The View from the Dean's Office

18

Lynn Buckvar-Keltz

Abstract

It is the role of a medical school student affairs dean to balance the responsibilities of advocating for students with upholding the integrity of the curricular program. This work is especially challenging when dealing with students who are struggling and require remediation. Given her diverse portfolio of responsibilities as dean for student affairs, which includes overseeing the academic progress of students, disciplinary process, mentoring and advising, student health and wellness programs, international health program, student life, and chairing of an executive committee for admissions, she is often the first one to identify and intervene with a struggling student. In addition to working with students and faculty to identify the underlying causes of a student's problem, the dean's office needs to be concerned about resource availability for and cost of remediation, legal and privacy issues, the implications of labeling students, the definition of the official written record, and final competency decisions. In this chapter, the author discusses the resources needed for remediation, their costs, and resources currently not available. This experienced student affairs dean shares her experience reviewing admission information, discusses preadmission factors that may portend the need for remedial assistance once in medical school, and offers NYU School of Medicine technical standards as an example. She discusses her approach to counseling students regarding how to communicate their remediation history to future training directors and employers. She thereby demonstrates how it is possible to balance the school's interests with obligations to students, faculty, and society.

L. Buckvar-Keltz, M.D. (✉)
New York University School of Medicine,
New York, NY, USA
e-mail: lynn.buckvar-keltz@nyumc.org

A. Kalet and C.L. Chou (eds.), *Remediation in Medical Education: A Mid-Course Correction*,
DOI 10.1007/978-1-4614-9025-8_18,

A Monday in the life of the dean for student affairs:

8:30 AM*: Review the data on students to be discussed at the preclinical board meeting on Tuesday. I note that a student repeating the first academic year failed an exam last week, which will trigger a discussion regarding dismissal. I arrange to meet the student today to assess her recent difficulties.*

9:00 AM*: Email from second year student stating he has gastroenteritis and won't be able to sit for today's exam. This is the second time the student has asked to be excused from an exam due to illness.*

10:00 AM*: Phone call from an internal medicine clerkship teaching faculty member concerned that BD is "odd" and doesn't relate well to patients, nurses, and the clinical team. His peers seem to lose patience with him quickly, and the housestaff report he hasn't integrated into the clinical team after three weeks on the rotation. The attending observed BD interviewing a patient and found him to have difficulty developing rapport and eliciting the "narrative thread" of the patient's history. The attending does report that BD seems to be working hard and "has a good heart." I find out that nobody has given this feedback to BD verbally or in writing. I speculate that his performance may be in the failing range, and the attending immediately states, "Oh, I don't want to fail him. I just want you to be aware so you can do something for him." Then he asks, "Also, has he had problems like this in other clerkships?"*

10:30 AM*: Meet with a student requesting a letter of recommendation for a research fellowship.*

11:30 AM*: Email from a student requesting a housing change due to issues with her roommate.*

1 PM*: Meet with a student who just failed her second NBME shelf exam during her core clinical clerkships.*

(continued)

2:30 PM*: Meet with a medical student who is concerned that her classmate "may be manic" but doesn't want me to let the friend know that she told me.*

3 PM*: Meet with student council president regarding current housing policies.*

3:30 PM*: I pull out the list of concerning students I wrote Sunday evening. I email two of the students to check in with them.*

4 PM*: Meet with a student applying in dermatology who is wondering if she "needs to do a research year."*

4:15 PM*: Finalize slides for town hall meeting on the residency application process.*

4:30 PM*: Faculty member stops by to express his concern that a student in his seminar group seems very anxious and worries about failing the upcoming exam.*

5 PM*: Review the neuropsychological report of a second year student sent by our consultant learning specialist (with the student's permission) that includes a new diagnosis of ADHD and recommendation for test accommodations.*

5:15 PM*: Run into a disciplinary committee faculty member, who asks, "what ever happened to the student that was accused of cheating and went before their committee but was not found guilty due to lack of evidence?" The faculty member implores me to announce at yearly orientation for new students that cheating is not allowed.*

5:30 PM*: Email from director of student health service informing me that two students have not complied with yearly PPD testing and asks me if I will be "pulling them off the wards" until they get it done.*

5:45 PM*: Email from student unhappy with his grade of high pass in the psychiatry clerkship because he feels his performance warrants an honors grade, especially because he stayed later than most of his classmates on the unit, volunteered to give an extra presen-*

