Navigating Academic Law in Competency Decisions

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The purpose of this article is to help clinical competency committees (CCCs), program directors, and institutions better understand existing case law regarding *due process* and a *decision-making process* in order to enhance their policies and procedures in consultation with their own legal and human resources (HR) team members. We will review the legal issues involved in assessing, synthesizing, and judging resident and fellow performance, especially when arriving at decisions that may impact the learner's intended career path, such as suspension, delayed promotion or "graduation," or dismissal. The word *learner* is used to apply to residents and fellows in programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), as distinguished from *students*, the term used to describe individuals enrolled in undergraduate medical education. The online supplementary data delineates key legal decisions that are relative to graduate medical education (GME) academic decisions.

GME programs prepare learners for safe and effective autonomous practice. Some view GME legal issues primarily in the context of professional liability.[1] However, there are also legal issues involved as programs make judgements about learner performance and subsequent status in the program. The ACGME Common Program Requirements require the program director (PD) to provide "a final evaluation for each resident (fellow) upon completion of the program"[2] verifying "that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice."[2] The ACGME requires programs to have a robust assessment system and use a clinical competency committee (CCC) to synthesize information, use their judgment to make decisions on learner Milestones acquisition, progression, and performance, and *recommend* these decisions to the PD.

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Editor's Note: The online version of this article contains descriptions of key legal cases supporting professional judgement in graduate medical education.

Furthermore, the ACGME requires sponsoring institutions (SIs) with oversight over individual programs to have policies including those for grievance and due process.[3] Table 1 lists pertinent ACGME Institutional and Common Program Requirements. While grievance policies provide for a process by which learners can raise a broad range of program-specific issues, due process policies assure compliance with legal requirements for decisions that could affect a resident's intended career path.[4] They must meet minimum legal requirements and be uniformly applied to adverse actions, including nonrenewal of contract, dismissal, extension/repeat of training, or denial of academic credit.[4–6] CCC decisions have the potential to be challenged legally by the learner, typically those who have had adverse actions imposed. With the greater adoption of competency-based medical education (CBME), GME learners are simultaneously *enrolled in educational programs*, under continuous supervision, and *employed* by organizations providing requisite education and experience. Institutions and programs should expect that learners will progress on different developmental trajectories. Difficulties or inconsistencies in performance should be expected, even for those who eventually become the highest-performing learners. Two decades ago, one-fourth of residents were thought to be sufficiently "behind" enough that they required a remediation process.[7] As the GME community improves its evaluations and has greater experience in synthesizing performance data using nationally specialty-specific benchmarks, or Milestones, it is likely suboptimal performance will be identified more frequently.

Due Process

Although residents are both learners *and* employees, in the context of GME, they are "first and foremost … learners."[8,9] HR departments of most organizations have robust policies and procedures for managing employees. However, these procedures do not serve the educational purposes of GME. Employees are hired to serve the interest of the employer, and

TABLE 1
ACGME Institutional Requirements on Promotion, Appointment Renewal, Dismissal, and Grievances

IR Number	Requirement	Implication
IV.C.a	SI must have policy requiring each program to determine the criteria for promotion and/or renewal of resident/fellow's appointment (contract).	Criteria for promotion and renewal should be clearly available to all residents/fellows, CCC members, and faculty for instance in resident/ fellow program handbook. SIs and programs should define what these terms mean and what and in what circumstances anything will be reportable to future entities.
IV.C.1.b)	SI must ensure programs written notice of intent when agreement (contract) will not be renewed, no promotion to the next level of training, or dismissal.	Explicit notice to resident/fellow of intent for non-renewal, non-promotion, or dismissal. Any "status" within the program that carried with it this consequence should include and describe these potential consequences.
IV.C.1.b)	SI must have policy that provides due process related to suspension, non-renewal, non-promotion, or dismissal.	Program and SI policies should align. Program/SI should make these available to residents and fellows routinely.
IV.D.	SI must have policy outlining procedures for submitting/processing resident/ fellow grievances at program and institutional levels . . . that minimizes conflicts of interest	Program and SI policies should align. Program/SI should make these available to residents and fellows routinely.

