Not Your Typical Remediation Workshop: Leveraging the Pygmalion Effect to set learners up for success

Andria Tatem, Rupa Kapoor, Phillip Thomas, Teri Turner

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- The presenters do not intend to discuss an unapproved/investigative use of a commercial product/device in our presentation.

Objectives

- Describe how our attitudes influence a learner's success in remediation.
- Develop biopsychosocial strategies within the context of a remediation plan to help set up a learner for success.
- Practice behaviors, both verbal and nonverbal, that communicate your belief the learner will be successful

NEEDS ASSESSMENT

Circle of Trust

Please use the paper in front of you write down in a column on the left-hand side the initials or names of six to ten people whom you trust the most who are not family members. These could be trusted friends, mentors, confidantes that you would go to for any advice or help.

Circle of Trust

Now I am going to read different categories. First categorize yourself, then put a check mark next to the names on your list who you classify as the same category as yourself. For example, the first category is gender, if you are female, check the names on your list that are also female.

Implicit Bias

- Consider the categories under which you have the most check marks. This may imply an **affinity bias.**
- Tendency or preference for people like ourselves is call affinity bias or ingroup bias and is well researched
- Increased trust, cooperation, empathy toward ingroup members; may manifest at aversive tendency towards outgroup members
- Instinctive and Unconscious
- What are the implications for this type of implicit bias for your role in remediation?

Overcoming Implicit Bias

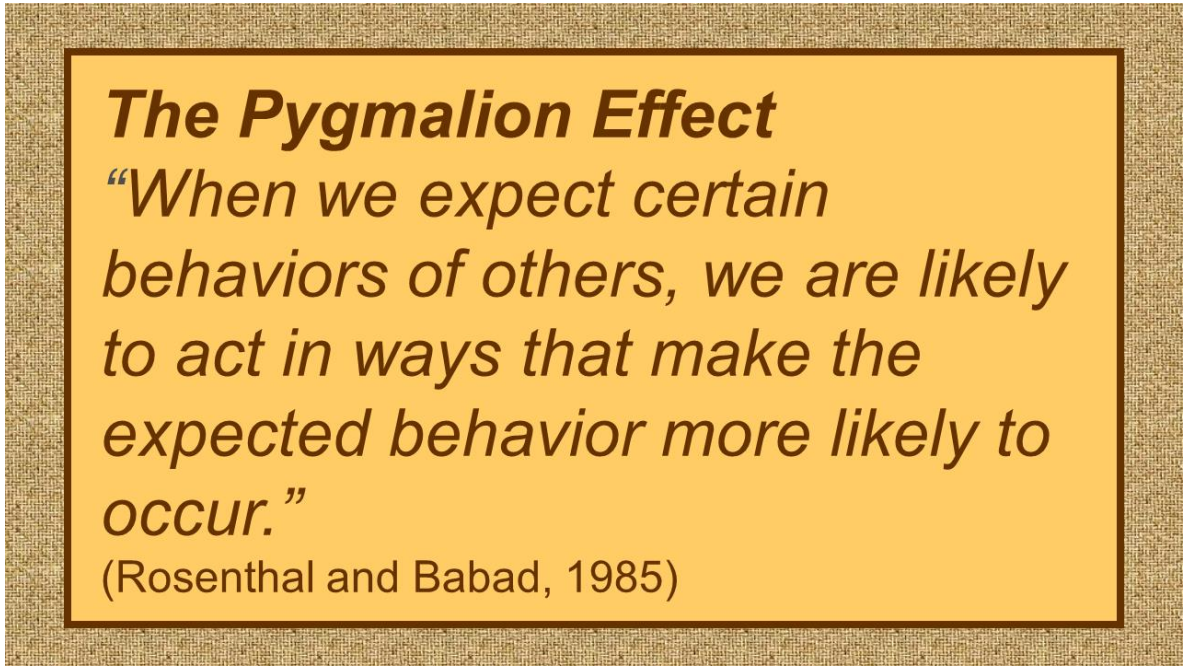
- Perspective taking
- What are some systems based practices you can use to decrease the effect of implicit bias during remediation?