(continued)

tation to his group, and was told that he did a great job by one of his attendings.
***6:00 PM**: As I'm leaving the office, a student comes by and offers to walk with me because she "doesn't want to hold me up." During our discussion the student becomes tearful and expresses worry that she will fail another exam and doesn't belong in medical school. Upon questioning, she is isolated, withdrawn from classmates, has difficulty sleeping, and feels exhausted all the time.*

18.1 Introduction

It is the role of a medical school student affairs dean to balance the responsibilities of advocating for students with upholding the integrity of the curricular program. This work is especially challenging when working with students who are struggling and require remediation. Given my diverse portfolio of responsibilities as dean for student affairs, which includes overseeing academic progress of students, disciplinary processes, mentoring and advising, student health and wellness programs, international health program, student life, extracurricular activities, and chairing of an executive committee for admissions, I am often the first one to identify and intervene with a struggling student. In addition to working with students and faculty to identify the underlying causes of a student's problems, the dean's office needs to be concerned about resource availability for and cost of remediation, legal and privacy issues, and final competency decisions. In this chapter, I will discuss the issue of medical student remediation from preadmission until graduation through the lens of the school's interests and obligations to students, faculty, and society.

18.2 Admissions

Medical school admissions policy is the most important factor determining who becomes a physician. The first time faculty may question a student's ability to succeed in medical school is when reviewing his or her application to medical school. Academic concerns arise when students have grade point averages and MCAT scores significantly below our mean for accepted students because studies have shown that these academic indicators correlate, albeit weakly, with learning foundational medical knowledge and USMLE Board scores [1]. Much attention is paid to an uneven academic record or fluctuating grades, as this may be a sign of lack of motivation, lack of interest, or emotional difficulties. Withdrawals from coursework, especially repeatedly, raise concerns. Additionally the record is scanned for certain patterns. Has the student been fully engaged in the extracurricular life at their undergraduate school? If not, why not? Is all of their nonclass time already devoted to studying, suggesting the student may not have "additional reserve" to handle medical school? A leave of absence may be another sign of some underlying difficulty. Indication of a disciplinary action is a concern. Unfortunately, the value of these application-based variables as predictors of success in medical school has not been well studied. However, studies have shown that unprofessional behavior of practicing physicians reported to state boards is correlated with a history of certain unprofessional behavior in medical school [2]. It is important for supporting materials such as a dean's letter (supplied by some undergraduate schools), the student's personal statement, or letters of recommendation explain any unevenness in performance without raising red flags. In order to assess nonacademic qualities of applicants such as ethical judgment, communication skills, and problem solving capabilities, some US schools have adopted McMaster University's model of multiple mini-interviews (MMI) with standard scenarios to be discussed by the applicant. The data thus far show that the MMI predicts success on national licensing examinations in Canada [3].

In the United States the competition for a spot in medical school is daunting—in 2011 the AAMC reported there were 43,919 applicants, 19,230 of whom matriculated to US medical schools. This is a 44 % acceptance rate for the

students "still standing" after grueling premedical coursework and the MCAT, both of which cull out lower performing students. This is intense competition even when compared with law school data: the law school admission council reported in 2011 there were 78,500 applicants with 45,600 matriculants, for a matriculation rate of 58 % [4].

The good news for these 19,230 students who matriculated to US medical schools is that they will most likely graduate with an M.D. degree. The AAMC followed three matriculating classes, 1987, 1992, and 1995, for 10 years and reports in their *Analysis in Brief* publication in 2007 that 96 % of students completed medical school within 10 years. This long time to completion was used to capture students enrolled in combined and dual degree programs. "Fewer than 2 % of all medical students across the three cohorts were reported as having left school for academic reasons" [5]. Thus, the admissions officers are more influential in determining who becomes a physician than those in the office of education. Given this, the question remains, are we giving our admissions officers the tools to make the most informed decisions?

