

Chapter 10: Working with Students with Difficulties: Academic and Nonacademic

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Introduction

Learners with difficulties in the clinical setting present challenges for clerkship directors, and include cognitive and non-cognitive difficulties. Cognitive difficulties include a weak knowledge base, underdeveloped clinical skills, poor problem-solving ability, and difficulty organizing information. Non-cognitive, behavioral difficulties include poor motivation, a negative attitude, and inability to work with colleagues in the context of an integrated care team. These broad categories are not mutually exclusive. A student with a poor knowledge base, for example, may refrain from participating fully in care activities as a means of hiding his or her deficits. Conversely, the student who does not participate in clinical activities squanders the opportunity to practice existing skills while forgoing the chance to acquire new ones. While most students are interested in and capable of learning, a disproportionate amount of a teacher's time and energy can be expended in addressing the needs of difficult learners. Successful clerkship directors must have effective systems of prevention, identification, screening, and intervention for the academic and nonacademic problems of students.

Problem Scope

It is difficult to estimate the impact problem learners have on their teachers, their fellow students, and the overall health-care delivery team. Certainly, the potential ineffectiveness of these individuals as team members and the disruption they cause to the health-care delivery system are enough to frustrate even the most seasoned educators.^{1,2} The degree of strife teachers report underscores the importance of preventing problems whenever possible and addressing them early when they do arise.^{1,2}

The impact of learners with difficulties on our training institutions, the health-care system and society is profound. Team communications are affected by disruptive actions, and patient safety and quality of care are directly related to the effectiveness of these communications. Patient dissatisfaction with physicians who have poor physician-patient relationships is associated with a higher malpractice rate.³ If the offending attitudinal behavior continues unabated, it may be associated with future problems, including subsequent disciplinary action by the state medical board.⁴ All participants in medical education share the responsibility to help identify and modify students' deficiencies before problems emerge later in their careers.

Table 1 illustrates the relative frequency of commonly identified student problems and the relative difficulty of managing the associated problem. The five most frequently identified student problems are 1) poor fund of knowledge, 2) inability to focus on what is important, 3) poor integration skills, 4) over-eagerness, and 5) excessive shyness or non-assertiveness.^{5, 6}

Causes of Learner Difficulties

Cognitive Problems

Knowledge or skills deficits are often identified more easily than behavioral issues. Knowledge and the ability to retrieve that knowledge is essential for students to develop effective diagnostic reasoning skills. Therefore, learners with an inadequate knowledge base are at a disadvantage. Cognitive deficiencies may be due to learning disability,⁷ diagnostic reasoning skill deficiency or inability to integrate knowledge,⁸ and immature development of critical thinking.⁹ Further, if the learner cannot think in the abstract, he or she will find it difficult to apply concepts from one clinical scenario to another.¹⁰

Non-cognitive Problems

Learners may show a poor attitude, demonstrating disrespect with flippant, arrogant, and other disruptive behaviors. Alternatively, a poor attitude towards learning may be manifested by tardiness, absences, lack of enthusiasm or commitment, or poor motivation. These problems may originate from a mismatch between the values and expectations of the learner and those of the teacher, from a deficit in professionalism, or from impairment due to mental illness or substance abuse.

Behavioral/Professionalism

Professionalism deficiencies result from behaviors that compromise honesty, integrity, responsibility, and communication. Examples of behaviors that demonstrate lack of professionalism are listed in Table 2.¹¹⁻¹³ Many teachers (faculty and residents) are uncomfortable or reluctant to assess honesty, integrity, maturity, and responsiveness to criticism. However, teachers should be responsible for assessing the professional behaviors as well as knowledge and clinical skills of the learner. Their responsibility includes teaching, assessment, feedback, and directed remediation regarding cognitive and professional issues. Faculty development to help teachers gain confidence and skills to assess professionalism is a critical function of clerkship directors. Table 3 lists examples of the 10 most common unprofessional behaviors exhibited by medical students.¹⁴

Substance Abuse

Impaired performance associated with substance abuse can be particularly difficult to identify because it may masquerade as behavioral problems. Chemical dependency, the leading cause of physician impairment, has a lifetime prevalence of 10% to 15%. Medical students and residents experience alcoholism at a rate similar to that of the general population and gender differences are small. Some studies¹⁵ have shown that medical students and residents may have a lower rate of non-alcoholic substance abuse compared to the general population, but other studies¹⁶ report a higher rate, comparable to that of practicing physicians, whose abuse of opiates and benzodiazepines is facilitated by self-prescribing.

Learner behaviors consistent with impairment due to substance abuse are not precise (Table 4) and, therefore, recognition may be difficult. In addition, diagnosis of substance abuse carries significant social and professional ramifications. For this reason, physician-teachers are often hesitant to identify behavior as an indication of potential substance abuse despite their understanding of the serious consequences for patient safety.¹⁷ Factors that may predict physician alcohol-related problems include a family history of alcoholism, narcissistic personality style, a perception of low parental warmth in childhood, and stressors in the learner

environment.¹⁵ Since stress is an integral part of the training process, maintaining abstinence requires ongoing treatment and monitoring.

