Strangers in a strange land: The experience of physicians undergoing remediation

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RESEARCH ARTICLE

REMEDIATION

Strangers in a strange land: The experience of physicians undergoing remediation

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Abstract

Introduction: The experience of remediation in practising physicians has not been widely studied. Remediatees frequently present negative emotions, but observers can only infer the underlying reasons behind these. Understanding remediatees' perspectives may help those mandating and organising remediation to structure the process in ways that improve the experience for all concerned parties and maximise chances of a successful outcome for remediatees.

Methods: Seventeen physicians who had undergone remediation for clinical competence concerns were interviewed via telephone. Participant data were first iteratively analysed thematically and then reanalysed using a narrative mode of analysis for each participant in order to understand the stories as wholes. Figured worlds (FW) theory was used as a lens for analysing the data for this constructivist research study.

Results: Participants entering the FW of remediation perceived that their position as a 'good doctor' was threatened. Lacking experience with this world and with little available support to help them navigate it, participants used their agency to draw on various discursive threads within the FW to construct a narrative account of their remediation. In their narratives, participants tended to position themselves either as victims of regulatory bodies or as resilient individuals who could make the best of a difficult situation. In both cases, the chosen discursive threads enabled them to maintain their self-identity as 'good doctor'.

Conclusion: Remediation poses a threat to a physician's professional and personal identity. Focusing mainly on the educational aspect of remediation—that is, the improvement in knowledge and skills—risks missing its impact on physician identity. We need to ensure not only that we support physicians in dealing with this identity threat but that our assessment and remediation processes do not inadvertently encourage remediatees to draw on discursive threads that lead them to see themselves as victims.

1 | INTRODUCTION

As more jurisdictions and health care organisations implement quality improvement (QI) programmes, the number of physicians requiring some form of practice change will likely increase. In the continuing professional development (CPD) literature, QI focuses on identifying areas for learning and practice improvement; such QI activities are meant to hold positive connotations as educational responses to identified needs.[1–3] However, some participants targeted by such activities have resisted engagement. One

explanation offered for this resistance is that physicians sometimes view QI as synonymous with 'remediation'.[4] This raises an important question: What is it about the experience of undergoing remediation that is so discomforting? While we have some knowledge of how residents in training perceive remediation[5] and how such residents actually experience remediation has been explored,[6] remediation and its connotations may differ for practising physicians. We do know that practising physicians undergoing remediation may not always be viewed as full members of the medical fraternity,[7] but the personal experience of those undergoing remediation has not, to our knowledge, been described in the literature. Understanding the experience of physicians undergoing remediation could usefully inform the design not only of traditional remediation programmes but perhaps also of QI systems that physicians tend to conflate with remediation.

The data on the experiences of physicians undergoing remediation are sparse. Although some assessment and remediation programmes conduct surveys or exit interviews, these data are collected to inform programme process improvements, not to unpack the impact of remediation on the physician remediatee. Furthermore, these results may be of limited scholarly use because remediatees are likely hesitant to express their true sentiments to the organisation that will also determine their professional future. In the formal academic literature, several recent manuscripts have addressed remediation in residency training by describing graduate medical education intervention programmes, but these papers do not include the perspectives of residents who underwent remediation.[8–11] Similarly, whereas recent papers on remediation in practice focus on best practices,[12–14] only one of these included insights from a remediated physician—in this case, as a member of the author team.[12]

Some research relevant to this question has focused more on the emotional impact of receiving negative performance feedback (i.e. that does not support a physician's self-assessment)[15–18]; however, there has been less attention paid to the emotional challenge that remediation itself can pose for individual remediatees. For example, a recent scoping review on emotion in remediation references several papers that include the need for emotional support for either learners or practitioners requiring remediation.[19] However, although these papers note that remediatees showed anger and denial and 'felt embarrassed and defensive',[20] these assertions were based on outsider observations of the remediatees' behaviours rather than on reflections from the remediatees themselves. Because these emotions were categorised by observers, the lived experiences of remediatees are poorly understood. Remediatees may express anger, embarrassment or other negative emotions for a variety of reasons. Although the observer might infer the causes of these reactions, only data from the remediatees themselves can confirm those inferences, data we currently lack.

