Educator, judge, public defender

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REMEDIATION

Educator, judge, public defender: Conflicting roles for remediators of practising physicians

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Abstract

Context: Practising physicians who remediate their peers face unique challenges. Recent research suggests that leaders of regulatory and educational institutions (ie, those who might be seen as responsible for overseeing remediation programmes for practising physicians) view remediation as a duality: education and regulation. Research has yet to study the perspectives of remediators; therefore, to address that gap we asked: What is the nature of remediation as experienced by remediators?

Methods: We used a theory-informing inductive data analysis study design with positioning theory as a sensitising concept. We interviewed nine remediators from five Canadian provinces, asking them to narrate particularly memorable remediation experiences, then exploring the stories in more depth by asking probing questions around topics related to the research question. We used a hermeneutic analytic approach to explore the meanings that participants gave to their remediation work by iteratively reading their stories, examining the sense making that participants achieved through these narratives, and identifying the positions and responsibilities they described.

Results: In their remediation narratives, participants variably position themselves in three different ways: (a) educator; (b) judge, and (c) public defender. For each position, remediators in turn framed the remediatee in a particular way. Participants shifted between educator, judge and public defender in response to evolving experiences with the remediatee, but they expressed preference for the educator position. However, they sometimes encountered serious obstacles to enacting that educator position. Those obstacles were imposed both by regulators and by remediatees.

Conclusions: This study suggests that the duality of remediation as both education and regulation may be contributing to the challenges faced by those working one to one with remediatees. Understanding the dual nature of remediation and equipping remediators with the tools to manage this duality might contribute to improving the experience for both remediators and remediatees, and ultimately to a greater number of successful remediation outcomes.

1 | INTRODUCTION

With intensified public demands for professional accountability and the ensuing development of revalidation programmes, the need to provide remediation for practising physicians is acute. Remediation is a distinct phenomenon. Unlike discipline, which denotes correction of non-compliance and can be enforced via fines and licensure restrictions, remediation is not the punishment of individuals for transgressions. Remediation, rather, is aimed at helping individuals improve their practice. Depending on the jurisdiction, the need for remediation may be identified by either the workplace or the licensing authority, whereas the actual remediation may be delegated to community peers or to programmes run by universities or not-for-profit organisations. Researchers have only recently begun to grapple with the practical and conceptual issues related to the remediation of practising physicians. Recent research has suggested that leaders of educational and regulatory institutions (ie, those who might be seen as responsible for overseeing remediation programmes for practising physicians) hold some ambiguity with regard to their conceptualisation of remediation. That is, they view remediation simultaneously as both an educational process and as a regulatory action (in that it involves usurping the remediatee's right to autonomously self-regulate decisions about his or her own learning activities).[1] The tendency of individuals to shift between these two conceptualisations without explicit awareness might well be the source of several ongoing challenges in remediation, including the issues of what falls under the definition and who should be responsible for offering it. This raises questions regarding how this ambiguity might be experienced by remediators themselves (ie, those who are tasked by regulatory and health authorities to oversee the learning and practice of physicians with significant competence gaps).

Despite extensive searches of the peer-reviewed literature, we were unable to locate any studies focused on how remediators of practising physicians conceptualise themselves and their role. Given the paucity of literature at the practice level, we looked at how remediators at the residency and undergraduate level conceptualise what they do. The only study that engaged with remediators of residents[2] explored how remediation should be conducted, not how they conceptualise their role. Kalet and Zabar[3] imply a particular role for residency remediators by suggesting specific competencies for clinical educators conducting remediation, but this was based on expert opinion on different facets of remediation, and not on discussions with remediators. Notably, these papers focus on the development of skills such as feedback skills, assessment skills and the skills required to develop remediation plans. Given this, it appears that remediators of residents are being positioned as an educator (specialised in the education of struggling learners). Consistent with this positioning, elsewhere, coaching and mentoring skills have been emphasised by those developing resident remediation programmes,[4,5] although it is not clear that actual remediators at the residency level have identified and aligned themselves with these educator, coach or mentor roles. At the undergraduate level, Hu et al found that remediators positioned themselves as diagnosticians, judges and confidants,[6] whereas Winston et al's participants at the pre-clinical level saw themselves as active facilitators, nurturing mentors, disciplinarians, diagnosticians and models for enthusiastic learning.[7] However, whether these positionings match well with individuals who are remediating practice-level physicians is difficult to extrapolate.