Mental Illness

Mental illness may cause physician impairment that threatens patient safety, but at a much lower rate than substance abuse.¹⁵ Depression, anxiety, and other psychiatric disorders that are not adequately controlled often manifest during the learner's clinical experiences when multiple stressors are applied in novel situations. Recognition and modification of stressors before the learner experiences problems requires vigilance. Anxiety, depression, or other psychiatric disorders can predispose an individual to alcohol abuse. Therefore, initial evaluation of suspected substance problems should include screening for anxiety and depression.

Disabilities

Physical Disabilities

The Americans with Disabilities Act (ADA)

The ADA, passed in 1990, defines a disabled person as an individual with a physical or mental impairment that substantially limits one or more major life activities. Medical school applicants must be able to perform the "essential functions" of the training program after being provided with reasonable accommodations. Essential requirements or functions are the physical and mental abilities, skills, attitudes, and behaviors that medical students must demonstrate at each stage of their education. Reasonable accommodations must not cause undue burden for the school or require a fundamental alteration in the curriculum. The Association of American Medical Colleges (AAMC) has proposed guidelines for proficiencies, including technical skills that students applying to medical school must possess.^{18, 19} These guidelines include "motor" skills or specific technical standards, such as ability to perform a complete physical examination, to perform and interpret diagnostic tests, and to respond appropriately to immediately life-threatening medical conditions. The Medical School Objectives Project proposes that medical school graduates should be proficient in performing technical procedures including venipuncture, lumbar puncture, and suturing.²⁰ Medical schools are required to provide reasonable accommodations for those whose impairments may hinder their ability to perform these technical procedures, but the guidelines are vague. Established policies vary significantly from school to school, depending upon attitudes, experiences, and resources.

Application of the ADA to Medical Schools

One survey of 128 medical school deans (60% response rate),²¹ yielded descriptive information about 64 medical students with physical disabilities enrolled in medical school at the time of the survey. The disabilities included neurologic problems (e.g., paraplegia, multiple sclerosis, dyslexia, stuttering), musculoskeletal disabilities (e.g., limb amputation, achondroplasia, scoliosis, congenital hand deformity), visual loss, and hearing loss. The vast majority of these students were performing at average or above average compared with their peers. Approximately half used accommodative devices including a wheelchair, cane, hearing aid, artificial limb, or learning device.

The requirement that all students must be able to perform specific technical skills presents a barrier to some applicants who are qualified otherwise. Some argue that skills used for observation and interpretation are more important than skills necessary to perform procedures. The historical assumption that each student should graduate with a level of proficiency in knowledge, attitudes, and skills to function as an "undifferentiated" physician who could enter

any field of medicine with additional training presents a barrier for some students. The concept of the “undifferentiated graduate” is increasingly being called into question.^{22, 23} As of 2005, the AAMC was in the process of updating advisory materials regarding the ADA.

Clerkship directors must be aware of the ADA and its ramifications for medical students. They should also know their individual school’s policies regarding the required “essential functions” and resources available for providing reasonable accommodations. Students and physicians may learn from working with students who are coping with a disability. As a result, they may provide more compassionate and effective care to their patients with disabilities.

Student Disability and Patient Safety

The clerkship director should seek clarification about two issues. The first deals with student disability and patient safety. The question of whether a disabled student may pose a direct health or safety threat to others should be considered on an individual, case-by-case basis. The risk must be significant and likely, not merely hypothetical, and one that cannot be eliminated by modification of policies or accommodations. An example is a student with a borderline personality and a history of psychotic episodes in which she physically harmed herself and others. She was denied readmission to a medical school (*Doe v. New York University*). The second deals with the definition of an essential skill. These questions are best answered at the local medical school in conjunction with the dean’s office, legal affairs, and the clerkship directors’ group.

Learning Disabilities

Learning disabilities (LD) are a diverse group of disorders that affect approximately 10% to 15% of the general population and 3% of U.S. medical students. This group of disorders, presumed to be related to central nervous system dysfunction, includes dyslexia, dysgraphia (difficulty in expressing thoughts in writing and graphing), dyscalculia (difficulty performing math calculations), and difficulty with auditory and visual processing despite normal hearing and vision.

Attention deficit disorder is not an LD, but is a frequent co-morbid condition. The majority of students with LD who are admitted to competitive undergraduate and even medical school programs are undiagnosed. The lack of diagnosis may relate to their above-average intelligence and perseverance that enable them to succeed until they reach a volume and pace of learning that overcomes their compensatory strategies. When compensatory strategies fail, the student often works harder and harder, only to find diminished returns, frustration, and failure.

The following features may help to identify students with LD:²⁴

- History of difficulty with taking standardized tests
- MCAT scores above the mean in science, but below in reading skills
- Poor reading comprehension
- Poor spelling
- Illegible handwriting

Most students with LDs have more difficulty with the first two years of medical school than the last two. They perform better in the clinical clerkships because of good verbal abilities and strong communication skills. These students frequently perform marginally during the first two years and clerkship directors should be observant for students who demonstrate these characteristics. Students who are suspected of having an LD should have the option of referral

for diagnostic testing. The results of an evaluation also help the student understand his or her relative learning strengths and weaknesses and offers information to guide effective interventions and accommodations. Students, however, may be reluctant to undergo testing for a “disability” unless they have experienced “failure.”

