Maastricht University

Conceptualizations of remediation for practicing physicians

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Addendum: Valorisation paragraph

Increasing demands for physician accountability and quality improvement initiatives in healthcare are leading to more discussions regarding how best to address identified deficiencies in the care provided by individual physicians. Remediation programs struggle with logistics of how best to organize, implement, and fund programs. As someone who was for 10 years the director of such a program, I am well aware of the challenges involved. However, as my supervisors stressed at the beginning of the PhD process, the goal of a PhD is not to solve a problem; problems not only differ from place to place depending on the local context, but also have a way of morphing over time, so that solutions tend to be short-lived and only applicable to restricted contexts. The goal of a PhD then is not to solve a problem but to help people think about a problem differently, so that they can develop better solutions suited to their particular place and time. The goal of this PhD was thus not to determine the 'best' way to design and implement remediation programs for practicing physicians but to explore how the profession conceptualizes remediation and those requiring it, and to consider how these conceptualizations influence organizational willingness and ability to develop remediation programs for practicing physicians.

Valorisation in this case, then, is not so much a matter of developing new products or processes as it is of presenting my findings to those in a position to implement new processes such as organizations and institutions developing remediation programs. I was able to do so in an international venue at a meeting of regulators in June 2019, as well as at a national remediation symposium in September 2019. As a plenary speaker at the latter meeting, I was asked to discuss where I thought remediation in Canada should go. I was able to both present my research findings and suggest implications for change arising from my research. Several of the participants at that symposium had been interviewed for my research, and were thus particularly interested and attentive.

Idea that were shared and that resonated included our finding that remediation is both educational and regulatory (in the sense that it removes an individual professional's right to self-regulate both their learning and their practice). That finding might help explain why regulatory authorities would prefer universities to take on remediation programs - they are focusing on the educational aspect that universities are better equipped to provide. It also explains why conversely universities hesitate to become involved in remediation- they are focusing on the regulatory aspect, and don't wish to be viewed as an arm of the regulator. Finding ways to minimize the loss of self-regulation, perhaps by allowing remediatees to preserve as much autonomy as possible might facilitate not only individual remediatee engagement in the process, but also that of universities and university Continuing Professional Development(CPD) offices.

Our research results lead to a number of recommendations, some of which I was able to share with the attendees at the national symposium, attendees who have the authority to make changes. Others have been developed when considering the PhD project as a whole. These recommendations include both conceptual and practical changes.

Recommendations for conceptual changes include:

- Rather than thinking about remediation as education, conceptualizing it as supported practice change, and focusing on facilitating the individual's motivation and ability to change by providing personal, social and structural supports.

- Changing the questions we ask when developing remediation programs. For example, instead of asking ourselves what are the characteristics of successfully remediated physicians, we might reframe the question to ask how we determine whether remediation goals are feasible for a particular physician in a particular context.

- Focusing on how we can ensure that programmatic structures facilitate long-term change rather than short-term achievement of learning objectives.

- Conceptualizing the education/regulation duality of remediation as a polarity and focusing on remaining in the upper/positive quadrants of the polarity map i.e. on maximizing the benefits of each conceptualization and minimizing the disadvantages.

Recommendations for practical changes include:

- Ensuring that what individual organizations learn about remediation be published in scholarly journals, and not be available only in the grey literature, where it can disappear/be lost over time.

- Engaging remediatees in the construction of remediation plans that provide them with as much autonomy as possible.

- Ensuring that the remediator, and the person assessing the success of the remediation are two different individuals.

- Developing and supporting a remediator community of practice. This includes advocating for their work to be understood as the important contribution to the community that it is, and ensuring that it is considered in tenure decisions.

- Providing faculty development for remediators that addresses the concerns identified by our remediator participants. These concerns include: lack of information provided by those mandating the remediation, uncertainty regarding the extent to which they are allowed to modify the process as they see fit in a particular circumstance, dealing with boundary issues, unique logistical challenges such as remediating in a small community, and dealing with power and gender imbalances. In addition, our research suggests that discussing how to identify the positions of educator, judge and public defender, and move gracefully between them as needed would facilitate the remediator role.

We also found that much of what is available regarding remediation in practice, particularly data on programs and outcomes, is never published, or else appears in the grey literature, only to subsequently disappear again. Much of what individual remediation programs learn is either kept internally or shared at conferences and meetings of regulators or program developers i.e. remains within a small community. Our results suggest that it is time to make this data more widely available. Not only might this encourage more researchers to study this area, wider dissemination of remediation practices and outcomes would counter the perception that remediation is an extremely rare, and therefore shameful, event. At the aforementioned meeting, I made a plea for wider dissemination of program data. I believe I can state that the entire presentation was very well received, as evidenced by the session evaluations. One regulatory authority representative stated afterwards that they had never stopped to think about what remediation actually is, and that this would change their conception of it.