Remediation Workshop Didactics

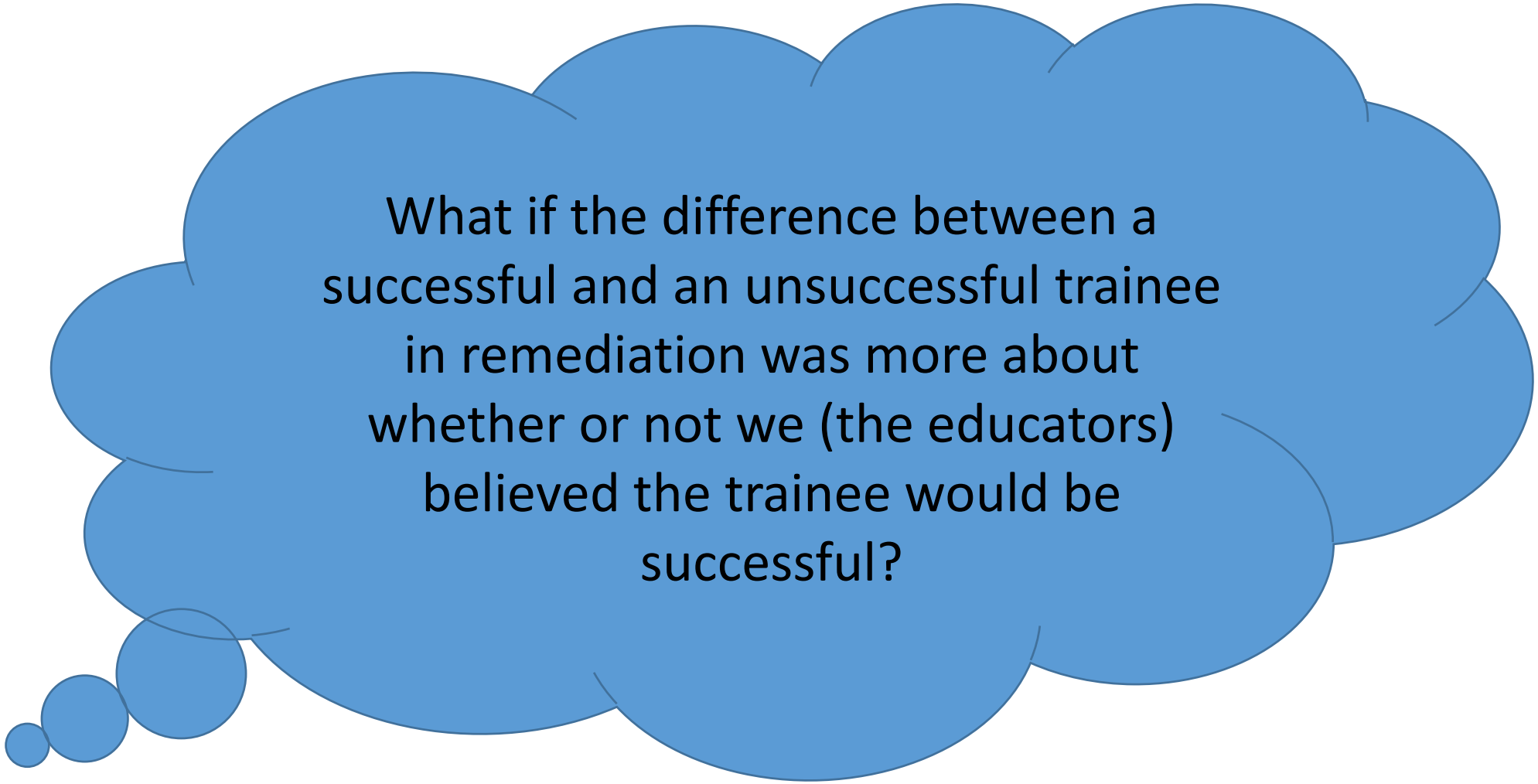
Reflection Activity

Pygmalion Effect

- What is the Pygmalion Effect?