Systems Issues

Workload and Stress Problems

Large workloads and multi-tasking are routinely part of medical training.²⁵ Workload as a source of stress may diminish with the 80-hour work week. However, other common sources of stress, such as financial, marital, pregnancy/child care issues, or marginal academic status may cause some learners to have problems keeping up with the curriculum. High performance expectations may cause considerable distress, including anxiety, somatization, and depression.

Cultural Problems

Foreign-born students may present with unique needs.²⁶ Many of these students have superb science knowledge and problem-solving skills, but may speak English as a second language and lack the cultural familiarity of native-born students. Stated and unstated expectations, or the “hidden curriculum,” may be barriers to learning for some students.²⁷ Cultural differences may affect communication and interpersonal interactions between students and patients, colleagues, faculty, or their ward team. How such differences are handled and how international learners assimilate to the clinical training environment of another country may require customized education regarding US or Western medical and societal cultures.²⁶

Screening and Identification

Clinician-educators, including clerkship directors, are often uncomfortable identifying and providing feedback to students who exhibit difficulty. The teaching clinician may be inclined to focus on cognitive performance and accept knowledge gaps and difficulties with integration and synthesis as appropriate for the learner’s level of education. Learners with underlying behavioral difficulties often are not noticed or the “warning signs” are overlooked, and, therefore, the difficulty remains unidentified.

The problem is compounded further when educators assume that medical students, as adult learners, are self-reflective and thus apt to recognize and rectify behavioral problems. Even when students are self-reflective, diagnosing the source of a particular behavior can be problematic. It is particularly difficult to identify problems with motivation, level of interest, or knowledge when a student is shy or non-assertive. Separating the learner’s innate character (e.g., shyness) from non-productive behaviors (e.g., lack of motivation) is challenging. As a result, the learner may be perceived to be the problem, rather than his or her behaviors.²⁸ Feedback and interventions should focus on learner actions, which are changeable, rather than on the individual’s personality characteristics, which are not. The teacher may prefer to avoid addressing behavioral problems. However, allowing the non-productive behavior(s) to continue unchecked compromises the educational experience of the individual student and his or her teammates and, potentially, the care of patients.

The learner’s peer group may be more astute at identifying problem behaviors than the teachers. Peer-learners readily identify problems related to teamwork and work ethic.⁵ However, like teachers, they are often reluctant to address the problem. Identification of

problems by peers and others in a 360-degree evaluation can be an effective tool in identifying this type of learner difficulty.

The individual learner may not be aware of his or her behavior or its effects on others. Alternatively, the student may become stressed by his or her own difficulties. Even if distressed, he or she may be unable to pinpoint specific causes and may readily place blame on others. Guidance is therefore an integral part of the internal reflection and behavior modification process.

Teachers are often inexperienced in identifying problem behaviors. Their contacts with learners may be episodic, superficial, and lack the depth required to identify problems. Further, they may be concerned about seeming judgmental towards a student. Clerkship directors must support and reinforce the important role of teachers in identifying problem behaviors. Remember, the learner is not the problem; the problem is the unprofessional actions or unacceptable behaviors.²⁸

Part of the problem in identifying students with difficulties resides in the teacher. Faculty are often unwilling to record negative comments about students because of inadequate guidelines for handling problem students, uncertainty about whether the problem is “real” (which may result from a lack of sharing information before the start of the rotation), or fear of repercussions. Teachers may overlook problems and pass the student and problem to the next rotation, thereby avoiding the inconvenience and awkwardness of a confrontation. However, in the long run, ignoring the issue does not help the student and reflects abrogation of responsibility.

Standard Clerkship Evaluations That Document Behaviors Help Identify Problems

Clerkship Director and Teacher Assessment

Narrative summaries are often based on faculty and resident comments concerning student performance. Most programs use mid-clerkship formative evaluations to give students feedback and end-of-rotation summative evaluations to determine grades and provide additional feedback. At a minimum, these evaluations should cover knowledge base, clinical skills, and communication-interpersonal skills. Assessment of professional attributes based on observation of behaviors is an important dimension of evaluation. Evaluators should be encouraged to document problematic student behaviors and, with the assistance of the clerkship director, determine how best to address problems and document issues. Faculty development sessions on writing evaluations should be available for all faculty and residents.

Self-assessment

Self-assessment during medical school is valuable for assessing non-cognitive skills and prompting continuous professional development.²⁹ First-year medical students' self-evaluations tend to be more critical of their performance than those of the faculty. Helping students develop self-assessment skills promotes reflection on and improvement in behavioral attributes. Self-assessment also illustrates whether students have insight into their problem behaviors.

Peer Assessment

Peer evaluation of medical students can be helpful in giving feedback on trends and perceptions of performance.³⁰ Medical students are astute at identifying peers who do not display acceptable professional behaviors. However, in one study they exhibited less skill in judging their peers' cognitive ability. The 360-degree evaluation process is a useful tool to provide learners with insight into how others perceive their actions.

Patient/family/care team assessment

Checklists of observed behaviors completed by patients, families, and health care team members may be used to augment teacher assessment of professionalism, communication, and interpersonal skills.