Our research results could thus be used to refine existing remediation processes and programs as well as for the development of new programs. They also have implications for how remediation is presented to individuals whose practice gaps require addressing, as well as for how it is presented to potential participating organizations. Acknowledging both the educational and regulatory aspects of remediation, and developing processes that focus on maximizing the upsides of both, while minimizing the challenges of each might help engage remediatees. For example, one way to diminish remediatee resistance might be to encourage them to focus on the educational aspects by allowing them to retain as much autonomy as possible in individual program design and the development of learning objectives. Taking into consideration the 'social determinants of competence' in each case might both improve long-term results and convince remediatees that this process is indeed about helping improve performance, and not about 'shame and blame'. It would also suggest that we need to look at the role of the health care system and of the workplace in facilitating and in some cases, impeding, competence.

Our results suggest that remediation programs should be aware that remediation is both educational and regulatory, and that this dual nature needs to be acknowledged and kept in mind when developing processes. Programs might focus on maximizing the positive aspects of both remediation as education and remediation as regulation, while simultaneously focusing on minimizing the downsides of each. For example, in regards to remediation as education, they might emphasize not only closing the knowledge, skills or attitude gap, but also developing skills so as to avoid future need for remediation. Integrating remediation into the CPD education system so as normalize it and decrease the stigma, and making it constructive, not punitive, might improve engagement in all quarters. At the same time, remediation program developers might want to ensure that the focus on education does not de-emphasize the seriousness of the situation the individual finds themselves in, nor the fact that the ultimate stakeholder, the individual whose well-being comes first, is the patient/public, not the individual physician/the profession. Hence the simultaneous focus on remediation as regulation. It should be made perfectly clear that practice change is not optional, and that the individual has failed the important professional responsibility of self-regulating to ensure that they provide competent, up-to-date care. However, 'shaming and blaming' and treating the individual

as 'a bit of a tainted product', as one of our participants put it, serves neither the individual being remediated nor the broader public. Remediation programs focusing on maximizing the upsides and minimizing the downsides of both education and regulation might also help maximize positive outcomes, although proof of that would require further research.

Our finding that stakeholders carry ambivalent attitudes towards remediation and remediatees suggests that the profession needs to find ways to address these attitudes. However, since culture change is notoriously difficult, it may be easier to proceed in the opposite direction i.e. rather than wait for culture change in order to develop remediation programs, we might seek instead to normalize remediation by integrating it into the CPD curriculum. This might help address one of the biggest challenges for remediation program directors (according to those through whom we went to access participants for our remediator study), that of recruiting preceptors. There are likely several reasons for this, including the general discomfort with remediation identified in our work, as well as lack of familiarity with remediation and thus hesitance to engage. Our findings, however, show that working with remediatees can be profoundly gratifying; sharing the deep satisfaction that can come from doing this work might help with recruitment. On the other hand, our remediator participants also shared challenges, which, if not addressed, might discourage potential remediators. Our results will then also be of interest to those who recruit remediators and those who provide faculty development for them.

In addition to those directly involved in the remediation of practicing physicians, our results might also be of interest to undergraduate and postgraduate academic program directors who may wish to consider whether some of the attitudes that we found at the practice level and their related challenges are also present to some extent at earlier points in the continuum. At least one of our participants suggested that such attitudes are evident across the continuum. Several of our stakeholder participants mentioned their concern that if professional organizations don't deal with dyscompetent colleagues, external forces such as governments, will do it for them. Our results are thus very relevant to such organizations, and suggest the need for more engagement with remediation than they have hitherto been willing to provide. Our results may also be indirectly beneficial to patients, by helping have that the profession deals with dyscompetent colleagues. Removing such physicians from practice or limiting privileges is, of course, another, perhaps faster, way to address incompetence, but that route is frequently associated with patients losing access to health care or to a provider they have come to know and trust. Patients thus have a stake in remediation.

Our results are innovative in that they suggest previously undiscussed reasons behind barriers to the development of more widespread remediation programs. We have uncovered hitherto undiscussed obstacles to service development, in this case, to the development of services to support, coach and guide physicians whose practice in some way fails to meet the standard. The literature and presentations at meetings and conferences tended to focus on logistical barriers such as funding, clinical resources (e.g. competition for patients with postgraduate learners, particularly for surgical and other procedures), and time. It will be difficult to overcome these logistical barriers without

addressing the ambivalence towards both the process of remediation and towards those individuals who require it.

I have been sharing these results with individuals and groups outside academia who are directly involved in the remediation of practicing physicians. They have suggested further avenues for research, such as directly talking with remediatees, which I hope to pursue. The regulators have not only expressed an interest in the potential results but also given suggestions as to some of the questions they would like answered.

I would hope that by adopting some of these ideas and keeping in mind our findings as they refine their processes, regulatory authorities and universities will find it easier to recruit and support remediators, and to engage remediatees in practice improvement. These ideas are not necessarily more costly to implement than current practices; they require a shifting of focus more than an injection of new resources. Ultimately, I hope that by starting a conversation about how we as a profession view remediation and remediatees, that some of the stigma can be reduced so that remediation occurs earlier with the result that practice gaps are addressed before they become too broad or deep.