Pygmalion Effect



Golem Effect

- Opposite of the Pygmalion Effect
- Lower expectations lead to a lower performance

Theories Associated with Our Expectations

Labeling

Self-Fulfilling Prophecy

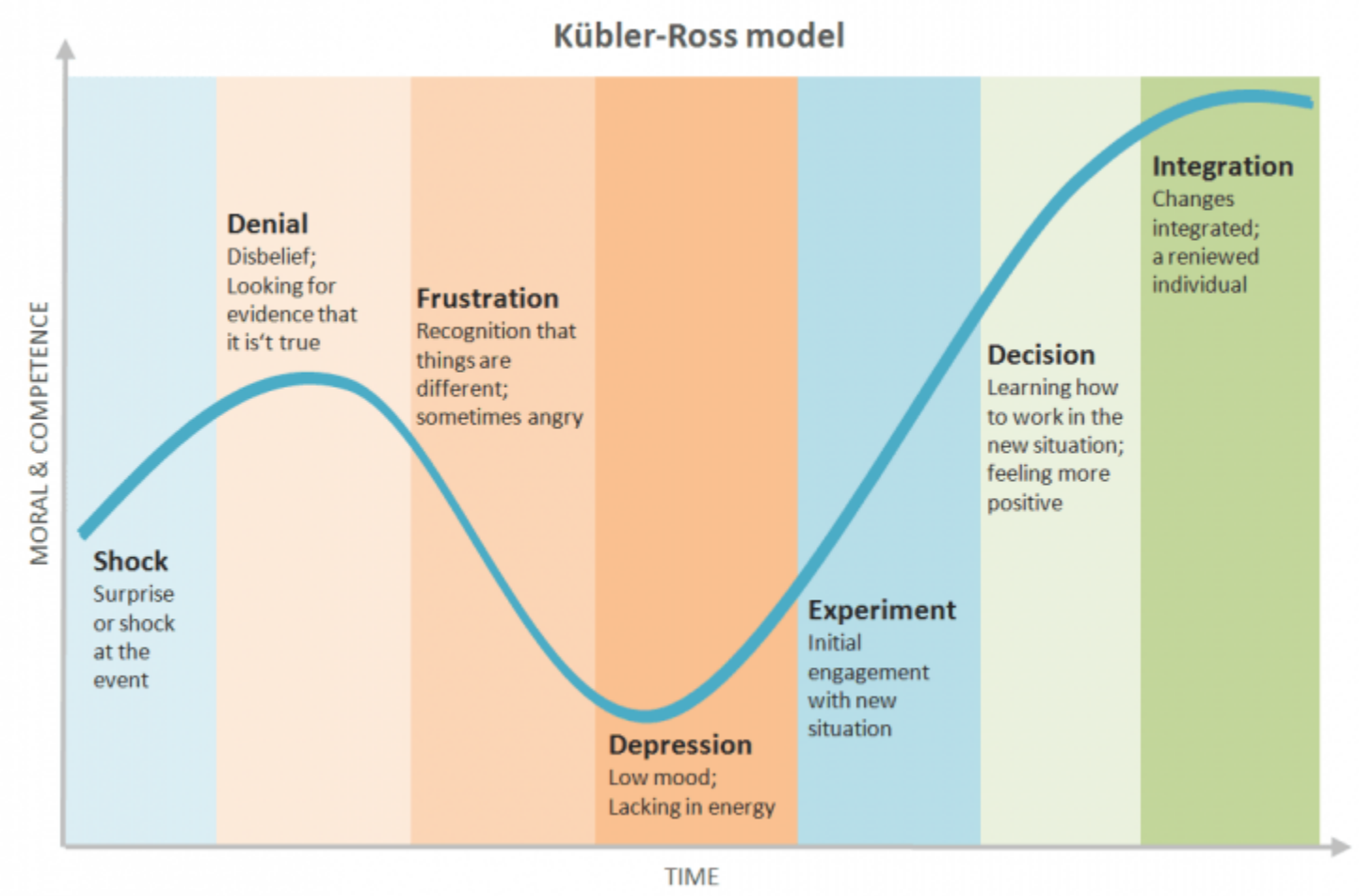
Group Think

Implicit Bias

Mindset

Unrealistic Expectations

Learner's Attitude



From Theory to Action: Strategies for Successful Remediation

- Create the right environment
- Diagnose the problem or the cause of the “FEVER”
- Come to a common understanding of the problem
- Come to a consensus of objectives and agree to move forward
- Agree to communicate openly in the future