Objective Assessments

Oral, essay, or multiple-choice examinations may assess learner knowledge about process and content of professionalism, but are not useful for assessing actual behaviors. Objective structured clinical examinations (OSCE), ratings of audio or videotape, and directed/scored observations with real patients may be used to assess competency.^{31, 32}

Screening to Identify Impairment

Substance use is not uncommon among medical students. The stress of medical education and high performance expectations may be associated with substance use or abuse. However, whether to screen medical students is controversial. Many schools have a “wait to act” attitude and, therefore, impairment or abuse usually comes to the attention of administrators after an “event.” Faculty hope that a “wait to act” attitude fosters students’ trust, professionalism, and a sense of responsibility. Many schools, however, are adopting more aggressive approaches. However, non-random testing may not result in any more advance notice than waiting for some evidence of impairment.

Screening for a criminal record or drug or alcohol use is an institutional, not a clerkship-specific issue. Nonetheless, clerkship directors and faculty should be aware of the policies and trends.

Criminal Background Checks

Increasingly, hospitals are requiring criminal background checks for all students who rotate through them. This is especially true for hospitals that treat children. In our experience, most difficulties that are brought to light with a background check involve substance use/abuse. A formal policy requiring background checks helps to identify students with problems and enables medical school administrators to help them deal with their problem and gather the information that medical boards will require before issuing a resident training certificate or license. For example, some medical boards require that an applicant have a 28-day inpatient treatment program and regular outpatient follow-up before they will issue a training certificate for an individual who has been convicted of an offense involving substance use.

Routine Screening for Drugs and Alcohol

Routine urine drug and alcohol screening is controversial. Many hospitals require urine drug screens on new medical staff and have a policy of “screening for cause.” Traditionally, screening programs are costly and their effectiveness in preventing or identifying users is unclear. The effectiveness of urine screens in medical education has not been defined.

Hopefully, more students who have substance problems will be identified before an “event” occurs as a result of increased emphasis on symptoms indicative of substance problems and professional responsibility to identify colleagues with problems. Students should be educated about identifying, assessing, and managing substance abuse. They should also be engaged in discussions about professional and personal responsibilities relevant to substance use and abuse. Once identified, treatment and intervention strategies must be implemented discretely.

Clear expectations and goals for treatment need to be expressed. If a student fails to progress, then follow-through with next-step interventions is required.

Assessment for Learning Disabilities

Some students with LD are identified before they enter medical school. Others will be identified in medical school when previously successful learning strategies decompensate because of the stress caused by a greater work load. Diagnosis and documentation should be comprehensive and performed by a qualified evaluator. The school's administration should consider how recently the assessment was conducted, the appropriateness of documentation, and evidence to support the need for each recommended accommodation.²⁴ The evaluator should provide evidence to demonstrate that the student has a significant limitation to learning. Ultimately, each medical school must have its own policy regarding diagnostic testing and documentation. Neuropsychological tests with adult normative data are available, but no single battery of tests can identify all LDs and there is no clear consensus about which tests should be used.³³ Guidelines for documentation of LDs in adults are available.³⁴

Prevention of Problems

Primary Prevention

Primary prevention of student problems can begin with the selection and admission processes, and should continue throughout the medical school experience.

Curriculum design

A well-designed and progressive curriculum allows learners to grow in stages and is built on prerequisite material. Design of the curriculum should ensure that no one step is too large or that it skips steps in developing fundamental reasoning skills.³⁵

Vigilance

Vigilance and targeted feedback are critically important in the early stages of the learner's progress.^{36, 37} If a learner has academic difficulty, a formal mechanism to help that student and follow his or her progress in the future may prevent further difficulties.

Previous identification

Early identification of high-risk individuals remains controversial. Students at risk for behavioral problems can be identified from prior poor performance or poor pre-course test scores. Exchange of information from one set of instructors to the next is controversial. Students are concerned they will be "labeled" before a rotation begins. However, the advantage is decreased time required to identify problems. And increased time for helping the student improve performance.³⁸

Clerkship/rotation design

Strategies to prevent difficult learner-teacher situations begin with clear communication of expectations for learning and performance. Objectives that clearly state expectations for performance should be shared with all students and evaluators. Orientation of learners is critical and should include information such as arrival time, dress code, and format for documentation and presentation in the clinical setting (See also Chapter 16, The Clerkship Orientation).

The clerkship director should strive to create an atmosphere where learners feel comfortable reporting any type of difficulty and feel assured of a non-punitive response. Learners' expectations should be discussed openly and, if they cannot be met, the learner should understand the rationale and the options that are available. Formal, mid-rotation feedback allows learners and teachers to identify and rectify problems. If the learner is having any difficulties, interim feedback can be helpful in creating a path for improved performance. Feedback should be provided to both learners and teachers. Testing provides measurement of competency and achievement of specified learning objectives³⁹ and can be used for formative or summative purposes.

Systems Support

Most institutions have programs that provide support for stress reduction, financial assistance, supervision and risk control, and assistance with effective communication. These programs should be used effectively and their availability reviewed with faculty, residents, and learners.

Secondary Prevention

Secondary prevention refers to early identification of incipient problems before the learner displays significant problematic behavior. Clerkship directors should encourage faculty and residents to notify them of students with potential problems as soon as they are identified. A poor mid-rotation formative evaluation indicating behavior problems, such as lack of professionalism or repeated errors, may identify a student who is having difficulty in time for the student to receive feedback and improve performance before the end of the rotation. Early hints of problematic behavior are often communicated vaguely by a concerned staff member, a disgruntled patient or family member, or as a result of a problematic interaction with a fellow learner.