Recognising this deficit, the research agenda set out in Kalet and Chou's seminal book, *Remediation in Medical Education: A Mid-Course Correction*,[21] stresses the need for a better understanding of the perspectives of trainees undergoing remediation. We suggest that this need also applies to practitioners undergoing remediation. Therefore, in this study, we set out to explore the experiences of practising physicians required to undergo remediation. Understanding how physicians experience remediation might enable us to develop better remediation processes and to better support physicians remediatees. Thus, we set out to answer the following question: 'How do practicing physicians undergoing remediation for clinical competence experience the remediation process?'

2 | METHODS

In this study, we used a constructivist inductive research approach that harnessed the process of theory-informing inductive analysis.[22] In keeping with this tradition, we held many different theories in mind as the study was conducted; we only began to narrow this scope during the data analysis processes, when deep exploration of the data led us to understand which theory could best help us understand and explain the experiences of our participants. To use this approach, we began our study with a broad-scoped data collection approach informed by the principles of narrative research.[23] We chose to borrow from narrative research because this orientation is built on the premise that individuals make meaning and understand social experiences by constructing stories.[23] By collecting the stories of remediatees, we were able to understand how these physicians constructed and inhabited the lived social reality of remediation.[23] In other words, using the principles of narrative research allowed us to explore participants' personal construction and understanding of remediation and to study their ways of making meaning of their position as a remediatee in their larger social and cultural contexts.

The study received ethical approval from the UBC Behavioural Research Ethics Board (protocol no. H20-02084).

2.1 | Participants

Finding participants to engage in this research required the support of regulatory authorities who offer remediation programmes because, in our national context, these are the structures that hold information about which physicians have undergone remediation. We approached four Canadian provincial regulatory authorities who had participated in previous studies in our programme of research.[4,7,24] Only two agreed to send out the recruitment email, one from a large province and one from a smaller province. This email invitation explained to potential participants that the study was being conducted for research purposes and that their participation was in no way connected to the regulatory authority. The email also stated that their information would not be shared in any way with the regulatory authority. Physicians who agreed to participate were asked to contact the first author directly so that anonymity was preserved. No remediatees contacted us from the smaller province. Therefore, all participants were sampled from the larger province. Participants were loosely representative of the national physician population in terms of proportions of

TABLE 1 Participant demographics

Participant demographics	
Gender	**13 male; 4 female**
Specialty	11 general/family practice; 6 specialists
Training	5 international medical graduates; 12 Canadian medical graduates
Time in practice at time of remediation	<10 years: 2 (*shortest 5 years*) 11–20 years: 3 21–30 years: 2 31–40 years: 5 >40 years: >5 (*longest 50 years*)
Reason for assessment	Patient complaint: $n = 6$ Assessed because of age only: $n = 4$ Complaint by other health care provider: $n = 4$ Other: $n = 3$ (as part of facility assessment; suggested by participant themselves; follow-up re previous multiple remediation episodes)
Reason for remediation	Updating on specific topic: $n = 3$ Updating on more than one topic, or general updating: $n = 11$ Poor opioid prescribing: $n = 3$ Half (8/17) also require remediation for poor medical record-keeping

Note: Remediation in all cases included time spent with a preceptor/remediator.

generalists versus specialists and Canadian versus internationally trained physicians. Aggregated participant demographics are outlined in Table 1.

2.2 | Data collection and analysis

The first author conducted individual interviews[25] with participants in one of Canada's two official languages (i.e. English and French) between January and March 2021. In the interview, participants were asked to tell the story of their remediation experiences (see Appendix A for the interview protocol). Interviews were conducted by phone except for one interview conducted via Zoom at the participant's request. Interviews were audio-recorded and transcribed by an external transcription service. Due to budgetary constraints (note: there were more interviews in French than anticipated), only those portions of the French interviews pertinent to the research question were translated by an external translation service. The extent of the translation varied from a few paragraphs to almost the entire interview. Two of the four authors (GBL and LV) are French speaking and reviewed the translations to ensure that the meaning of the original was preserved in the translation.