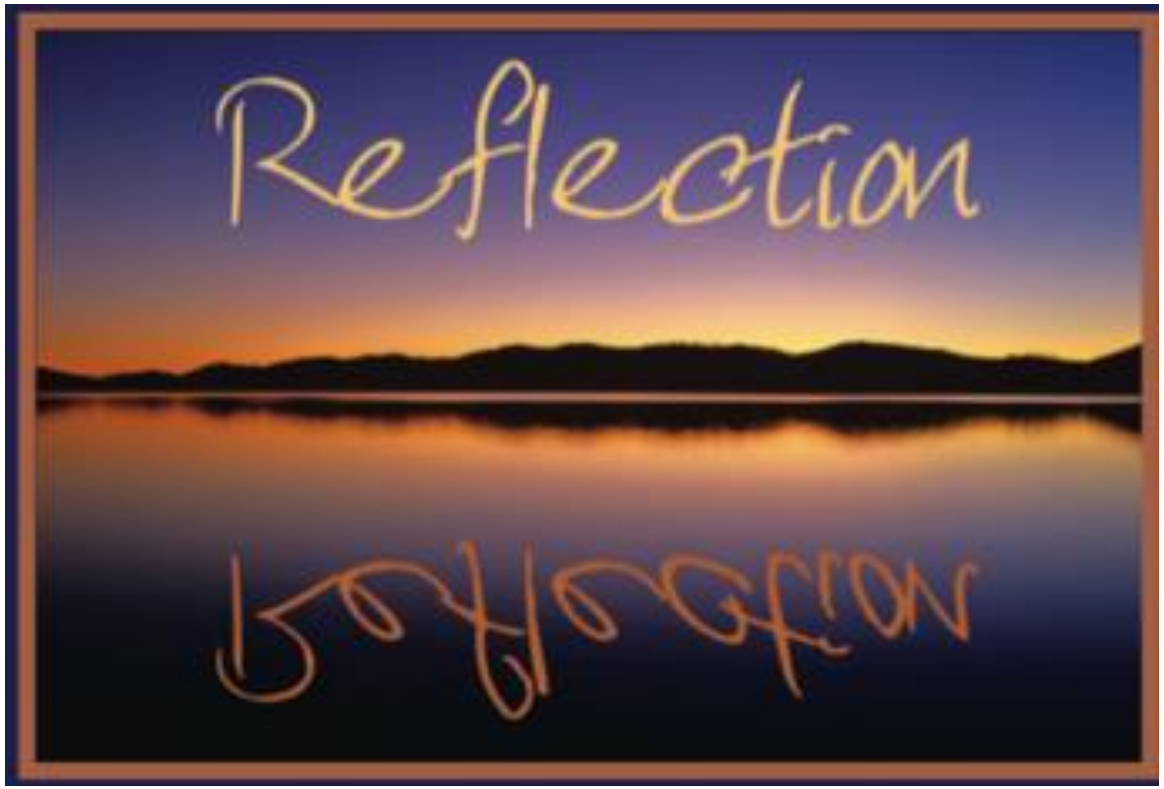
Roles Needed to Support the Learner

- Judge
- Academic Coach
- Wellness Coach
- Mentor/Advocate
- Outside Support System

How can we communicate high expectations?

- Model appropriate behavior
- Let them know when they do things well
- Normalize failure
- Use motivational interviewing techniques

Reflection Activity



Small Group Exercise #1

Case #1

Dr. XYZ started a pediatric residency program as a PGY–1 categorical pediatric resident. Dr. XYZ's body of work included stellar step 1 and step 2 scores as a medical student and had some pediatric research experience. ERAS application spoke of a student that was great at test taking (USMLE scores), committed to pediatric research and for all intents and purposes ready for pediatric residency at a mid-level to large pediatric residency program.

In the beginning months, Dr. XYZ was noted to have some minor issue working with a team. Dr. XYZ was very vocal about not agreeing with the plan of care initiated by senior residents and attending physicians. Many of the initial issues were overlooked given that no harmful outcomes or near misses took place.

As Dr. XYZ started rotations with more critically ill patients, severe deficiencies were noted involving patient and family relations. These include executing the medical plan of care and again working as a part of the medical interdisciplinary team. On multiple occasions, Dr. XYZ verbally clashed with attending physicians during rounds.

There was one severely unprofessional encounter where Dr. XYZ went back to the patient and family after the attending counseled them and told them that the attending's diagnosis and plan of care was incorrect. Program leadership was made aware of this encounter and Dr. XYZ was started on a remediation plan.