Intervention After Problems Emerge

A General Approach: SOAP

Langlois and Thach⁴⁰ recommend intervention based on a "SOAP" framework, using the following steps:

- **Subjective:** Use your experience and opinion to gain an individualized impression of the student's difficulty.
- **Objective:** Document specific examples of the problem
- **Assessment:** Diagnose the problem
- **Plan:** Develop and implement a plan to address the problem.

This approach encourages specific, constructive feedback to the learner as well as a plan for correction of problem or remediation, including review with the student. Education leaders at your institution may be helpful with this process. You should have a low threshold for seeking assistance and advice. These are difficult situations to handle, even for experienced clerkship directors.

Intervention for Behavioral/professional Issues

Designing an approach to remediate deficiencies in professionalism must be focused on changing student behaviors, not on changing underlying attitudes or motivating factors.

Changing behavior requires adaptation and assessment of readiness to change. Prochaska and DiClemente's⁴¹ model of behavior change, originally designed for changing patient behavior, can be useful in changing learner behavior also. Their model consists of three stages of change, pre-contemplative, contemplative, and determination.

Pre-contemplative Stage

In the pre-contemplative stage, the learner's self-awareness and reflection are minimal. The learner does not realize he or she has a problem, and does not understand the need for change. The learner often has no insight into how he or she is perceived. The student must be made aware of the problem by frank, objective examples of the offending actions. It may be helpful to help the learner walk through the possible outcomes and consequences of his/her unacceptable actions. Multiple examples from various environments are helpful in making the student understand the problem. The most common defensive mechanism students use is to blame others or the system for the events/actions. When the learner becomes aware that he or she has a problem behavior, the process can move to the contemplative stage.

Contemplative Stage

At this stage, the learner is aware that a problem exists and recognizes the need to change. The student knows something is wrong, can describe the settings in which the problem arises, and realizes his/her response is not optimal. However, he/she may not have enough insight and experience to develop strategies to correct the problematic behavior.

Determination Stage

The determination stage occurs when the learner both recognizes the problem is larger than a single example (i.e., he or she sees the problem abstractly) and knows that change is needed. Once this stage is reached, the learner can develop strategies to correct the problem.

Behavioral change requires ongoing involvement of a faculty mentor and the learner. A daily log and behavioral contract may be helpful tools in facilitating behavior change. The daily log should include a list of specific desirable actions or responses in checklist format and the behavioral contract should establish boundaries and limits regarding tolerance of breaches in the agreement. Continuity of the faculty mentor is helpful to establish trust and consistency. Decisions about sharing performance difficulties with up-coming faculty must be made on an individual basis and the learner involved when additional faculty are included in otherwise confidential guidance. Such information could be helpful in allowing faculty to help the student or could bias their view of such learners.³⁸ You should discuss your school's policies and seek guidance with the appropriate person in the dean's office.

The student may experience relapses and disappointments, but the mentor's approach should remain consistent and encouraging. The learner will understand and better adhere to the plan if the learner and mentor acknowledge the difficulty of changing behavior and underscore the need for that change. Documentation with the learner's signature on frequent evaluations is mandatory to minimize liability and maximize the remediation process with difficult behaviors.

Intervention for the Learner with Impairment

Physicians are more likely than the general population to respond to alcohol and drug addiction programs. Their success with abstinence may be related to the direct consequences of failure to comply with their treatment plan, including loss of hospital privileges and state licensure review.⁴² Intervention is most likely to succeed if it consists of a combined approach of

confrontation and concern.⁴³ When behavior consistent with impairment is present, the institutional policy usually requires a review by a specialist. An institution-level committee usually refers the student for evaluation. Members of the committee are usually either directly aware of a student's addiction or are addressing behavior concerns that may be related to addiction. Meticulous documentation, involvement of faculty, and strict adherence to due process are critical for the success of referrals and intervention programs.⁴⁴ Students diagnosed with addiction who undergo appropriate treatment may be required to be monitored throughout the remainder of medical school and beyond.

Intervention for the Learner with Academic Failure

Exploration of a problem should begin as soon as a potential problem is suspected. The clerkship director should talk to the student and explore the student's perception of the problem, the student's strengths and weaknesses, and current life stressors. A history of past academic performance should also be ascertained. One should try to assess if current problems are due to teacher-student incompatibilities or problems arising due to the learning milieu.

Steinhert and Levitt⁴⁵ generated a useful algorithm for working with the "problem" resident, which also applies to working with students with problems. They outlined specific questions to ask when designing an effective remedial intervention.

What is the precise problem to be addressed?

Does it involve knowledge, skills, or attitudes?

What methods will be used to address the problem?

Some of the methods that may be useful to help learners with knowledge problems may include:

- Personal one-to-one assessment of knowledge and skills deficits by attendings or resident teachers
- Clinical case discussions
- Assignment of additional reading to provide a clearer knowledge foundation, with subsequent discussions of the reading
- Assigned exercises such as time in clinical skills lab, extra patient assignments, etc.
- Recommendations about time management or organizational skills
- Referrals to other sources of help if it appears that the student has personal problems that interfere with efforts to study or evidence of learning disabilities
- Involve the student in the design and assessment of the intervention

Who will be involved in the intervention?

The clerkship director, residents, and attendings on the team may be involved. However, educators beyond a single clerkship may be needed.

What is the time frame for the intervention?