18.3 Technical Standards

Occasionally an applicant will apply to medical school, but may not possess the functional ability to perform as a medical student. The Americans with Disabilities Act (ADA) protects citizens with disabilities from discrimination. The purpose of the ADA is to provide opportunities for persons with disabilities to compete with other applicants on the basis of their ability. The ADA requires medical schools to provide accommodations to disabled persons to enable them to access the benefits, services, and opportunities available to the nondisabled (see Chap. 9). Schools are expected to assess applicants on the basis of their ability to complete the educational program. This means that applicants must be able to perform the "essential functions" and meet the "essential eligibility requirements" of the program once provided with the appropriate accommodation. Each school is free to determine the "essential functions" or "essential eligibility requirements" of its educational program. While schools cannot inquire about a disability prior to admission, they can seek information to ensure that an applicant can perform these essential functions [6]. In recent years many schools have developed *technical standards* to clarify and communicate those essential functions and eligibility requirements.

At NYUSOM we developed technical standards after reviewing the standards of approximately ten peer medical schools (see box) [7]. The technical standards at NYU reflect our mission of graduating students who can be practicing clinicians without the aid of intermediaries such as a person to conduct a physical exam for them.

NYU School of Medicine Technical Standards

Preamble:

All candidates for the Doctor of Medicine degree must possess the physical and mental skills and abilities necessary to successfully complete the NYU School of Medicine curriculum. To achieve the optimal educational experience, students are required to participate in all phases of our training program. The study of medicine is not a pure intellectual exercise; a specific set of minimum physical, mental, emotional and social abilities, as well as professionalism, are needed to be a successful student and physician.

To successfully complete our medical school curriculum students must possess all of the abilities listed in the following six categories. The use of an intermediary that would, in effect, require a student to rely on another individual's power of observation and/or communication skills will not be permitted.

The NYU School of Medicine will consider for admission any applicant who meets its academic and nonacademic criteria and who demonstrates the ability to

(continued)

perform the skills listed in this document, with or without reasonable accommodations, consistent with the ADA and the Rehabilitation Act.

Behavioral and social attributes: *Candidates must*

- Demonstrate the maturity and emotional stability required for full use of their intellectual abilities.
- Be capable of adapting to changing environments and possess flexibility in learning to function in the face of uncertainty.
- Be able to perform under physical, mental, and emotional stress.
- Exercise good judgment and have the ability to promptly complete patient care responsibilities.

Communication: *Candidates must*

- Be able to effectively, in both written and oral English, and efficiently speak, write, hear, read, and use technology to communicate with patients, families, and members of the healthcare team.
- Be able to identify nonverbal communication, such as changes in facial expression, posture, body language, mood, and activity.
- Be able to record information accurately and clearly.
- Communicate effectively in English with other healthcare professionals in a variety of patient settings.
- Be able to establish rapport with patients.

Ethics and professionalism: *Candidates must*

- Maintain ethical and moral behavior consistent with professional standards for interactions with students, faculty, staff, patients, and the public.
- Understand the legal and ethical aspects of the practice of medicine and function within both the law and ethical standards of the medical profession.

(continued)

Intellectual—conceptual, integrative, and quantitative abilities: *Candidates must*

- Have sufficient cognitive abilities to effectively learn, retrieve, assimilate, analyze, sequence, and organize complex details.
- Be able to adapt to multiple learning techniques and environments including, but not limited to, classroom instruction, small group instruction, team and collaborative activities, individual study, preparation and presentation of reports, self-assessment, peer review, and use of computer technology.

Motor: *Candidates must*

- Possess sufficient motor function to perform physical examinations and diagnostic maneuvers.
- Be able to respond to emergency situations in a timely manner and provide general and emergency care.
- Adhere to universal precaution measures and meet safety standards applicable to inpatient and outpatient settings and other clinical activities.

Observation: *Candidates must*

- Be able to observe required demonstrations and experiments including, but not limited to, anatomic dissection, microscopic studies, and patient demonstrations.
- Be able to use vision, hearing, and sensation to accurately observe a patient and assess findings.

18.4 Medical Student Privacy: The Family Educational Rights and Privacy Act

The Family Educational Rights and Privacy Act (FERPA) [8] (http://www.ed.gov/policy/gen/guid/fpco/ferpa/index.html) is a Federal law that

protects the privacy of student education records. The law applies to all schools that receive funds from the U.S. Department of Education. Under FERPA, schools must have written permission from the student in order to release any information from a student's education record and must remind students of their rights annually.

However, FERPA allows schools to disclose those records, without consent, in certain cases, including to school officials with legitimate educational interest. *These rules*, *as well as concern for students' privacy*, *discourage extensive discussion across certain boundaries regarding problematic students*. Interpretation of these rules varies widely from school to school.