Initially, Dr. XYZ showed adequate medical knowledge and improvement with patient interactions and working as a part of the team. As training continued, Dr. XYZ again started clashing with supervising residents and attendings. One encounter resulted in an adverse patient outcome. Multiple meetings were held with Dr. XYZ and program leadership. Dr. XYZ was defensive throughout these meetings and resistant to feedback regarding medical knowledge, professionalism and feedback.

Case #2

Dr. QRS started a pediatric residency program as a PGY–1 categorical pediatric resident. USMLE scores were in the 240-250 range. Dr. QRS's experience in research and extracurricular activities were outstanding and noteworthy. During orientation to the residency program, it is noted that Dr. QRS has difficulty communicating with peers, patients and the greater medical team. During the first rotations, evaluations reported showed large gaps in medical knowledge and Dr. QRS showed difficulty in the ability to communicate medical plans effectively.

At the beginning of Dr. QRS's first inpatient rotation, Dr. QRS had not pre-rounded on patients and stated that this was not an expectation on previous rotations in medical school. . Other significant gaps of knowledge noted were in physical exam skills and appropriate medical communication regarding patient care. As training progressed, several attendings and senior residents noted that Dr. QRS was unable to handle a patient load of more than 1-2 patients. Dr. QRS's ability to recognize sick patients and the need to escalate care was questioned. Program leadership found that senior residents were adjusting patient loads so that Dr. QRS saw half the patients of peers in the same rotation.

It was deemed that this action was not an effective use of time, and it was not safe for patient care. Dr. QRS was removed from clinical duties in order to formulate a remediation plan to prepare for successful matriculation through residency. Program leadership met with Dr. QRS who had an outstanding attitude towards feedback. However, Dr. QRS felt that this route was unnecessary and only a few more days were needed to "get used to the rotation".

Debrief #1

1. Recall the implicit bias activity. With new awareness of our possible biases, consider how these may have affected a prior remediation experience with a trainee. What strategies can we use to reduce the impact of implicit bias in our role as educators?

2. Knowing what we know now about the Pygmalion effect and the Golem effect, what can we do as educators to use this to our advantage? Are there deliberate thoughts that we can use to prepare ourselves for interactions with our trainees?

3. Bring to mind what we learned about labelling, self-fulfilling prophecy, and group think. We often work closely with other educators in remediation of a learner. Write down some of the recurring themes or common language from conversations with colleagues regarding remediation. Are there opportunities within those conversations to decrease labelling and group think?

4. Are there any systems-based interventions or strategies that you currently use to mitigate the negative effects of some of the concepts we discussed today?

Small Group Exercise #2

Case #3

Dr. ABC is a PGY-2 in a pediatric residency program. Dr. ABC was what most attendings described as a “model resident”. Dr. ABC performed at a level above that of his peers and was found to be personable and trustworthy by co-residents, nursing, staff and attending physicians. At the end of intern year, Dr. ABC completed a run of 7 inpatient months. Because of excellent evaluations and trustworthiness from all staff, Dr. ABC was started on more difficulty rotations in PGY-2 year.

The first two rotations of PGY-2 year for Dr. ABC were intensive care and emergency medicine. Many traumas resulting in morbidity and mortality were experienced during these two rotations. Comments were raised to program leadership that Dr. ABC wasn’t behaving as usual. Peers were afraid that Dr. ABC wasn’t handling the stress of the rotations well.

Comments included that Dr. ABC appeared more sleep-deprived than usual, was not eating as much, and was withdrawn. Attending physicians also reported to program leadership that Dr. ABC had missed a couple of shifts without contacting anyone, lied about documentation of patient care encounters, and had a couple of “near misses” regarding patient safety. Nursing staff reported that Dr. ABC was very short tempered and often angry during nursing encounters. None of this was typical behavior for Dr. ABC. When approached about the concerns from program leadership, Dr. ABC seemed withdrawn and apathetic.

Debrief #2

1. What do you think is the cause of Dr. ABC's changes during PG-2 year?
   - Burnout
   - Mental Health
   - Substance Abuse
   - Organic Medical Problems

2. How would you approach Dr. ABC to discuss the concerns?

3. How do you think our own biases would affect our approach to Dr. ABC?

Wrap Up