Determine reasonable expectations for the duration of a successful intervention. It may be longer than the duration of one clerkship.

How will the relevant issues be documented?

It is essential that the clerkship director document the nature of the problem, discussions about the problem, and the intervention plan.

How will the intervention be evaluated?

The evaluation mechanism for assessing improvement must be defined before the intervention is implemented. Sessions for feedback and evaluation between the student and teacher must occur regularly to monitor progress in meeting the goals of the intervention.

Who should know about students with problems?

Some problems can be handled during a single clerkship or rotation, but most problems that come to the attention of a clerkship director are manifestations of an ongoing problem. One mechanism of dealing with students with problems is to convey information to other teachers so that an individualized teaching strategy and optimal learning condition may be planned for the student on subsequent rotations. One potential risk of sharing information is potential bias against the student during subsequent interactions and assessments. However, the benefits of shared knowledge exceed the detriments. Most medical schools have mechanisms and policies regarding when, how, and with whom to share information about students with problems. In various circumstances, information may be shared with faculty, course directors, student advisors, clerkship directors, student review subcommittees, and the office of the appropriate education dean to facilitate ongoing educational interventions. Students should be aware of the process of sharing such information and should be notified of what data will be shared and with whom.³⁸

Intervention for Academic Failure due to Learning Disabilities

Once a learning disability is diagnosed and documented, interventions include remedial plans and appropriate academic accommodations. Rosebraugh²⁴ emphasizes that colleges of medicine must be prepared to assist students with LD by developing policies and procedures, assembling a team of resource people, and educating administrators, staff, and faculty about LD. Faculty must understand that learning disabilities are not related to intelligence, but rather represent areas of relative weakness in information processing. Students with LD often have areas of great cognitive strength and high motivation to learn. Diagnosis of a specific LD generally allows affected students to regain confidence as learners, to develop rational compensatory learning strategies, and to work with educators to develop alternative or supplemental learning approaches.

Examination accommodations are the most frequent adjustments made for LD medical students, including extra time (generally time and a half, but sometimes double time), a separate examination room to limit distractions, a reader or scribe for tests, a computer for essay examinations, and a flexible examination format. Other accommodations include extended time to complete assignments, courses, or the full degree program, academic counseling, tutoring, providing note-takers, video- or audio-recordings of lectures, and computer-assisted learning or other multi-modality approaches to instruction.⁴⁶

Legal Concerns

Negative Assessments and Dismissal

Medical school faculty and other evaluators often are reluctant to give negative feedback in medical student evaluations because they fear becoming involved in a lengthy review process. Academic review committees may temper their findings and pass marginal or even unsatisfactory students due to the threat of being sued for failure to provide fair treatment and due process. However, adverse academic actions are held to a different standard than civil

disciplinary actions. Courts generally uphold academic actions that are well documented and in the interests of the institution and society as long as they are not arbitrary and capricious, and the institution followed its own due process.

Students who are performing unsatisfactorily should receive feedback, including recommendations for improvement. Documenting meetings, interventions, and outcomes is essential. Documentation about student deficiencies and interventions should be similar to documentation in a patient's chart. Documenting that the student was made aware of deficiencies is important. Consequences of failure to progress need to be clear to the student and within the realm of the evaluator. For example, a clerkship director may fail a student in the clerkship or refer him or her to the dean's office, but may not dismiss the student from medical school unless dismissal is within the clerkship director's power. Even though you may be very clear on what transpired between you and the student, it is important that it is documented in a way that others who may view this information get a clear picture of how the issues were handled.

Fair and equitable treatment

Generally, courts will not intervene in faculty decisions regarding academic cases as long as the faculty members used professional judgment, reviewed the entire record of performance, and gave the student due process. There must be no evidence of arbitrary or capricious actions on the part of the faculty or institution.

Due process

Each institution must have a detailed due process policy that outlines the student's hearing and appeal rights, and the steps that must be taken by both the student and institution when an adverse action is initiated. Adequate documentation of adherence to the policy is helpful in upholding institutional decisions that adversely affect a student.⁴⁷

ADA and Medical Students

The ADA ensures protection to individuals with disabilities in areas of service relevant to colleges and universities, including admission and recruitment, student programs, academics, nonacademic services, and health services for both public and private institutions. Major issues related to adherence to the ADA for medical students include admissions policies regarding qualified individuals with a disability (beyond the range of this chapter), assessment, reasonable accommodations for the program, and academic progress examinations.⁴⁸

Within the setting of a clerkship, reasonable accommodations must only be provided for disabilities that have been made known to the college and for which an accommodation has been requested. A student may refuse reasonable accommodations. The student who believes that he or she has a disability is responsible for the financial costs of the evaluation, although many schools assist with this cost. The evidence necessary to document a disability should include an evaluation by a trained professional, conducted by accepted methods that yield objective and factual data. These data should demonstrate a disability that substantially limits at least one of the student's major life activities. The college of medicine must assess the written evidence and determine whether reasonable accommodations can be offered.

If a student with a disability refuses a reasonable accommodation that he needs to fulfill the essential functions of the program, he can no longer be considered a qualified individual with a disability. The college of medicine and/or its parent institution is responsible for the cost of the reasonable accommodation. The definitions of essential requirements/functions and reasonable accommodation are evolving.

