balancing the needs to document a complex process in a meaningful way and understanding the legal environment will help each program design an efficient record keeping process which serves both the program and the learners. On rare occasions, a student may not be successful in their remediation. The institution must be able to accept this outcome while supporting the student with psychological support and career advice.

Remediation of learners who perform poorly on an OSCE provides a unique opportunity to explore the underlying reason(s) for substandard clinical skills and to intervene in a highly impactful manner. Although many of these learners are challenging, there is rich opportunity for professional and personal growth in the student as well as development of a therapeutic alliance between the learner and remediation specialist(s). In our experience, most students gain valuable insight regarding their difficulties, are committed to working with the remediation team, and successfully complete the make-up academic exercises. Work remains to be done regarding the identification of the most effective, efficient, and least costly remediation techniques for the various subtypes of problems leading to failure on clinical skills examinations.