Data analysis took place in two phases, the first informed by *analysis of narratives* and the second by narrative mode of analysis.[26] Analysis of narratives involves organising data into ordered and consistent groups with common features and seeking out overarching relationships across groups and features.[27] To that end, in the first phase of data collection and analysis, GBL analysed the interview data using thematic analysis[28] in an ongoing, iterative manner to examine the narrative(s) constructed in each transcript. A subset of the interviews was also reviewed and coded by LV.

In the second phase, we sought to go beyond constructing themes to focus on the configuration of each individual participant's narrative of their remediation journey as a unique whole (i.e. narrative mode of analysis).[26] We attended to the differences and diversity in the stories, focusing on the complex interaction of factors—both individual and social—to understand the *how* and *why* shaping each person's story.[27] To realise this analysis, interview transcripts were analysed by GBL, and a subset of the interviews was reviewed and analysed by LV. In this analysis, GBL and LV used to-and-fro recursive readings to examine the data as parts (including themes occurring in the transcript) to the whole narrative from each participant and as wholes to parts in a hermeneutic manner. They attended to the significance of the participants' stories of their lived experiences of remediation and sought to bring the themes created in the first phase into coherent wholes with new insights generated from the whole data set. Once GBL and LV had constructed these insights, they met with the whole research team to discuss the data, articulate the evolution of analysis and collect their comments on the analysis work and confirm interpretations. It was during this process that a theory to help inform analysis was selected: figured worlds (FWs).

2.3 | Theory: FWs

The theory of FWs, originally applied to education, and more recently to medical education,[29] provided a lens with which to explore and understand the participants' narratives. FW theory was developed by Holland et al as part of their sociocultural theory on how identities form in the course of activities and social interactions.[30] FW theory posits that an individual's identity is a product of that person's personal history and social context. Holland et al defined a FW as 'a socially and culturally constructed realm of interpretation in which particular characters and actors are recognized, significance is assigned to certain acts, and particular outcomes are valued over others'.[30] From this perspective, academia is a FW, as are medical education and medicine. Actors in a FW (i.e. the people who are part of the FW) have positions in that world, but these positions are not stable nor are they unchallenged. Individuals use their agency to draw upon various discourses in the FW (i.e. ways of thinking and communicating about people and things) to position themselves in relation to others and to construct positions for themselves. For example, as Bennett's research has previously established, in the FW of medical education, there are different discourses around being a 'good doctor' that medical students and residents draw on to construct their individual personal identity as physicians.[29] This position of 'good doctor' is foundationally important to

the actors in the FW as it holds power and authority for these individuals in relation to others—that is, in relation to those who are not 'good doctors.'

In this paper, we use FW theory to analyse how physicians undergoing remediation for clinical competence concerns use their agency to draw upon various discourses to make sense of their remediation experience in the unfamiliar FW of remediation. In other words, we looked at how participants actively drew on the 'meanings, experiences, orientations, events, material objects and social practices' (i.e. discourses) that surrounded them to conceptualise of their remediation experience.[31]

2.4 | Reflexivity

Given the constructivist orientation of this research, it is important for us to reflect on how our perceptions and interpretations may be affected by our experiences. GBL is a retired physician whose 10 years as the director of an assessment and remediation programme led to her wanting to figure out ways to improve the process for all concerned. GR is a PhD trained researcher in cognitive science with 30-year experience supporting both qualitative and quantitative researchers in health professions education. PWT is a gynaecologist with a PhD in workplace learning in health care. LV is a qualitative research scientist with expertise in FW theory research. Her interest in discourse and the construction of identity via discourse shaped her interpretations of the study data. The team has worked together on several papers regarding conceptualisations of remediation, developing a duality theory of remediation as both education and (loss of) self-regulation/professional identity. That theory that also informed the interpretation of the data.