Academic Progress Testing

Students with documented disabilities may request accommodations for testing, including additional time and alternative format testing. If a college rejects a request for alternative format testing, it must demonstrate that it considered the request and alternative formats, and rejected them for sound academic reasons. Reasons for rejection of a request might include a decision that altering the test would lower academic standards or significantly alter the academic program. Extended time for examinations is often granted to students with various disabilities. However, extended time should not be considered a reasonable accommodation when an essential part of the testing is time to respond (e.g., time to identify and react to an emergency situation in a simulated patient scenario). Decisions about accommodations must reflect rational consideration of the requested accommodation and a justified response.

Preparation and Documentation

Clerkship directors must be familiar with the policies of their college of medicine regarding assessment for disability and provision of accommodation. They should also know what resource faculty members are available in the college to help implement the policies. Clerkship directors should be aware of their institution's policies regarding requirements and/or essential functions for students for completion of each year of medical school and should develop their own list of clerkship requirements. Clerkship directors must keep records of all requests for and attempts to provide accommodation for students with disabilities. It is important to realize that a college of medicine may dismiss a student with a disability who has been unable to fulfill the essential functions of the program despite the provision of reasonable accommodations.^{49, 50, 51}

Summary

Teachers are natural advocates for their learners, and should strive to develop each learner regardless of learning difficulties. The clinical setting, with its focus on patient care and safety, has natural tension between the needs of the patient and those of the learner. Thus, the learner who has significant difficulties that may affect his or her ability to deliver safe and compassionate care can be very challenging for the teacher. Early in the educational progression of the developing physician, teachers should use a primary preventive approach. Strategies include orientation that communicates expectations for knowledge, skills, attitudes, and behaviors. If problems arise, early detection and intervention are important to successfully handle the problem.

Sample Cases

The Impaired Student

MJ was admitted to the College of Medicine with an undergraduate grade point average of 3.9 and an MCAT score of 32. MJ had excellent letters of recommendation. He completed anatomy in his first year with an average of 94. He came to the attention of the Dean's Office after he became intoxicated at a 3rd-year party and assaulted a woman student. The local police charged him with assault and disorderly conduct. The student who was assaulted reported the incident to the Dean's Office and the associate dean investigated it. This investigation revealed that many of his classmates knew the student was a binge drinker who became aggressive when intoxicated. A background check revealed that MJ had a charge of disorderly conduct and public intoxication in his 2nd year that was dismissed.

MJ did not understand why the Dean's Office was concerned about his behavior outside the hours he was scheduled to be at school. He was in the top 10% of the class and had no difficulties identified in his first or second year or previously during his 3rd-year clerkships. To continue on his clerkship, he was required to have a comprehensive substance abuse assessment. The assessment, performed by an independent, certified substance abuse counselor, recommended formal intervention that included counseling and AA meetings. The student refused. He was referred to the Clinical Academic Standing Committee and eventually to the Academic Review Board for consideration for dismissal. During these meetings he demonstrated little insight into his substance abuse. MJ asserted that his academic performance was good and he performed above average in the cognitive and non-cognitive realms. He denied being an alcoholic and requested that he be allowed to continue. MJ was dismissed from the College of Medicine.

One year later, MJ requested re-instatement. At the Academic Review Board meeting he indicated that he was receiving counseling, went to AA on occasion, and drank infrequently. He was working as a lab technician and getting excellent performance evaluations. He denied having a substance abuse problem. The committee denied his request for re-instatement.

Six months later, he submitted another request for re-instatement. At the Academic Review Board meeting, he provided documentation of regular counseling and substance abuse intervention. He had a supportive letter from his counselor and sponsor. He detailed a plan on how he would continue in his recovery if he were re-instated. At this meeting, MJ was clearly able to take ownership of his alcohol abuse problem and was able to convince the Academic Review Board to re-instate him. With the appropriate legal assistance, he was able to get his criminal record expunged and was re-instated into the College of Medicine. He completed his 4th year without further incident and successfully matched into a residency program of his choice.

Case Pearls:

- Students with substance abuse may not present with specific difficulties on rotation.
- A background check would have identified this student's problem earlier, and enabled earlier intervention.
- Students with substance abuse issues need to take ownership of their illness before they can be successful in the field of medicine.

The Student with a Physical Disability

KM was admitted to the College of Medicine with an undergraduate grade point average of 3.75, a total MCAT score of 31, and excellent letters of recommendation. He received excellent interview comments, none of which mentioned a physical disability. He submitted a history and physical to our admissions office after he was accepted that did not mention a physical disability. He excelled in his first year. During physical examination training in his second year, he revealed that he was an above-the-elbow amputee and used a myoelectric prosthesis with a cosmetic sleeve that was a close match to his opposite arm. He was referred to the Dean of Student Affairs Office by the physical exam instructor for recommendations on how to proceed with his clinical training.

In discussion with the Dean of Student Affairs, the student was open about his disability and agreed to an initial assessment by a physiatrist. This assessment was task based and specifically dealt with how the student could be helped to successfully acquire the skills necessary to meet the essential functions of a graduating medical student. The physiatric assessment provided concrete examples of how the student could best perform essential tasks. These included tasks such as venipuncture, sterile technique, starting IVs, and suturing. Interestingly, the physiatrist recommended that he switch to a manual operated prosthesis with a hook for certain tasks. The student would not agree despite the fact that he owned a manually operated prosthesis.