18.5 Improve Admissions Policy and Practice: A Research Agenda

Medical schools vary in their approaches to "feed-back" information to admissions offices and committees regarding students' performance once in medical school. Schools run the gamut from having admissions deans on promotions committees to having no communication to the admissions office regarding student performance once a student matriculates. It is my opinion that the latter policy hampers the admissions committee's ability to continuously improve upon their evaluations of future applicants; on the other hand, it would be ideal if there were rigorous research data available to guide decisions. This would reduce the inevitable bias for or against certain student characteristics when making predictions based on the limited and unsystematic experience at one school.

I routinely review the medical school application file of each struggling student to look for evidence of previous academic or behavioral problems. This review may inform us as to the nature of the problem, whether it is a chronic or recurrent issue, and may guide selection of remediation strategies. In addition, I meet with the deans of admissions periodically to feed back relevant data including "red flags" in application materials. From time to time, the admissions office will "take a chance" on an applicant with a subpar academic history because of a particular experience or talent that suggests promise to become an outstanding physician. In these cases, *it is not clear whether giving proactive support to the student is beneficial or not*. Labeling a student as at-risk for failure may seriously hamper their self-confidence and cause undue anxiety (see also Chap. 12). In addition, identifying students as at-risk may unconsciously bias the faculty. Some schools have elective academic support in advance of the start of medical school. For instance, the University of Texas Southwestern medical school offers the Summer Enrichment Program, a 6-week program for new first-year medical students to promote students' academic adjustment to their school.

18.6 Common Causes of Student Difficulties Across the Medical School Curriculum

There are many underlying reasons for a student to struggle while in medical school. The more common causes as viewed from my office, are discussed below.

18.6.1 Common Presenting Issues Arising in the Preclinical Curriculum

18.6.1.1 Weakness in Foundational Medical Knowledge

Apparent weakness in foundational knowledge is usually identified via poor performance on knowledge examinations and in small group discussions and comes to my attention within the first few months of school. Commonly, these struggling students were not undergraduate science majors and therefore relatively unprepared in this domain. Students may have difficulty acclimating to studying and taking medical school exams, as is sometimes seen with students who are accustomed to more conceptual testing, such as engineering majors or those who have taken time away from school between college

and medical school. Other students are less academically prepared in general (see Chap. 3). Students may also lack the appropriate knowledge base because they lack the motivation to study. These students often have difficulty articulating their reasons for wanting to become a physician and sometimes describe the pressure put upon them by parents and other family members. It is important to identify an unmotivated student, as the usual remediation resources will not help them. These students may appear to be sabotaging their own success (see also Chap. 12). Instead, serious reflection on the part of the student is necessary. Faculty and deans sometimes suggest clinical shadowing in an exciting area for the student as a way to remind them why they chose to attend medical school. Other times, a leave of absence to pursue other interests is helpful. Some of these students choose a different career path, which we view as a successful outcome for the student. Some students with weakness in foundational knowledge will benefit from a neuropsychological evaluation by a learning specialist to assess for an underlying undiagnosed learning disability (see also Chap. 9).

18.6.1.2 Psychological Distress

Some students become anxious regarding their academic performance in medical school, hindering their success. Because our medical students are exceedingly academically gifted, adjustment to being "average" in medical school is a challenge. Many of these students become disappointed and question their abilities. Support and encouragement is very helpful in this circumstance. Simply pointing out the obvious fact that 90 % of medical students cannot be in the top 10 % of their medical school class often helps students adjust their expectations. A pass/fail curriculum may lower the anxiety level for students.

Most medical schools preemptively encourage students to attend to their stress management and wellness and support this through formal and informal programing. Our student health psychiatrists have extensive experience with medical students and can be helpful with specific issues such as "test anxiety" (see Chap. 12). Our learning specialist speaks to the class on neurocognitive profiles and study strategies. We sponsor a "student appreciation week" during which a range of workshops and other sessions are available to students including healthy eating, acupuncture, and other complementary and alternative health strategies. Of interest, we find attendance at these voluntary events is enhanced when we emphasize the value it has in preparing them to help their peers rather than focusing on "self-help." We encourage students to get regular exercise and remind them about the importance of good sleep habits (see also Chap. 11).