3 | RESULTS

A risk in this study is that only individuals disgruntled with the remediation process would volunteer as participants. We therefore asked participants at the end of the interviews why they had chosen to participate in our investigation. Responses clustered along four reasons: to contribute to changing the process so that other physicians undergoing remediation would have an easier experience than they had had; to provide input that they hesitated to give the regulatory authority for fear of potential recriminations; to talk about/personally process the remediation experience; and to ensure that we did not only hear from people with negative experiences. These answers reassured us that our participants did not solely represent individuals dissatisfied with or resentful of the remediation process.

Our analysis suggested that participants were standing at a crossroads of FWs. In the FW of medicine, they had held a position as a 'good doctor' who was trusted to provide patient care without oversight. When mandated to undergo some form of remediation, they were forced to move into a new, unfamiliar FW. Finding themselves in this new FW of remediation was profoundly destabilising and painful:

> It's like being hit on the head with a hammer. (P7)

> it's very stressful and traumatic for doctors. (P10)

In this new FW of remediation, where their right to self-regulate their practice was removed, participants clearly expressed a perceived threat to their professional identity—an identity of a 'good doctor' (e.g. 'The only thing that hurt me was being told I had a dangerous practice' [P8]). Participants responded to this threat by seeking out confirmation of that position in comments from patients (e.g. 'if you brought in the patient and asked, "What did the doctor do that day? Were you happy?" You would see that the great majority would be satisfied' [P16]), colleagues (e.g. 'the colleagues I used to spend time with, well, they thought I was competent' [P1]) and even the remediator (e.g. 'During these six sessions that I had with the [remediator], every time I'd bring up sick patients he would say, "Well, that seems appropriate. What you're doing--have no problem with that"' [P6]).

With little support in understanding and navigating this FW, participants frequently struggle to construct a position they were comfortable occupying. When participants sought out advice from friends or colleagues, the advice tended to fall into two opposites: 'resist their demands' or 'resistance is futile so do what they tell you'. In addition to seeking insights from others, participants drew together various discourses, not only to reassert their position and identity as a 'good doctor' but also to make sense of their being subjected to the remediation experience. Although each participant's experience was unique, we could see commonalities across discursive threads being woven together by the participants. The language our participants used can be grouped into two major discourses: *I'm not supposed to be here* and *I'm going to make the best of a bad situation*. Table 2 presents different examples of the discursive threads narrated by participants, organised under each of these two major headings.

Participants drew threads from these two discourses together to construct ways of doing, thinking, feeling and being in the FW of remediation. These threads functioned like tools through which the participants constructed positions for themselves in the FW. To illustrate this discursive work of position construction, we offer two example narratives in the boxes. In each narrative, to preserve the anonymity of participants, we combine different aspects of multiple participants' stories; we preserve the discursive threads to illustrate the work remediatees engaged in to construct positions for themselves in the new FW. These examples show how participants attempted to deal with the threat to their identity as a 'good doctor'.