Exploring how remediators, and in particular remediators of practising physicians, conceptualise their role is important for ensuring that faculty development and professional support are appropriately targeted. Furthermore, insights into this role would enable us to better understand the nature of remediation at the practice level and the particular challenges faced in developing remediation programmes for practising physicians. As part of a larger programme of research exploring social constructions of remediation in medicine, therefore, this study explored these remediators' understanding of the work they engage in and the role(s) they adopt therein. More specifically, our research question asked: What is the nature of remediation as experienced by remediators?

1.1 | Theoretical lens: positioning theory

To explore these questions, we used a theory-informing inductive study design and analysis[8] relying on positioning theory[9-11] as a sensitising concept. In its social constructionist approach, positioning theory draws distinctions between roles and positions. It suggests that the roles individuals occupy don't change, but positions - how individuals enact their roles - vary and are subject to conscious negotiation between the individual and his or her environment. Positioning theory highlights the 'dynamic aspects of encounters in contrast to the way in which the use of "role" serves to highlight static, formal and ritualistic aspects.'[12] Positioning theory addresses the implicit rights and duties of each individual in a given role to take certain positions, thus both enabling and limiting the individual's ways of acting and speaking. For example, a physician remediating a peer might ascribe to him or herself the right to speak to the remediatee in a way that other peers would not. However, the language used might vary at different times during the course of the remediation, depending, at any given instant, on how the remediator wanted to be viewed by the remediatee at that moment (eg, as a support for the remediatee versus an agent of the regulator). Positioning theory also suggests that individuals not only position themselves but also others. For example, the remediator might variably position the remediatee as a learner or as a problematic physician, and ascribe to the remediatee the duty to respond to advice differently than he or she might expect a practice partner to do.

Another important concept in positioning theory is storyline. The rights and duties ascribed to individuals depend on the storyline of how an event or process is expected to unfold. Positions and storylines influence actions so that an individual's behaviour is determined not by a response to a stimulus but rather by the interaction between what one is capable of doing and what the context,

including other individuals and the stories told in that context, allows one to do.[13] Thus, positioning theory enables us to understand how storylines and the way individuals use language to represent themselves to others can influence behaviours.

Because positioning theory emphasises meaning, and the management of that meaning,[12] it aligns well with our aim of understanding the nature of remediation, both with respect to the processes followed to realise remediation and the meanings individuals construct of remediation itself. By distinguishing between roles and positions, positioning theory enables us to perceive the difference between the abstract role of remediator and the moment-by-moment embodiment of that role.

2 | METHODS

We constructed this investigation using a narrative approach[14] for several reasons. First, it provides a structured means by which to explore different aspects of remediation without imposing a structure on the phenomenon itself.[15] Because there is a paucity of literature addressing the remediation of practising physicians, we needed to engage in truly descriptive and exploratory research; a narrative approach supports such discovery-oriented inquiry. Second, narrative research goes beyond individual experience to consider how experience fits within relationships and the broader social context.[16] These considerations are important to our research because remediation is situated within a particular medical culture and within a variety of jurisdictional contexts. Finally, our choice of positioning theory as a sensitising concept suggested the use of narrative analysis. Positioning theory helps us understand how people describe themselves and what they do through the stories they tell. This aligns with the affordances of narrative analysis because it 'reveals the normative constraints of a storyline'[12] (ie, how individuals' actions and positions are limited by the stories they construct).