KM required one-on-one sessions with a clinical skills trainer in consultation with the physiatrist. There were certain tasks that he could not master, specifically CPR and intubation. However, he was able to accomplish these tasks with the assistance of someone else to whom he gave directions, ensuring that he knew the mechanics involved in each of these procedures. The student completed his third and fourth year successfully and was able to secure a position in residency through the match.

Case Pearls:

- The earlier a student's physical disability becomes known, the sooner faculty can begin to plan for appropriate interventions.
- Admission history and physical forms should include specific language about the presence of physical impairments that may present challenges to achieving clinical competence.
- Consultation with a physiatrist can be invaluable in helping clinical educators understand how best to help a student with a physical disability achieve essential functions.

The Student with a Learning Disability

HT was admitted to the College of Medicine through the post-baccalaureate pathway. Her undergraduate GPA was 3.1 and she had a total MCAT score of 27. She completed her first year with an average of 66.2% and her second year with an average of 65.6%. She excelled in all of her first- and second-year clinical activities, including preceptorships. She failed USMLE Step I the first time she took it and was referred for academic counseling. She was resistant at first, but finally agreed to meet with the counselor. Based on the initial evaluation, formal psychometric educational testing for learning disabilities was recommended. HT refused, indicating that she simply needed to study more and would be able to pass. She refused any support and failed Step I a second time. She did not make any improvement in her score between attempts. She was placed on a mandatory leave of absence because passing Step I is required to progress to the third year. Follow-up discussions with the counselor revealed that had she refused testing for a learning disability at the insistence of her parents. They feared she would be “labeled” and encouraged her not to complete the evaluation. However, after discussions with the counselor, she agreed to a formal assessment. She was found to have a processing disorder and was given specific feedback on how she could compensate for her deficits. She worked on compensatory strategies with a therapist and was able to pass the USMLE Step I the next time she took it. In addition, she passed USMLE Step II on her first attempt. She successfully matched into her chosen residency.

Case Pearls:

- The significant disparity between HT’s academic and clinical performance may have been an early clue to educators that this student might have a learning disability.
- Student concerns about stigma and labeling should be addressed head on when discussing learning disability evaluation. The educator should also be aware of cultural issues that may play a role in a student’s acceptance of a disability.
- Many cases of learning disabilities require formal intervention to teach the student how to approach material that needs to be mastered. Simply repeating a course or a test may not change the outcome.
- A thorough assessment is essential when evaluating a student for a learning disability to develop a plan that ensures that the student is trained in specific compensatory strategies.

Table 1	
Student Problems and Relative Difficulty of Management^{5,6}	
Type 1 -- Frequently encountered and difficult to manage	
<ul style="list-style-type: none"> • Bright with poor interpersonal skills • Excessively shy, non-assertive 	
Type 2 – Frequently encountered and not difficult to manage	
<ul style="list-style-type: none"> • Poor integration skills • Over-eager • Cannot focus on what is important • Disorganized Disinterested • A poor fund of knowledge 	
Type 3 – Not frequently encountered and difficult to manage	
<ul style="list-style-type: none"> • Cannot be trusted • A psychiatric problem • A substance abuse problem • “Con artist” (manipulative) 	
Type 4 – Not frequently encountered and not difficult to manage	
<ul style="list-style-type: none"> • Hostile • Rude • Too casual and informal • Avoids work • Does not measure up intellectually • Avoids patient contact • Does not show up • Challenges everything • All thumbs 	

Table 2 Behaviors Indicating Lack of Learner Professionalism in the Clinical Setting		
Unaddressed professional responsibility	Lack of awareness/effort towards self-improvement and adaptability	Diminished relationships with patients, families or care team
<ul style="list-style-type: none"> • Learner needs continual reminders regarding responsibilities • Learner cannot be relied upon to complete tasks • Learner misrepresents or falsifies actions and/or information 	<ul style="list-style-type: none"> • Learner is defensive/resistant to advice/criticism • Learner is unwilling to consider/change in behavior • Learner is abusive or critical during times of stress • Learner demonstrates arrogance • Learner does not acknowledge self as cause of failure, error 	<ul style="list-style-type: none"> • Learner is reluctant to listen and accommodate to wishes of patient (when appropriate to do so) • Learner has difficulties with establishing successful collaborative relationships with patients/families/care team • Learner is insensitive to the needs of patients/families/care team • Learner is lacking/ineffective in demonstrating empathy

Table 3 Top 10 examples of Unprofessional Behavior
<ul style="list-style-type: none"> • Dishonesty – intellectual and personal • Arrogance and disrespectfulness • Prejudices • Negative or abrasive interactions with colleagues • Lack of accountability for administrative oversights and medical errors • Fiscal irresponsibility • No or lack of commitment to life long learning • Lack of due diligence – i.e., carelessness, laziness, and not following through • Personal excesses – i.e., substance abuse, gambling, and reckless behavior • Sexual misconduct

Adapted from Duff P¹⁴

Table 4 Signs of Potential Substance Use in Learners in the Clinical Setting
<ul style="list-style-type: none"> • Poor appearance (grooming, dress) • Slurred speech • Erratic work behavior • Tardiness • Memory lapses • Inappropriate medical care • Inappropriate language • Other risk-taking behavior, including prescribing of controlled substances

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