TABLE 2 Participant positioning

Sub-theme	Description	Representative data excerpts
I'm not supposed to be here		
The College (regulatory authority) is wrong	The College does not understand my practice situation	'Most of it (the assessment report) was complete gibberish written by people who do not even know our practice. Do not even know the specialty, right' (P5)
The College is engaging in discrimination	The College is treating me differently because of my age	'Normally we are—at my age you have already been exposed to different processes of inspection from the College. But I've never been to this extent. It was always constructive and it was always relatively well done. But when you get to a certain age, their approach is, I would say, a little bit different. In other words it seems to be for them that your, the competent age is 70. From 70 on, you are a danger. You're a danger to society' (P15)
The College is the enemy	The College is a legalistic entity whose goal is to find as much wrong with my practice as they can	'I tell people do not assume that these people are your friends. They're not. They're not your colleagues or friends. Their role is to find fault and to cause you problems …. I felt they were trying to meet an agenda and they would provide me the least amount of information by law that they had to provide in an attempt to try and prove what they wanted to prove' (P6)
I'm a victim	The College has it in for me. The College is biased and unfair	'It's very frustrating because I feel like a victim' (P2) 'Me, look at all the stress I am going through, paying fees …. But someone who makes a big mistake, like for example (describes case of physician error that made the news) does not have the stress (of the remediation) does not pay a penny' (P11)
College doctors are not real doctors	Doctors who work for the College are out of touch, and their assessments are therefore not valid	'Among doctors, we laugh because they are people who are no longer in offices, they are disconnected. They have methods that they study together, I do not know, all the Colleges together to evaluate a doctor, to evaluate a (medical) record. But this is not the practice we do on a daily basis' (P10)
I am going to make the best of a bad situation		
I'm strong; I'll get through this	I refuse to let the College define me, or to let this situation get me down	'I can go through the disciplinary process but I'm going to stand up for myself. I do my best with what I have …. I'm someone who does not let the business with the College get them down' (P7) 'What can you do? You just toughen up and you take what comes and you have to solve the problem. It's a pain in the butt but you have to do it' (P5)
I can help my colleagues avoid my fate	I can be an ally to my colleagues by using my experience to warn them of aspects of their practice that could get them into trouble	'So I explained to them that the College had come to see me and, well, these were the recommendations that had been made for my records in the emergency room. At least, tell other people because if I make mistakes, other people can make mistakes too' (P9) 'I actually spoke to my colleagues because I warned them about things that they were doing that the College took issue with' (P6)
Remediation can have positive outcomes	Some good came out of this difficult experience	'You do not know yourself, at some point you get older, you pick up habits and all that, and then um, for me, it was like an experience that gave me a lot of reassurance that I can continue practicing' (P12) 'It's true that the (remediation) period, well it's inconvenient but it's an opportunity to discover how other doctors practice a little or perhaps to discover a practice that you did not learn at school because often we are all from different backgrounds' (P8)

John: I'm not supposed to be here

John was 70-year-old physician who had been assessed as part of provincial routine protocols (note: in several Canadian provinces, all physicians are assessed at regular intervals once they reach a certain age). John was well past the standard Canadian retirement age of 65, but he enjoyed clinical practice because it met both social and personal needs, not because of financial need. He enjoyed the company of his clinical colleagues and derived joy from helping his patients. The conclusion of the regulatory authority's assessment was that deficiencies existed in John's record-keeping practices and in the quality of care he offered to patients.

In the interview, John could not recall the exact words used by the assessor, but he perceived that he was no longer recognised as a good doctor. He was very upset with this assessment. He listed all the things he'd done to maintain clinical competence: he'd regularly attended continuing education sessions; he knew details about all his patients; and he provided care that best suited each individual even when that care might not follow the published guidelines for a particular condition. He conceded that his paper-based patient records could be improved, but he bristled at the suggestion that he was no longer a good doctor:

'I agreed to work on improving my record keeping. But as for the quality of my medical practice—No. No! I know my medicine and I can sit down with anyone at the [regulatory body name] and talk about medicine. I feel 100%. I feel I'm a good doctor. For them, good record keeping means quality medicine. And I do not agree with that. Good medicine means so much more than the paperwork. The older I get, the more my patients say to me: "I hope you will not leave us. I hope you'll still be here"'.

John was adamant that he was a 'good doctor' regardless of what the regulatory authority stated. He drew on the fact that his patients liked him and his colleagues supported him as evidence of his rightful standing as a 'good doctor.' He positioned the regulatory body as the enemy and dismissed them as ageist. He clearly drew on the discourse of not belonging in remediation. He did not agree with the assessment, and he dismissed the regulatory body by accusing them of simply 'harassing' him. He clearly did not feel that he belonged in remediation. Instead, he positioned himself as a victim of an assessor from a regulatory body that was out of touch with the realities of practice.