To transparently report the foundational underpinning of our narrative approach, we explicitly reflected on each of Thomas's four questions for clarifying narrative investigations.[17] These questions reference the study's underlying conceptual frameworks, epistemology, ethical stance and methods. In our study, conceptually, we looked at the narratives through the sensitising lenses of positioning theory to understand how our participants attempted to enact the roles of remediator of practising physicians. Our epistemological stance was that of relative subjectivism[18] (ie, that knowledge is the result of the interaction between researcher and participants, rather than derived from a hypothesis to be tested). Our ethical stance was that of an empathic colleague listening: the principal author and interviewer (GB-L) was for 10 years the director of a clinician assessment and remediation programme and could relate to the stories she was hearing. The co-authors (GR, PWT and LV) worked in close collaboration to ensure that the insights of participants were carefully considered in detail and that all analyses were collaboratively constructed. Methodologically, we collected data via one-to-one semi-structured interviews designed to evoke participant narratives about his or her experiences as a remediator and used a hermeneutic approach for analysis.[19]

2.1 | Participants and interviews

Because we sought perspectives from a wide range of remediators who worked in a diversity of contexts, but who were also connected through similar professional expectations, we decided to interview participants across Canada. In Canada, programmes for the remediation of practising physicians vary across provincial jurisdictions, but all physicians are expected to maintain competency standards set by national level organisations. We sampled participants from across provincial jurisdictions to obtain as wide a variety of experiences as possible. Contact information for Canadian remediators of practising physicians is closely guarded; therefore, we worked with regulatory authorities and university offices involved in the remediation of practising physicians to extend an invitation on our behalf to their remediators. All remediators who responded to our invitation were interviewed by phone, the discussions were audiorecorded, and the audio files were transcribed by a professional transcriptionist and rendered anonymous.

In the interview, participants were asked to narrate particularly memorable remediation experiences. When these stories were positive (ie, successful in the eyes of the remediators), follow-up questions asked participants to share a second story that was less successful. The inverse was asked when negative stories were offered initially. The interviewer (GB-L) helped participants to explore the stories in more depth by asking probing questions around topics related to the research question.

2.2 | Analysis

We used a hermeneutic approach to analyse the narrative,[19] exploring the meanings that participants gave to their remediation work by iteratively reading their stories, examining the sense making that participants achieved through these narratives, and identifying the positions and responsibilities they described. This was aligned with our overall research design, which aimed to understand the content of the stories and the meanings participants ascribed to elements of their narratives.

GB-L conducted the interviews, read all the transcripts and independently constructed initial interpretations. LV read four of the transcripts and independently developed preliminary interpretations. GB-L and LV met to discuss and confirm data interpretations, developing a shared understanding of the data and analysis directions. GB-L re-read all transcripts and coded the data following the direction collaboratively developed. The entire research team (GB-L, GR, PWT and LV) met on a regular basis throughout the analytic process to discuss the ongoing interpretation of the readings and the composition of the analysis.

2.3 | Reflexivity

GB-L is a retired physician doing her PhD on conceptualisations of remediation for practising physicians. Her past experience as the director of a clinician assessment and remediation programme enriched her understanding of the data, but also required ongoing probing by her supervisors (the other three authors GR, PWT and LV) to avoid preconceptions unduly influencing her understanding of the data. PWT is a gynaecologist with a PhD in health professions education and extensive experience supervising PhD students carrying out both quantitative and qualitative work. LV is a research scientist with expertise in qualitative research who has investigated health professions education for over a decade. GR is a PhD-trained researcher with extensive experience in the field of health professions education, conducting and supporting both quantitative and qualitative scholarship.

The study received ethical approval from the University of British Columbia Behavioral Research Ethics Board (protocol #H18030).

3 | RESULTS

Nine individuals, from five Canadian provinces, accepted the invitation to participate. Participants' demographics (presented in Table 1) reflected their widely varying experiences as remediators. Remediatee problems included poor charting, poor communication skills that led to adverse events, poor technical skills with increased complications, and generalised clinical competence deficits.

When narrating their unfolding remediation stories, participants seemed to variably position themselves globally in three different ways: (a) educator; (b) judge, and (c) public defender. Each of these positions in turn might include sub-positions; for example, educator included positions such as mentor, coach, assessor and preceptor, whereas defender included 'hired gun.' Although there were some nuances in these various terms for each position, in our analysis we were more struck by their overarching commonalities within positions, leading to the decision to formulate three global ways in which the participants positioned themselves. This decision was reinforced by the particular way in which, for each of their own positionings, remediators framed the remediatee.