Abbreviations: SI, sponsoring institution; CCC, clinical competency committee.

as such, policies and processes are designed to facilitate the management of the employer's business. Conversely, learners are *enrolled* to earn an academic credential from the SI, and policies and procedures specific to GME should be designed to guarantee they have a fair opportunity to earn that credential by receiving instruction, experience, and regular performance assessment. This distinction between academic and employment processes becomes particularly important in issues related to learner behavior. The core legal requirements for due process in the academic context includes providing the learner with a *notice of their deficiencies*, *an opportunity to cure those deficiencies*, and *a reasonable process for deciding whether the learner has cured those deficiencies* and met the standards for receiving the academic credential.[10] These academic standards have been defined by the US Supreme Court in the landmark Horowitz case and in the Board of Regents of the University of Michigan v Ewing.[10,11] These cases involved medical students failing to progress, but courts have routinely applied these principles to GME learners.[1,13,14] This distinction between academic and employment processes becomes particularly important in issues related to learners' behaviors. While many performance deficiencies are purely academic, such as lack of knowledge (or inability to apply it), inadequate judgement, or poor technical performance, others involve lapses in professional behavior or misconduct. Frohna delineates the gray zone between the (academic) competency of professionalism and behavioral misconduct.[14] Table 2 illustrates the difference in how due process in applied in academic issues compared to misconduct. Programs can and should differentiate between professionalism as an academic competency versus professionalism issues that are really misconduct, for example, dishonesty. It is reasonable to expect a learner knows lying is wrong. By the time they reach the age of a GME learner, it is unlikely that there will be an educational intervention that will teach them something "new" or a remediation that could adjust their attitude or behavior. Nor is there an assessment that assures the program their intervention has succeeded, and the learner is no longer lying. Perhaps they do become truthful, or perhaps it is only that they are not caught. In cases of misconduct, programs must still assure due process, but they do not have to extend an "opportunity to cure" that may risk recurrent misconduct. The minimum requirement for due process in academic misconduct cases includes notice of the accusation, an opportunity to be heard on the accusations, and a reasonable process for deciding whether the learner engaged in misconduct.[2,10–12]

Institutional and HR leaders are familiar with employment processes for failure to perform and misconduct that are typically structured as progressive discipline. Progressive discipline processes were established to protect employers' business interests and do not translate well to education because the priority for GME is to *protect the learning environment*, and assure the learner can receive a professional credential, complete their GME program, and retain

TABLE 2
Differences Between Academic Deficiencies and Misconduct

Performance	Academic Deficiencies	Misconduct in the Academic Setting
Examples	▪ Knowledge-based ▪ Deficiency in a core competency[a] ▪ Technical deficiency ▪ Lack of insight	▪ Dishonesty/lying ▪ Improper behavior[a] (harassment,[b] retaliation, plagiarism, etc) ▪ Disruptive behavior ▪ Theft ▪ Violence
What the law requires	Notice (of deficiencies) + Opportunity **to Cure** + Careful and reasonable decision-making process *Allows time to remediate and improve after a deficiency is identified*	Notice (of allegation) + Opportunity **to be Heard** + Careful and reasonable decision-making process *Does not require time/opportunity to repeat improper behavior*

[a] One of the ACGME core competencies is professionalism; programs must carefully distinguish professionalism which is "academic" from behaviors which are really "misconduct."[14]
[b] Some behaviors, such as alleged harassement may be required to be handled outside of the CCC, such as sexual harassment by human resources or a Title IX office.

eligibility to enter the process of board certification. However, hospital HR departments and employment counsel often miss the difference and seek to treat learners like employees. GME leaders must be mindful of this nuance to assure that due process is afforded properly to learners and to educate HR and legal teams at their institutions.

A Reasonable Decision-Making Process

The CCC serves as an integral component of the *reasonable decision-making process*. In Horowitz and Ewing, the courts identified the faculty evaluation committee as one of the core elements of a reasonable decision-making process. The committee's key attributes were "a regularly called meeting of the faculty for the purpose of discussing student performance," a defined meeting schedule, and identified committee members. The decision-making process was not a reactive response to a single issue. The Ewing case further recognized that a faculty decision-making committee (eg, CCC) provides for decisions that are "conscientious and made with careful deliberation" (ie, protecting decisions from not being arbitrary or capricious).[11] The CCC's use of Milestones derived from their own specialty further demonstrates that their decisions are not arbitrary or capricious and when conveyed to the PD, provide a legally sound defense of the decision-making process.

The CCC's reasonable decision-making processes should include all available information on the learner's performance, including all past *notices* and *opportunities to cure*. This includes the learner's entire portfolio of performance: verbal and written feedback, structured and unstructured observations of performance, solicited and non-solicited feedback from others, qualitative and quantitative assessments, and formative and summative feedback. The Ewing decision affirms the ability of an educational program to utilize all relevant information in academic decision-making, even performance before enrollment in the current program.