*Like most participants, John found the actual remediation (*i.e. *the time spent with the remediator, not the assessor who was sent to make a determination) to be a positive experience. John reported that the remediator agreed that he was a good doctor, focused on positive aspects of his practice and provided some suggestions that he could implement to be an even better 'good doctor.' John positioned the remediator as a peer John could discuss things with. John's efforts to maintain a social position of equality were frequently part of his narrative*:

'We were able to discuss how we did things, like, "This is how I do this. This is how I'd do that." And vice versa*'. So, I feel like there was a mutual benefit.*

John held on to his identity as a 'good doctor', but he did that at the cost of fully engaging with the remediation process. While the remediation was ultimately successful, the remediator had to request an extended remediation time to ensure that all objectives were met.

Jane: I'm a good doctor, but even good doctors can find themselves in remediation

Jane was a 56-year-old physician against whom a patient complaint was made to the regulatory authority. While the regulatory authority found no fault in her care for this patient, a full practice assessment was performed as part of the investigation. In this assessment, areas for improvement were identified. Jane found the process challenging on several fronts. It caused her to question her competence, and she felt that the culture of medicine was such that it was hard to seek support from colleagues.

'I tried to get over the fact that I was going to have to undergo remediation. That was the hardest part. I found myself constantly questioning my ability to be a competent physician. I had to accept that there were some aspects of my practice that needed improvement. What made it even harder was that, well, it's hard to talk about. You cannot just tell anyone about it. You're a doctor. That means you are strong and on top of it all. You should not have feelings or doubts. But I did. I had a lot of feelings and a lot of doubts'.

In time, Jane came to see the remediation process as an opportunity that she could harness to her advantage: 'I tried to learn from the situation. I got through it. I'm very resilient'.

Jane was critical of the assessment process, stating that it could have been carried out in a much less stressful manner. But, in contrast to John, Jane positioned the regulatory authority as an ally, there to help her remain in practice as a good doctor. Jane did ultimately confide in several colleagues; instead of complaining about the regulatory authority to her peers, she offered them suggestions for changes they might make in their own practice to avoid ending up in a similar situation. This positioning reinforced her position as a valued member of her clinical community.

While finding herself in the Remediation FW was the last place she wished or expected to be, Jane positioned herself as a 'good doctor' and as an individual capable of dealing with and learning from unpleasant circumstances. She discursively positioned the remediator as a helpful peer while simultaneously respecting that the remediator had a particular role to play.

'I really considered that he [the remediator] was a colleague of mine. We knew that he and I and the College [the remediation authority] had a triangular relationship with boundaries. He was definitely doing the College's work but I felt that I was being accompanied on a journey of growth more than being dictated to change'.

By drawing on different discursive threads than John, Jane was able to maintain her desired position of 'good doctor' while making the most of her time in the FW of remediation. The process was, however, not an easy one to engage in.

Of note, demographic factors could not account for whether an individual participant's choice of discursive threads resembled John's or Jane's or a mix of both. Although it might be tempting to attribute differences in remediatee responses to factors such as age or training or gender, some of the most inspiring stories of self-awareness and change were narrated by elderly or IMG physicians. When placed in the FW of remediation and when faced with a threat to their identity as a 'good doctor', participants' reactions were described in relation to a variety of factors, including past experiences, personality, practice context and support at home and at work. Another significant factor that all participants noted as shaping their engagement in remediation was the quality/nature of the interactions they had with the various people they encountered in their dealings with the regulatory authority (e.g. assessors and remediators).