3.1 | Positions

3.1.1 | Remediator as educator

When positioning themselves as 'educators,' participants described their activities as guiding the remediatee to make required practice changes. Remediators worked to develop an educational alliance[20] with the remediatee, to involve the remediatee in decisions, and to give or preserve as much remediatee autonomy as possible. They sometimes associated it with previous educational experience:

> *… in some ways, it was very much like teaching medical students.*
>
> (participant [P] 4)

> *… my questions are always what's going on for this individual and trying to make an educational diagnosis.*
>
> (P3)

TABLE 1 Participant demographics

Province	Alberta - 3 British Columbia - 2 Manitoba - 2 Ontario - 1 Nova Scotia - 1
Number of physicians remediated	1: $n = 2$ 2-10: $n = 3$ >50: $n = 4$
Characteristics	7 GPs and FPs, 1 specialist, 1 non-MD 7 women, 2 men
Training received	None: $n = 3$ Previous experience at UGME or PGME level: $n = 5$ Specific training: $n = 1$
Years performing remediation	<5: 4 5-10: 1 11-20: 2 >20: 2
Interaction with remediatees	Phone conversations: $n = 2$ Standardised patients: $n = 2$ Time in remediatee's practice: $n = 5$

Abbreviations: FPs, family physicians; GPs, general practitioners; MD, Doctor of Medicine; PGME, postgraduate medical education; UGME, undergraduate medical education.

Although they considered being quite directive as part of that work (eg, *'we got him to … [do x]' P1*), remediators also considered the impact of the required change, and attempted to facilitate that change in many ways, including identifying resources, facilitating connections and being supportive. They worked to empower remediatees to make needed changes:

> *I try to stimulate them and challenge them and encourage them.*
>
> (P1)

> *So the remediation was more around building his confidence, helping him with time management, helping him set limits with patients.*
>
> (P6)

When positioning themselves as educators, our participants framed the remediatee as a colleague in need of help because of circumstances, and as an individual who was not that different from themselves:

> *I guess when I first thought about physicians that need remediation, … you know, you think probably they're not good physicians or they're doing something wrong. But going through the process, I don't think that was the case at all. I think it's an easy thing to kind of run into these bad habits especially if you are busy. And then you don't really have the same external forces like when you're at residency or if you're not in a group practice and other people are doing the same thing you're doing, it's easier to kind of start adopting some of these habits that are not the best.*
>
> (P5)

3.1.2 | Remediator as judge

When positioning themselves as 'judge,' participants described their role as adjudicating whether the remediatee was ready to return to unsupported practice. Unlike 'assessing,' an activity all educators do at some level to determine the type of support an individual needs, the position of judge required the remediator to make a summative judgement on an individual's competence, thereby ascertaining if remediation has (yet) achieved success and therefore is complete. In other words, the remediator as judge needed to rule if the remediatee was ready to practise autonomously:

> *… being able to recognize when it's not safe and not only is it not safe, but it's not going to get safe.*
>
> (P1)

This responsibility weighed heavily on participants, especially when there was limited interaction with the remediatee:

> *So that felt a lot more responsibility because if you say that he's okay then he'll be seeing patients.*
>
> (P5)

> *… there's no measurable outcome particularly other than my impression of whether they're going to change their practice.*
>
> (P8)

When positioning themselves as judges, remediators tended to frame remediatees as akin to final-year residents (ie this was the competency standard to be achieved or at least to approximate). Consequently, there was a degree of inequality in the relationship; the remediatee was not at the level of a peer:

> *[He would] sort of try to have conversations with me at a consultant level that I have with my other consultants - colleagues. … But because his knowledge and skill level was so deficient, him trying to have consultant level conversations with me just didn't work.*
>
> (P9)

3.1.3 | Remediator as public defender

When remediation did not progress successfully, remediators positioned themselves as defenders of the social contract between the medical profession and the public:

> *I have never in my career felt happy to fail … it was absolutely what needed to happen both for the good of the community and for the good of the profession.*
>
> (P9)

When positioning themselves as public defenders, remediators described their position as ensuring that the public was protected from dangerous or incompetent practitioners and as protecting the profession's ability to self-regulate:

> *I want to make sure doctors are good doctors. And I want us to have a good reputation in the community and I would like us to continue to self-regulate … if there are a lot of doctors out there like this particular physician …. and we are at risk of losing our ability to self-regulate.*
>
> (P9)

The public defender position was invoked when the remediator began to question whether the remediatee could ever reach the standards of professional performance. Thus, when remediators took on this position, they tended to position remediatees as recalcitrant, unrepentant and unprofessional individuals who deserved their fates. To

be clear, remediators did not position all remediatees this way; rather, this was how remediatees were positioned when efforts at educating them were failing or were completely thwarted:

> *… it's going to be a big problem for him, Professional Conduct. Still ongoing. But it's not going to work out well for him.*
>
> (P1)

> *… three weeks of very difficult clinical experiences in which he tried to pretend he had knowledge he didn't have.*
>
> (P9)

Then, the relationship with the remediatee could be highly charged by a lack of trust on the remediatee's part and frustration for the remediator:

> *I could not get anywhere with him. He was fiercely defensive of his practice … And making excuses for anything else … So he was a very difficult individual, and in the end we tried to work with him and were unable.*
>
> (P1)

3.2 | Positioning obstacles and struggles

Participants expressed a preference for the educator position: they engaged in remediation processes to help remediatees improve their practice. However, they sometimes encountered serious obstacles to enacting their educator position. Those obstacles were imposed variously by regulators and by remediatees.

3.2.1 | Limitations imposed by the regulator

Participants described regulatory authorities as generally positioning them as educator or some variation thereof (eg, coach, mentor or preceptor). However, remediators felt they were not always given the tools required to fully enact that position. For example, unless remediators were involved in the original assessment or decision that led to the remediation, they frequently could not access the information necessary to address the problem(s) that instigated the process:

> *I'm not privy to the complaint, really. Only just sort of a sketch … So part of the issue for me was that the [first meeting with the physician] happened right before we started the session … The cases selected for the first session did not address the doctor's stated goals.*
>
> (P8)

Remediators also had to contend with limitations imposed by the regulatory authority over the conduct of the remediation. For example, regulatory processes constrained what they could do in terms of time and scope:

> *Participant: I would have liked to continue on longer to see how the person progressed.*
>
> *Researcher: So who decided how many sessions and when things ended?*
>
> *Participant: The College did.*
>
> (P4)

As an additional complication, although the explicit message from the regulatory authorities positioned the remediators as educators, the remediators suggested that they heard an implicit message to (also) position themselves as judge and gatekeeper to varying degrees and with varying authority, leading to ambiguity regarding how to balance these various positions:

> *I would want to tease out the assessment and preceptorship piece a lot more specifically. And probably try and separate those more than I was supposed to for this particular case.*
>
> (P9)

This limited their ability to effectively adopt any position. Although they strove to be supportive, even when expected to be a judge, they remained aware of the dangers inherent in trying to balance different positions:

> *that was absolutely part of the challenge in that if it had just been strict assessment I think that would have been a lot easier in having a defined role for a defined timeframe …*
>
> (P9)

The lack of information regarding regulatory processes or of the circumstances regarding the individual remediation case may have led remediators to question the ultimate purpose of the remediation. Participants raised concerns that the process was a *'rubberstamp'* (P8) and that the regulating bodies would ignore the preceptor's report (P9).

3.2.2 | Limitations imposed by the remediatee

Positions imply storylines. That is, the position one assumes or accepts is usually accompanied by a narrative that one expects or wishes to unfold. The ideal storyline in remediation is that remediatees ultimately come to accept the situation and, having recognised

the problem(s), turn their practice around and become the physicians they were meant to be:

> *Seeing other docs [doctors] improve their performance and being proud of that and then being grateful and saying things like: "Boy, when I first met you I was scared and I thought this was going to be a horrible thing. But, man, it was really worthwhile and I'm really glad we got together and that you took the time to work with me on this. 'Cause it's certainly helped me."' I get somebody who says that, I feel pretty good.*
>
> (P1)

However, positioning is not a one-way street.[21] The remediatee could implicitly or explicitly refuse his or her assigned position. When this happened, the remediator was forced into a more adversarial position (*'I'm the five-foot-tall female bad guy'* [P8]), and often found themselves switching to a more authoritarian position to exert authority (*'There's a reason why I'm in this position and you're in that position'* [P4]). By persisting in positioning the remediator as an adversary instead of as an educator, remediatees could force remediators to switch their focus from empowering and supporting a struggling colleague to protecting the vulnerable public. Remediators, therefore, struggled to maintain their position as educators in the face of remediatees who refused to accept them as such.