Documentation of Performance

When defending a legal case, the routine evaluations completed by faculty can be beneficial in documenting what they observed and how well the learner performed. ACGME requires written rotational evaluations and semiannual performance evaluations; however, there are no federal or state laws requiring written evaluations or performance feedback and faculty commonly provide learners with verbal feedback. Verbal feedback constitutes *notices* and *opportunity to cure* as much as do written assessments. The absence of written feedback should not deter CCC members and PDs from utilizing verbal feedback to inform their decisions. Faculty may be reluctant to provide written feedback that is perceived as negative due to concerns about their personal legal risk.[15] Legal precedent affirms that learners enrolled in academic programs give implied consent to being evaluated as part of their enrollment. Negative comments regarding cognitive and noncognitive performance are not considered defamatory as long as they are honest and given without negative intention.[16] Fairness to learners demands honesty.[17]

Program assessment systems must include feedback from faculty regarding learner performance in a variety of settings and situations, and use input from multiple evaluators including faculty, peers, patients, self, and other professional staff members. These data

should be provided to CCCs to consider in addition to their own experiences and observations. The CCC's dialogue may be the first time that issues emerge to show a pattern of performance and provides a more accurate consensus regarding learner performance than written evaluation alone.[18]

Decision Process

The ACGME requires the CCC to advise the PD of their recommendations regarding learner performance and subsequent recommended action(s). The ACGME requires the PD to be the final decision-maker[2] with input from the CCC's deliberations. When there is disagreement, there is almost always a learning opportunity for the program to enhance communication, increase the use of alternate data sources, or improve assessments.

There is no requirement that CCCs vote on their recommendations or that unanimous agreement is required. The authors recommend CCCs not vote. Recommendations can often be reached by consensus. The CCC chair must be prepared for situations in which different opinions are strongly held that do not yield consensus. These differences of opinion and the tensions created are crucial to authentic assessment and inherent in CBME.[19] CCC members should undertake regular faculty development including best practices for effective group decision-making.[20] Robust CCC discussions are valuable to support the formation of individual performance evaluations, to allow for individualized learning plans for all learners, even those who are high performing, and to demonstrate a *fair and reasonable decision-making process* when institutions must defend adverse actions, such as a dismissal.

Minutes

Although the ACGME has no requirements on how CCC documentation should be recorded or maintained, it is customary for most CCCs to keep minutes. Ekpenyong et al[21] offer practical guidance regarding documentation of minutes (BOX). CCC minutes should align with relevant program and institutional policies, including record retention, state peer-review statues (if applicable) and local HR and legal experts' guidance. Some institutions may prefer CCC minutes to be brief and perhaps limited to the Milestones reported to the ACGME. Carefully prepared CCC minutes can provide one of the strongest legal defenses to demonstrate due process and support adverse actions. They also provide the framework for consistent verifications of training for learners long after they have left the institution.

BOX CCC Documentation

Suggestions for proper documentation related to clinical competency committee (CCC) discussions:

- Know relevant institutional, program policies, and state peer-review statutes (if applicable).
- Collaborate with designated institutional official, human resources, and legal team.
- Create a written document reflecting a concise summary of each learner's performance and any action items or follow-up required.
- Manage this document confidentially along with all information discussed at the meeting (eg, limited distribution to CCC members, the program director, and others as appropriate such as the resident's advisor or the program administrator).
- Archive document in accordance with institution and/or graduate medical education document retention policy.
- Determine if this documentation is to be shared/not shared with learners and communicate this to them.

Improper CCC discussion and documentation—CCCs should avoid:

- Discussion and/or documentation of:
  - Personal health or medical issues, whether known or suspected
  - Discussions of how health may be impacting performance (eg, "Dr X has ADHD and it impacts their ability to manage multiple tasks.")
  - Recommendations or requirements for medical follow up (eg, "Dr X must be evaluated for depression.")
- Written transcripts of the full meeting
- Verbatim documentation (eg, "I found Dr X pretty stupid about the nuances of the case and one of the worst residents we have ever had.")
- Disclosure of CCC discussion outside of defined structures (eg, other faculty/residents who may interact with the resident[s])

Peer-Review Privilege

Peer-review statutes in most states create a privilege that protects institutions from disclosure of certain information about a physician's performance. These statutes vary from state to state, but in general, they are intended to encourage continuous improvement by allowing physicians to acknowledge error to a peer-review committee without risk of this admission being used in a medical malpractice case. The privilege does not apply in federal courts, and in many states, it only applies in medical malpractice cases. Even in states where the privilege has been read broadly, it is inconsistently applied to academic assessments of learners and only a few states have extended it to GME learners.

Generally speaking, the peer-review privilege protects internal discussions of clinical performance, not the evaluation, discussion, or decisions intended to be communicated externally. Peer review also typically protects records of in-person meetings where the information is maintained internally and not communicated outside of the peer-review process (eg, to clinical advisors, other departments, or external agencies).

Each institution should be familiar with its state's peer-review statute and review it with legal counsel to determine its applicability to the CCC. Given the evolving legal environment and the frequency of litigation regarding resident performance, new case law and state decisions should be regularly reviewed.