4 | DISCUSSION

FW theory has provided a valuable lens to inform our understanding of participants' experiences of remediation. Our participants were placed into the remediation FW; they did not choose to move to that FW. In the context of our study (i.e. Canada), the permanent actors in the remediation FW are the regulatory authority, the assessors, the remediators and the organisation that delivers medical liability protection to physicians. Remediatees are temporary actors in the FW of remediation—individuals who, to use Holland et al's term, were 'recruited' therein.[30] Unlike the FW of medical training, where 'legitimate peripheral participation'[32] enables newcomers to learn how to construct their place therein, newly arrived remediatees struggle to understand and to define their position in the FW of remediation. Their previous positionality as a 'good doctor' in the FW of medical practice was destabilised and threatened. Reacting to this threat, participants used the discourses available to them and which they perceived as legitimate in this new FW to craft narratives that asserted their standing as a 'good doctor', as shown in the sample narratives above They sought confirmation of that standing from patients, peers and the remediators sent by the regulatory authority that had forced them into this new FW. Participants improvised new positions for themselves in the FW of remediation by discursively positioning themselves as erroneously assigned to the FW (i.e. *I'm not supposed to be here*) or as a protagonist who will prevail (i.e. *I'm going to make the best of a bad situation*).

The FW of remediation is not well delineated or understood. Remediatees like our participants are familiar with the FW of medical training and of medical practice; however, in the FW of remediation, they are strangers in a strange land. It is also a marginalised FW, one that remediatees have likely been oblivious to before their mandated entry. Given these considerations, it may not be surprising that there is little guidance for physicians as to how to engage in remediation.

Using the lens of FW allows us to understand some of the negative, aggressive or otherwise problematic responses to being required to undergo remediation. Our participants expressed or described the gamut of negative emotions referenced in the literature including shame, embarrassment, anger, blame and denial. For some of our participants, the discomfort and pain of being forced into the FW of remediation may have interfered with their ability to harness the educational opportunity afforded to them via remediation and to enact the necessary changes to their practice.

Thus, our results suggest that a narrow focus on the educational aspect of remediation (i.e. the improvement in knowledge and skills) risks missing the deeply personal meanings and implications of being cast as a remediatee. In our previous research, we called that aspect of the remediation process the threat to self-regulation that remediation invokes[4] and noted how it might be conceptualised as a temporary deprofessionalisation, because self-regulation is the hallmark of a professional.[33] The results of this current study suggest that remediation strikes at the core of the physician's identity, not only as a self-regulating professional/physician but also as a 'good doctor.'

4.1 | Implications

What can the medical education system do to ensure that future physicians can interpret remediation as part of being a 'good doctor' (i.e. a process of being assessed for weaknesses in practice and supported in improving those weaknesses) rather than an existential threat to their identity? How can regulatory authorities—while still dealing effectively with 'repeat offenders' or the rare medical con artist—modify their practices so that they do not traumatise the majority of doctors who truly want to do the best for their patients?

Professional regulatory authorities exist to protect the interests of the public, not of doctors. Although almost all participants understood this fact, they were frequently critical of the heavy-handed way regulatory authorities enacted their mandate. Our participants, even those who ultimately came to view remediation as a positive experience, generally felt that the regulatory authority focused solely on problems and sought out things to criticise. Except in the most egregious cases of negligence or of unprofessional behaviour, physicians undergoing remediation may need to hear 'you're a good doctor' before they can hear 'this is how you need to improve'.

Our results align with the findings of a recent realist review on optimising the delivery of remediation programs. Price et al found that a successful remediation outcome requires insight, which leads to motivation, which in turn leads to practice change.[12] Factors contributing to insight included providing safe spaces and affirmation. As noted earlier, many of our participants did not feel safe as evidenced by the fact that they chose to speak with us out of concern about potential repercussions from the regulatory authority should they provide honest feedback. Also, when some participants did not hear positive affirmations or acknowledgements that they were trying to do their best by their patients, they were unable to hear or accept the need for change. Remediatees thus require support to be able to navigate the FW of remediation and to deal with the threat it can pose to their identity.

Price et al also found that involving the remediating doctor in remediation planning, destigmatising remediation and facilitating practice change led to increased motivation. Our participants were generally not involved in planning their remediation unless it was to help identify a colleague who would be willing to serve as remediator. Additionally, several participants felt stigmatised by the regulatory authority, which led to defensiveness rather than motivation for change. Addressing these concerns may help facilitate engagement with remediation.