Age and gender could also have an impact on how remediatees responded to remediators. Female participants described struggling to establish authority and credibility with older male remediatees:

> *So there was a power differential in that I [female remediator] was the preceptor. But there's also a power differential in that he had been practicing longer than me. And I think felt also he had his feelings around having to go through this process and having me, who was younger and less experienced, be his preceptor, I think, was a big challenge. And there was probably a bit of a gender power differential there as well.*
>
> (P9)

Further, the way remediators positioned remediatees was not fixed. Remediatees could start out angry and defensive but could change to see that the remediator was there to help them (we did not hear stories of the inverse, ie, where a remediatee went from accepting to uncooperative):

> *… so it took a little bit of time to kind of get her to see me as a person that's trying to help her instead of someone who might be, you know, causing her to lose her livelihood or causing her to lose her license.*
>
> (P5)

Interestingly, our participants noted that their previous experiences as an educator and remediator of trainees did not fully prepare them for the challenges in negotiating being an educator for colleagues.

> *I'm used to being the one with the power and that being generally acknowledged by learners. But when it comes to preceptoring your colleagues that's trickier. And you kind of have to figure out ways to navigate that.*
>
> (P9)

4 | DISCUSSION

The aim of this study was to deepen our understanding of remediation by listening to the stories of those who directly remediate physicians. The results of a previous study had suggested to us that remediation in practising physicians can be viewed as both an educational process and a regulatory activity, and that failure to appreciate the inherent contradictions in this duality might be contributing to the profession's difficulties in addressing poor performance.[1] The results of the present study suggest that failure to articulate, appreciate and deal with this duality might also be contributing to challenges faced by those who work directly with struggling physicians. Positioning theory enabled us to see that our remediators strove to manage the meaning of the remediation process for themselves and for those whom they were asked to remediate by focusing on the educational component and ignoring as best they could the implied loss of professional autonomy. That positioning was difficult to sustain if remediatees were unwilling to accept either the remediator's position or the implications of the remediatee position.

An underlying question at the beginning of this programme of research on the nature of remediation in practising physicians was whether remediation at the practice level is qualitatively different from remediation at the undergraduate or postgraduate education levels. Thus, we might well ask whether this effort at positioning is unique to remediation in the continuing professional development (CPD) world. We would posit that one important difference is that only at the practice level do remediators have to contend with the aforementioned duality; only at the practice level do remediatees lose their professional autonomy. Remediatees at the undergraduate and postgraduate levels do not have, nor do they expect to have, full educational and clinical autonomy. Remediators at the practice level thus face a unique challenge: to make this hopefully temporary loss of professional autonomy palatable to the remediatee so that the necessary learning (defined as per the behaviourists as a permanent change in behaviour) can take place. Thus, we might speculate that they face greater challenges in developing the necessary educational alliance.[20]

Although there is no study on how residency educators position themselves, Chou et al[22] do discuss the need for balancing empathy for the struggling individual with the profession's responsibility to future patients and to society, which could be construed as a variation of balancing educator and public defender positions. However, it is only at the undergraduate level that we find a study that explicitly uses positioning theory to look at how educators position themselves in relation to struggling learners. Hu et al,[6] in their study on positioning in medical student support encounters, note that

educators struggle with contradictory aims of support and sanction; our respondents similarly struggled with the educator and public defender roles. The undergraduate educators, not surprisingly, used metaphors from parenting that were absent in our peer remediators. As did our respondents, Hu et al's participants generally shifted between positions, often unconsciously.[6] Unlike our participants, however, some of Hu et al's respondents were fixed in one or other of either judge or confidant 'as if it were a personal philosophy for student support.'[6] Whether this is unique to trainee remediation or a characteristic of remediators that would also apply at the practice level but our study did not uncover is unclear. It is, however, unlikely that practice remediators who adopted a fixed position (eg, educator) would be asked by the regulatory authorities to remediate on a recurring basis.