Academic stress can trigger an anxiety disorder, major depression, a bipolar episode, and other mental health issues. Faculty and deans need to be vigilant in identifying medical students at risk for developing mental health issues and have mechanisms for intervention. At NYU School of Medicine, we have psychiatrists at our student health service who care for our students at no charge to them. In addition, we regularly refer students to outside mental health professionals for ongoing treatment.

18.6.1.3 "Forward feeding" Information

The dean for student affairs needs to determine which faculty member will be informed of a student's struggles and what level of detail to disclose within the guidelines of FERPA. At NYUSOM, the preclinical board on academic standing, comprised of course directors and chaired by the dean for student affairs, reviews each student with failures and marginal grades on assessments in the areas of foundational knowledge and clinical skills. Unless a student gives explicit permission to share their information, the dean does not disclose details of the cause(s) of the students' difficulties.

There are different opinions regarding the "forward feeding" of data about struggling students to faculty who will be working with them (see also Chap. 20). On the one hand, this knowledge may prepare faculty to better support these students through early identification and intervention. In addition, students with a pattern of marginal performances are a concern and may

fly under the radar if there is no forward feeding [9]. The counterargument is that these faculty members may be biased by this information, which may lead to treating these students differently and possibly assessing them differently [10]. At our school, we have a preclinical board on academic standing that is separate from the clinical board on academic standing. In retrospect, we often observe students flourishing in the clinical curriculum after struggling in the preclinical curriculum and believe it is best not to "feed forward" information outside of a few select instances. One particular observation is worth noting—in my experience, students with a history of mental health issues often find the core clinical clerkship in psychiatry to be particularly challenging. I counsel students regarding this phenomenon and will occasionally ask permission to speak with the psychiatry clerkship director in advance of the student's rotation to alert them of the student's background.

18.7 Common Issues in the Clinical Curriculum

To be successful in the clinical setting requires students to rapidly gain a new set of skills. The transition from preclinical to clerkship curriculum is often the time that deficits in interpersonal skills and professional behavior are noted. Some of these students are identified earlier as a result of early clinical exercises in which communication and behavioral difficulties are identified. Below I address the most challenging patterns of behavior, which although often previously suspected tend to become major difficulties in the clinical clerkships.

18.7.1 Autism Spectrum Disorders

Students with previously identified or suspected autism spectrum disorders including those identified as having high functioning autism spectrum disorder (formerly known as "Asperger's syndrome") are often viewed as competent but quirky in the classroom setting. Interacting in clinical teams and with patients can be challenging, as they cannot accurately read the social and emotional cues of others. While it is common for these students to engender significant sympathy from classmates and faculty as they are well meaning and earnest, their communication behavior can be very "off putting" to patients. Although current treatment strategies for those with autism spectrum disorders are expensive, time-consuming, and often unsuccessful, we have found some can benefit in demonstrating the ability to function effectively as a medical student from intensive coaching and role-play practice focused on clinical interviewing (see also Chap. 10). The best predictor of success in these cases is the student's level of motivation and awareness of their own challenges.

18.7.2 Personality Disorders

Students with antisocial personality traits are of great concern in medical school because of their socially irresponsible and exploitative behavior. These students have disregard for school policies and expectations of professional behavior, do not show remorse, and don't usually learn from the consequences of their actions. In addition, a lack of empathy is common and disconcerting to patients and peers. These students need clear expectations outlined for them and close follow-up. The recent AAMC-facilitated national criminal background check service for applicants at the time of their acceptance to medical school, currently used by most schools, may reduce the number of medical students and physicians with antisocial personality disorder in the future.

Students with borderline personality traits are emotionally labile, have unstable relationships with others, and are impulsive. Many people with borderline personality disorder also have coexisting mood, anxiety, substance use, and eating disorders. Impulsivity and emotional distress often result in these students having difficulties. Faculty often experience working with these students as intense and emotionally exhausting. Support teams working with these students should be aware of the student's common tendency to "split"

the team members into extreme groups of "good" and "bad" and pit them against each other. This behavior makes remediation very challenging.

Students with schizotypal personality traits are often described as "odd" or "eccentric" and have difficulty interacting with others. The challenge with these students is ascertaining whether or not a thought disorder is present. In these situations it is essential to have an administrative psychiatrist at the school assess the student. These students struggle on clinical teams and in their interactions with patients.

In general, the persistence of personality traits or disorders and their relative lack of responsiveness to treatment make working with these students challenging and careful monitoring and follow-up throughout medical school is important (see also Chap. 17).