Appeals and Due Process

Institutions should carefully craft policies and procedures that specify what can and cannot be subject to appeal by a learner. The ACGME requires institutions to have a policy that "provides residents/fellows with due process relating to adverse actions such as suspension, non-renewal, non-promotion, or dismissal."[2] Most institutions limit due process to these actions.

The ACGME does not require assessments, including Milestones determinations, and evaluations to be subject to review, appeal, or due process. This should encourage faculty to provide learners with candid, robust evaluations reflecting actual performance to identify strengths and deficiencies, which is essential to help learners improve.

Allowing learners to appeal performance evaluations (rotational evaluations, semiannual evaluations, etc) serves to discount faculty member or PD feedback as negotiable. It can also signal to faculty members and PDs that their feedback, when critical, can be subject to scrutiny and even reversal, a powerful demotivator to encouraging truthful assessments. Most institutions do not allow due process for regular, routine feedback, including assessment and evaluations.

The Mechanics of Appeals Processes: The Hearing

The ACGME does not specify how due process should be operationalized, only that institutions must have written due process policies. The vast majority of SIs have due process procedures that mimic employment policies (ie, progressive discipline). This may take the form of a remediation status, followed by probation, preceding an adverse decision. Also, it has been common to provide a multi-party hearing to review disputed actions in an attempt to assure fairness to the learner. Hearings, while well intended, can be time and resource intensive, and often result in unpredictable decisions that increase the risk of liability for the SI.[4,22] In fact, the Horowitz decision noted that the dean's agreement to review the faculty decision, then request additional feedback, provided "much more process than was due."[10]

To assure the fairness required by due process, adverse decisions should be reviewed by another decision-maker than the original one. This does not require a committee, a panel, or a hearing board. The review process can simply be a meeting between the learner and another neutral decision-maker such as a dean, the designated institutional official, or the chief medical officer. The intent of this meeting is to hear the learner's concerns, assure the process preceding the decision provided notice and opportunity to cure, and that the decision was reasonably made. The review should focus on assuring policies and processes were followed. The expert judgement of the faculty or the program should not be second-guessed.

Reporting and Disclosure to External Entities

Programs are obligated to disclose subjective opinions regarding learner performance to third parties in a variety of circumstances, even decades after the learner leaves the institution. For most learners this is not problematic. For the consistently struggling learner or one subject to an adverse action, this reporting can lead to legal action. Most queries come from other training programs, employers, credentialing bodies, and licensing boards. Given the important gatekeeper role programs serve in regulating access to the medical profession, the information provided must reflect the PD's honest academic judgment.[5,23]

The ACGME strongly recommends that Milestones not be used for this purpose, or any purpose for which they were not designed. "The ACGME does not have evidence that individual Milestones data can be validly used in any other context beyond provision of individual resident and fellow feedback, especially for any higher stakes decisions"[24] such as licensure. The ACGME has described potential adverse consequences if Milestones are used by external entities[25] and asked institutions and programs to limit the release of Milestones data to the ACGME.

Programs typically convey information to external entities in a final evaluation.[2] The final evaluation must be part of the learner's permanent record, accessible for review, verify the acquisition of the knowledge, skills, and behaviors necessary to enter autonomous practice,

consider CCC recommendations, and be shared with the learner upon program completion.[2] It should include significant weakness or non-remediated deficiencies across the core competencies. Though inherently subjective, it is neither arbitrary nor capricious. It should not be negotiated by the learner or modified to avoid potential legal action. Information that is censored or negotiated as part of a settlement or dispute resolution can ultimately harm patients and the public. At least one court has recognized a cause of action for misrepresentation by a hospital that failed to accurately disclose information concerning a physician's performance to another hospital.[26]

The ACGME requires the final evaluation to be requested and provided when learners change programs.[2,27] Programs and institutions are obligated to respond to requests from outside agencies such as credentialing and licensing boards.

Finally, to date, there have been no successful suits for educational malpractice (eg, a learner suing a program/institution for failure to provide adequate education or a program/institution being held liable for a future patient's injury due to a learner who "graduated" but with some deficiencies in training).[28]

Conclusions

Although the legal ramifications of academic decision-making can be unsettling to medical educators, CCCs should be reassured by understanding the established legal guidelines regarding academic decision-making.

We concur with Irby and Milam who wrote more than 30 years ago, "Faculty (should) document performance problems candidly and in detail… resident review committees should act early to identify marginal and failing… residents… trainees should receive notice of their deficiencies and the consequences if... not rectified…. Learners (should have) access to their evaluations and … some form of informal give and take (with) the faculty. When performance problems have been clearly identified and remediation fails, the faulty should act promptly to dismiss… perhaps (the) only unfairness… (is) failure to dismiss… earlier when… ample evidence of… inability to meet… standards….The law provides… liberty and freedom needed to uphold high academic standards. Let us use that freedom wisely and courageously."[28]

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