Our participants' stories suggest that the experience of remediatees in practice is highly variable, more so than that of trainees undergoing remediation. This variability in remediatee experience, along with the increase in the number of individuals undergoing remediation, points to an urgent need to integrate remediation into the continuing medical education system.[34] CPD systems are evolving to incorporate continuous QI principles. Resistance to the assessment and improvement activities involved in these QI processes may be rooted in the identity threat that assessment and potential remediation poses to one's self-concept as a 'good doctor'. However, this resistance may also be rooted in other issues such as an inability to self-reflect and self-assess. These factors, and others, are important considerations that should be investigated in future research. Frankly, some of the incidents described and comments shared by participants did make us consider that not only individual factors such as an inability to self-reflect might sometimes be involved but that participant concerns about bias, systemic and other (e.g. ageism) might on occasion be well founded. Integrating remediation into CPD systems as one component in a continuum of practice support, and ensuring as much as possible a standardised set of processes for identifying and supporting remediatees, might help mitigate some participant perceptions of unfairness.

4.2 | Future research

This study enabled us to develop some understanding of the experience of physicians undergoing remediation. It follows previous studies where we sought the perspectives of institutional stakeholders[4,7] and of remediation preceptors.[24] The challenge is that we do not have the perspective of all concerned parties for individual remediation experiences, which makes it more difficult to look at the remediation system as a whole. Although it would be logistically challenging, being able to study individual remediation experiences from the vantage point of all parties—the organisation mandating remediation, the remediator and the remediatee—might better enable us to understand how the various factors within the remediation system work to facilitate or impede successful remediation experiences.

Finally, the one stakeholder that has been ignored in the remediation literature is the patient. In both this study and the one with remediators, we heard that patients may on occasion support their physician and express anger at the regulatory authority, but we do not know how patients in general might react to information that their physician requires some form of upgrading/remediation. Understanding various patient perspectives might help in designing and framing QI and remediation programs so that it becomes accepted that, as one participant in our stakeholder study said: 'all of us are essentially responding to (learning and improvement) needs and therefore we're all remediating something'.[4]

4.3 | Limitations

Persuading regulatory authorities to contact remediatees on our behalf proved to be a substantial obstacle to our research aims. Their main concern appeared to be that they did not have remediatee's permission to contact them for research purposes. We therefore do not have a cross-national participant distribution. However, given the demographic distribution of our participants, the fact that the provincial regulatory authorities regularly discuss and share their practices, the findings from our previous studies interviewing remediation stakeholders and remediators, and the first author's experience as the director of an assessment and remediation programme, we are confident that our participants represent the gamut of how individuals undergoing remediation respond to the process and did not feel the need to continue trying to persuade additional provincial regulatory authorities. Nonetheless, our data bear replication in other jurisdictions in order to ascertain the transferability of these findings to a broader set of contexts.

5 | CONCLUSION

Practising physicians undergoing remediation find themselves in an unknown FW of remediation that threatens their identity of 'good doctor' in their primary FW of medical practice. This identity threat may underlie some of the obstacles that impede these remediatees from getting the most out of their remediation experience. Except in extreme cases of repeated recidivism or psychopathology, ensuring that assessment and remediation procedures do not unnecessarily threaten a physician's identity and position as a 'good doctor', and providing affirmation and support as they navigate the FW of remediation, may contribute to remediatee engagement and better remediation outcomes.

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CONFLICT OF INTEREST

None.

ETHICAL APPROVAL

The study received ethical approval from the UBC Behavioural Research Ethics Board (protocol no. H20-02084).

AUTHOR CONTRIBUTIONS

All authors contributed to this paper. GBL conceptualised the study, collected, analysed and interpreted the data and wrote the first draft of the manuscript. LV contributed methodological expertise, reviewed narratives and contributed to the analysis and interpretation of data. GR and PWT contributed substantially to the study conception and to the analysis and interpretation of data. LV, GR and PWT critically revised the manuscript. All authors have given final approval of the submitted paper and agree to be accountable for all aspects of the work.

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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of the article at the publisher's website.

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