18.7.3 Unprofessional Behavior

What keeps student affairs deans up at night? The high-profile unprofessional act of a medical student. Though most students behave professionally all the time, unsavory behavior by a trainee is long remembered by faculty and classmates. At NYUSOM, a disciplinary committee comprised of faculty and medical students adjudicates cases that are not resolved by the dean for student affairs. This committee gives final recommendations to the dean of the medical school. Academic dishonesty, HIPAA violations, and failure to meet academic responsibilities in a timely manner are the most common instances of unprofessional behavior at our school. Schools vary in their policies regarding remediation versus immediate dismissal for unprofessional behavior.

More frequently, unprofessional behavior may be minor and investigated and remediated without the formal activation of the disciplinary committee. However, this becomes problematic when a pattern of relatively "low level" inappropriate behaviors develops. Since the student affairs dean may be the only one to appreciate the pattern early on, and because early intervention is thought to be the most effective remedial strategy, I have found it is essential to keep a private record ("written memory") of these minor issues. I am also transparent in my communication with the involved student explaining that a pattern of behavior will trigger an official complaint to the disciplinary committee.

18.7.4 Substance Abuse

Students may be impaired due to use of legal or illegal substances. Peers are usually the most knowledgeable about a classmate's substance use and may come forward to a faculty member or the dean's office to share this information. Care should be taken to be supportive of classmates' concerns and privacy while also obtaining accurate, reliable, and complete information. The school should confront the impaired student with information (test scores, evaluative comments, informal comments) that supports the conclusion that the student is unfit to in their role as a student. The school may require an individual student undergo random blood and urine testing. Students found to be impaired are required to undergo treatment and monitoring. In New York State, medical students can be enrolled in the Committee on Physician Health (CPH) for ongoing monitoring and treatment.

> *The mission of the New York State Medical Society's Committee for Physician Health "is to promote quality medical care by offering non-disciplinary confidential assistance to physicians, residents, medical students and physician assistants suffering from substance use disorder and other psychiatric disorders. The Committee monitors the treatment and compliance of program participants and provides advocacy and support as well as outreach activities, including prevention and education."* [11].

Students should be required to allow communication between CPH and the medical school for the duration of their time as a student. CPH requires continued random drug testing and therapy as conditions of their program and reports periodically to the medical school regarding ongoing compliance with their requirements.

18.8 Fitness for Duty Evaluation

On occasion a student's psychiatric illness or suspicion of impairment will call into question their fitness to continue in medical school. We have an administrative psychiatrist who conducts fitness evaluations using primary, and sometime ancillary, data to make a determination. Students found to be "unfit" are placed on a leave of absence by the school and are required to address their issue in order to be allowed to return to the school. The same administrative psychiatrist will evaluate any student on a leave of absence for mental health or substance use issues who requests re-matriculation at our school.

Fitness for duty issues may be more common at the GME level and in practice. It is required that we report physician impairment to New York State, and we strongly encourage physicians to participate in CPH.

18.9 Dean's Office Resources for Remediation

Schools develop their own resources to remediate students and vary widely on what is available and on who pays for the remediation. Philosophically, schools need to determine whether their supports (i.e., offering and paying for remediation) are helpful to the student or enabling a lack of responsibility and ownership on the student's part. The box shows a list of the resources we commonly use for medical student remediation, a list of "dream resources," those we currently don't have but would be of great help and an estimate of the cost of remediation per student at this point in time.

At NYU, we have used the following resources for remediation:

1. Learning specialist
2. Academic tutoring
3. Student health psychiatrist
4. Administrative psychiatrist
5. Course faculty
6. Expert faculty on remediation
7. New York State Committee on Physician Health
8. Outside professionalism programs
9. Simulation experiences with expert faculty at a simulation center

"*Dream resources*" *that I would like to have*:

1. Fund to cover mental health expenses not covered by student health service and health insurance (co-pays for medication, support for intensive psychotherapy).
2. Remediation program developed by expert faculty to be delivered at our simulation center.
3. Fund to develop extensive assessments of professionalism to test students who have failed on professional grounds.
4. Social skills therapist to work one on one with students on the autism spectrum to observe them in clinical settings and then treat them.