Remediators at the undergraduate level sometimes struggled with resolving tensions between positions, in their case between assessment and support. They were either unable to resolve those tensions or resolved them by accepting that they couldn't effect change unless the student desired it. Our peer remediators were in a sense more fortunate because they had neither been responsible for calling for remediation, nor were they ultimately responsible for the final decision, even when the regulator depended on their report or recommendation. They were thus able to resolve the tension between educator and public defender by referring the remediatee back to the regulatory authority. It was no longer their problem, which is not to say that it didn't leave them sometimes wishing they had been more successful and thinking about what they might have done differently.

Despite our explorations of the literature using a wide array of search terms, we have not been able to locate peer-reviewed investigations of the relationship between remediators and remediatees from the perspective of the remediatee at any level of the continuum. Winston's study,[7] alluded to earlier, included student comments on the perceived effectiveness of the various teaching strategies employed by the remediation facilitators but did not include student perspectives on the role of the teacher or remediator. We suspect a variety of factors contribute to maintaining this gap in our knowledge. For instance, remediatees may not be comfortable participating in such studies. Furthermore, collecting the perspectives of remediatees may be a less pressing need at the trainee levels because the trainee is provided with support from several remediators and from student affairs or the resident wellness office.

4.1 | Implications

Our results suggest that our remediator participants experienced remediation as both education and regulation, although they may not have expressed it in those terms. Remediation at the practice level requires remediators to move skillfully between several positions that include varying degrees of educational and regulatory components. Our participants were more comfortable with the educator position, particularly those remediators who were fairly new at the process; however, they felt somewhat unprepared even for this role, as prior experience remediating trainees did not adequately equip them to work with practising physicians. A framework that enables them to understand the dual nature of remediation at the practice level might prove helpful. Faculty development regarding the different positions they may need to adopt in their role of remediator may be helpful. Finally, preparation for when and how to transition between positions might enable remediators to more skillfully manage the dual aspects of education and regulation.

4.2 | Limitations

We were unable to recruit in Québec - one of Canada's two largest provinces, and the one with the most organised remediation programme - because of regulatory authority rules, which forbade their preceptors from speaking with us. However, we did recruit participants from across Canada in five provinces, so our data includes a breadth of programmes and experiences. Narrative research of necessity is limited to small numbers of participants who choose to tell their stories; it allows us to uncover the meaning of the experience. Because the overall aim in this research was to uncover the meaning of remediation, we suggest that our small population pool is an acceptable limitation. To better understand the actual process of remediation, it might be helpful to use the insights from this study to conduct focus groups using semi-structured questionnaires. Ensuring that the focus remains on the process of remediation and stressing the avoidance of mention or discussion of the individuals being remediated, should help address the inherent ethical concerns.

5 | CONCLUSION

Remediation in practising physicians includes both educational and regulatory aspects. This study suggests that this generally undiscussed duality may be contributing to the challenges faced by those working one-to-one with remediatees. Understanding the dual nature of remediation and equipping remediators with the tools to manage this duality might contribute to improving the experience for both remediators and remediatees, and ultimately to a greater number of successful remediation outcomes.

AUTHOR CONTRIBUTIONS

GB-L conceptualised the study, collected, analysed and interpreted the data, and wrote the first draft of the manuscript. GR and PWT contributed substantially to the study conception, and to the analysis and interpretation of the data. LV contributed methodological expertise, reviewed narratives, and contributed to the analysis and interpretation of the data. LV, GR and PWT critically revised the

manuscript. All authors (GB-L, GR, PWT and LV) contributed to this paper, have given final approval of the submitted paper and agree to be accountable for all aspects of the work.

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None.

CONFLICTS OF INTEREST

The views expressed herein are those of the authors and do not necessarily reflect those of the United States of America's Department of Defense or other federal agencies.

ETHICAL APPROVAL

University of British Columbia Behavioral Research Ethics Board (protocol #H18030).

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