Examples of the costs associated with remediation per student:

1. Complete learning specialist evaluation ~$3,500/student
2. Tutoring $25/hour
3. Student health psychiatrist—included in support of our student health service
4. Administrative psychiatrist—included as part of physician's responsibilities to the school
5. Course faculty—no additional cost
6. Expert faculty on remediation—no additional cost

(continued)

7. Comprehensive clinical skills exam (CCSE) remediation—~$400/student excluding faculty time
8. New York State Committee on Physician Health—sponsored by the medical society of the state of New York, at no cost to the impaired student/physician or to the school
9. Outside professionalism programs $2,500–4,500

At our school, out of about 650 students enrolled at any one time, approximately 10–20 students receive tutoring for failure on knowledge assessments per year. We only offer tutoring to failing or marginal students. Approximately 5 students undergo a detailed learning evaluation each year. Approximately 20 students undergo remediation for skills exams each year, which includes students remediating within preclinical modules (such as after failing an OSCE) and students remediating a failure in our CCSE (see Chap. 2).

Each school has its own method of remediation of medical students. While often the remediation occurs within a course or clerkship structure, at NYU we have found it helpful to also have faculty with expertise in remediation of clinical skills and professionalism lapses. In addition, there are outside resources available for remediation of professionalism issues including the Vanderbilt Comprehensive Assessment Program for Professionals at Vanderbilt University Medical Center and Acumen Assessments in Kansas.

18.10 Official Academic Record

The contents of the official academic record are specific to each school. At many schools the official academic record consists of a student's transcript, student's duplicate record (in addition to the transcript it includes biographical information and USMLE scores), narrative evaluative comments from faculty, the medical student performance evaluation ("MSPE," aka "Dean's letter") and, for a small number of students, a disciplinary report. The entire official academic record can be obtained by subpoena in a court of law. The AAMC has official guidelines for the MSPE.

The AAMC guidelines for the MSPE include such issues as:

- Inclusion of students' academic history including any gaps in education such as a leave of absence
- Information, based upon school-specific policies, of coursework that the student was required to repeat or otherwise remediate
- Information, based on school-specific policies, of any adverse action(s) imposed on the student by the medical school or its parent institution
- Narrative evaluation of students in the core clinical clerkships and electives that focuses on summative, instead of formative, feedback
- Assessment of professional behavior
- Appendices which include a graphic representation of a student's performance as compared to his/her peers

Each state medical licensing board has its own requirements for documentation and some states, such as California and Massachusetts, are quite extensive. For instance, California currently asks if a student has been on probation during medical school. Some schools have policies in which students are placed on probation for academic or professionalism reasons during medical school, with the agreement that the record will be "sealed" if the student does not have any repeat issues. This becomes an issue if a student is applying for licensure in select states that ask this question. The definition of probation is evolving and becoming more formalized and specific in response to this changing landscape. Some institutions are now preserving the term "probation" for use after the effectiveness of early stages of remediation can be

assessed. In these cases the terms "focused review" or "academic warning" are used to denote the early states of remediation (see also Chap. 20). Credentialing services contact medical schools on behalf of graduates and institutions to verify completion of medical education. Typically they request information about interruptions in medical education, academic or disciplinary probation, unprofessional conduct or reports of negative behaviors, or questions of academic incompetence. Such reports should be completed based on the official academic record. Student data that is outside of the official academic record ***cannot*** be shared with outside parties including residency programs and licensing boards. This includes oral or written "off the record" comments by faculty, peers, or others in the administration. Many student affairs deans keep records of discussions with students. These records, as long as their only purpose is to serve as the written "memory" of the dean, are private and not available at the time of subpoena.

18.11 What to Recommend to a Graduating Medical Student

Students who have undergone remediation in medical school may or may not be at risk for difficulties during postgraduate training. All students should be counseled to seek out training programs that best fit their goals, strengths, work styles, and personal requirements. Divulging remedial work that is not part of the student's record is the personal choice of the student and should be made carefully. I counsel students to always be honest and professional while understanding their own right to privacy. It has been our experience that students who engage with enthusiasm and successfully complete remediation programs are prepared for residency training and practice. The student may perform as well, or better, than their colleagues who did not struggle during school. We encourage graduates to optimize their success by asking for feedback frequently from peers and supervisors and acting on the information gained. Graduates with disability accommodations in place should be encouraged to bring documentation to their program director well in advance of needing the actual accommodations to ensure appropriate supports are instituted. Students need to be aware that accommodations within hospital systems can be particularly difficult to enact as patient care and patient privacy policies supersede their rights in some cases.

18.12 Dismissal of Medical Students

The percentage of medical students dismissed from school is strikingly small when compared to other professional schools such as law or business. I have found medical school faculty are naturally interested in "diagnosing and treating" the problem student and are more comfortable with their role in remediation than in determining when a student cannot meet milestones and must be dismissed.

If dismissal from medical school is being seriously considered, the student must be informed. In my experience, this discussion is often enough to motivate a learner to be an active participant in successful remediation. It is also important to clearly outline the school's requirements, including exact deadlines, for the student to complete their remediation activities. This should be done both verbally and in writing and reflect the school's policies on student promotion and professional behavior. Legal counsel can be helpful with reviewing these documents as policies may be subject to interpretation. At NYU, I notify a student when the school is considering dismissal and encourage the student to advocate for themselves in writing to the appropriate committee. Typically, students in this situation have already been told multiple times they are at risk for dismissal and have undergone remediation unsuccessfully. Many schools have the appropriate committee (preclinical board on academic standing, clinical board on academic standing, or disciplinary committee) deliberate and vote on recommending a student's dismissal to the dean, who makes the final decision. Students should have the right to appeal the decision within a defined time frame (see also Chap. 20).

The dismissal of a student is the most high-profile example of when the dean for student affairs and the involved faculty have to balance their advocacy for the student with their obligation to the medical school and society at large. In addition to following the institution's policies and procedures, I also consider the immediate needs and issues facing the dismissed student. Given the gravity of the situation, I recommend the student talk with a trusted friend or relative, and I also refer him or her to a mental health professional for support in addition to notifying the student health service in case the student contacts them for care. Students need time to move out of on-campus housing. Once a student is officially dismissed, they need to leave school in a timely fashion. If the school's policy allows it, refunding all or part of the semester's tuition is appreciated. A dismissed student may also appreciate if the dean for student affairs helps explain the dismissal to a parent or spouse with them.

References

1. Julian ER. Validity of the Medical College Admission Test for predicting medical school performance. Acad Med. 2005;80(10):910–7. PubMed PMID: 16186610.
2. Papadakis MA, Teherani A, Banach MA, Knettler TR, Rattner SL, Stern DT, Veloski JJ, Hodgson CS. Disciplinary action by medical boards and prior behavior in medical school. N Engl J Med. 2005;353(25):2673–82. PubMed PMID: 16371633.
3. Eva KW, Reiter HI, Rosenfeld J, Trinh K, Wood TJ, Norman GR. Association between a medical school admission process using the multiple mini-interview and national licensing examination scores. JAMA. 2012;308(21):2233–40.doi:10.1001/jama.2012.36914.
4. Law School Admissions Council. Law school admissions council volume summary. LSAC data; 2013. http://www.lsac.org/lsacresources/data/lsac-volume-summary.asp. Accessed 17 July 2013.
5. Garrison G, Mikesell C, Matthew D. Medical school graduation and attrition rates. Anal Brief. 2007;7(2):1–2.
6. American Association of Medical Colleges (AAMC). Executive summary: medical students with disabilities—Group on Student Affairs (GSA)—member center [Internet]. Washington, DC: Association of American Medical Colleges; 1995–2013. Available from https://www.aamc.org/members/gsa/64660/gsa_ada.html
7. NYU School of Medicine. NYU School of Medicine Technical Standards [Internet]. New York: NYU Langone Medical Center; n.d. Available from http://school.med.nyu.edu/nyusom-technical-standards
8. Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g; 34 CFR Part 9 [Internet]. Available from http://www.ed.gov/policy/gen/guid/fpco/ferpa/index.html
9. Cleary L. "Forward feeding" about students' progress: the case for longitudinal, progressive, and shared assessment of medical students. Acad Med. 2008;83(9):800. doi:10.1097/ACM.0b013e318181cfbc.
10. Cox SM. "Forward feeding" about students' progress: information on struggling medical students should not be shared among clerkship directors or with students' current teachers. Acad Med. 2008;83(9):801. doi:10.1097/ACM.0b013e318181cfe6.
11. Medical Society of the State of New York. MSSNY-CPH Mission [Internet]. New York: Medical Society of the State of New York; 2011. Available from http://www.mssny.org/mssnyip.cfm?c=i&nm=Mission_Statement