Unheard Voices: A Qualitative Study of Resident Perspectives on Remediation

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ABSTRACT

Background Remediation is an important component of residency training that ensures residents are progressing toward competency and unsupervised practice. There is literature describing educators' attitudes about remediation; however, little is known about residents' perspectives regarding peers who are struggling and remediation. Understanding this perspective is critical to supporting struggling residents and developing successful remediation programs.

Objective The objective of this study was to describe residents' perspectives on peers who are struggling and remediation processes within graduate medical education programs.

Methods In 2015, we conducted focus groups of residents in a multi-institutional exploratory qualitative study designed to investigate resident perspectives on remediation. Focus groups included questions on identification of residents who are struggling, reasons residents face difficulty in training, attitudes toward remediation, and understanding of the remediation process. Using conventional content analysis, we analyzed the focus group data to discover common themes.

Results Eight focus groups were performed at 3 geographically distinct institutions. A total of 68 residents participated, representing 12 distinct medical specialties. Four major themes emerged from the participants' discussion: lack of transparency, negative stigma, overwhelming emotions, and a need for change.

Conclusions Resident perspectives on remediation are affected by communication, culture, and emotions. The resident participants called for change, seeking greater understanding and transparency about what it means to struggle and the process of remediation. The residents also believed that remediation can be embraced and normalized.

Introduction

The Accreditation Council for Graduate Medical Education (ACGME) frames the progression of a resident physician using 6 core competencies[1] and complementary milestones.[2] This framework serves as a tool for education, accreditation,[3] and as a means to identify residents who deviate from an expected course. Residents who fail to progress within this framework require remediation, often defined as "the act of facilitating a correction for trainees who started out on the journey toward becoming a physician but have moved off course."[4] Many remediation efforts, however, neglect to consider broader contextual and social factors, leading to unsuccessful remediation of learners who are struggling and the "failure to fail" phenomenon which results in learners progressing through their training programs despite not meeting performance expectations.[5–7]

Although we lack evidence supporting standardized language or a structured approach to designing and implementing a comprehensive remediation program,[8] there are strategies to address specific components of remediation. These recommendations include developing a robust feedback culture, identifying strategies for early recognition of learners who are struggling, acquiring information from multiple assessment sources, intervening proactively with learners who are struggling, and exploring areas of struggle beyond medical knowledge.[4,9–17] However, there is a gap in understanding how the residents themselves perceive remediation.[18]

Given that residents frequently are the first to sound the alarm about peers who are struggling,[18,19] and evidence that remediation efforts must consider the impact on not only the remediating resident but also the local educational community,[5,6,11] understanding how residents perceive the remediation process is critical. This understanding will allow us to provide tailored education for residents about remediation, empowering them to take an active role in the identification and subsequent action plans for peers who are struggling. The objective of this study was to elicit and describe resident perspectives on peers who are struggling and remediation processes

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Editor's Note: The online version of this article contains the focus group guide used in the study.

within graduate medical education (GME) programs. By understanding the resident perspective on remediation, we can improve our feedback and remediation processes.

Objectives
The objective of this study was to describe residents' perspectives on peers who are struggling and remediation processes within graduate medical education programs.

Findings
Four major themes emerged from the participants' discussion: lack of transparency, negative stigma, overwhelming emotions, and a need for change.

Limitations
Asking participants to recall experiences, perspectives, and feelings around remediation activities that may have happened in the past is limited by recall bias.

Bottom Line
This study provides new insight into the unique perspective of one of our most important stakeholders in GME—the residents themselves. A cycle of overwhelming emotions, lack of transparency, and stigma all feed a negative remediation culture. Educators should use the insights from this study to guide creation of future remediation programs.

Methods

Sampling

GME residents beyond their first postgraduate year (PGY-1) were invited by email to attend 60-minute focus group sessions. To ensure broad representation, residents from all specialties were invited. These invitations were sent through listservs (UVA, CUSOM) or direct communication with program directors (UICOMP), and any resident available on the focus group dates was invited to participate. We purposefully targeted residents later in training to ensure the discussion was maximally informed and reflected their current GME experience. Participants provided informed consent with limited demographic data to ensure broad representation of the GME training community. Detailed demographic information including personal history of remediation was not collected to preserve the anonymity of our participants and respect the sensitive nature of this topic. UICOMP offered $10 gift cards as incentive to participate.

Design

We conducted a multi-institutional exploratory qualitative study in 2015 to better understand resident perspectives on the identification of peers who are struggling, reasons residents may face difficulty in training, attitudes toward remediation, and general understanding of the remediation process. The focus group approach was selected for its ability to foster discussion from multiple perspectives on poorly understood topics within an interactive setting.[20] Focus groups can yield richer data compared to individual interviews when discussing a topic that may be perceived as taboo, such as remediation.[21] Recognizing that focus groups may be challenging when discussing sensitive topics,[22] residents were not asked to disclose history of remediation within the group setting.

Our research team consisted of 3 physician educators (2 emergency medicine, 1 internal medicine), 1 PhD educator, and 1 senior medical student. All had experience with focus group facilitation and qualitative data analysis. Additionally, all physician educators had experience with remediation through their leadership roles in GME. Three authors (S.W., S.K., B.K.) hold residency leadership positions and are actively engaged in remediating residents who are struggling. One author (D.L.) was a medical student at the time of the study and provided insight into approaching participants for this learner-centered project. Another author (E.B.) provided expertise in qualitative research methodology. Three authors (S.W., S.K., B.K.) collaborated previously on the topic of resident remediation, thus influencing the selection of the research questions and methodology.

The study sites included University of Colorado School of Medicine (CUSOM), University of Illinois at College of Medicine Peoria (UICOMP), and University of Virginia School of Medicine (UVA-SOM), representing 32, 11, and 21 residency programs, respectively. Each institution's respective institutional review board approved the study.

Focus Group Guides

Drawing on the research team's collective experience with resident remediation, we developed a 13-question semi-structured focus group guide (available as online supplementary data) to explore resident perspectives on peers who are struggling and the remediation process. The goal was to stimulate discussion around remediation-related topics rather than elicit first-hand experiences from residents who had undergone remediation, thus the questions were intentionally broad with optional prompts provided for the facilitator to encourage deeper discussion. The guide was piloted with 8 GME fellows, and no major changes were made. Each institution conducted 2 to 3 focus groups led by members of the research team who were explicitly not in an assessment role for the resident participants (2 authors were affiliated with UICOMP at the time of this study). Verbatim transcriptions of each focus group's audio recording provided data for analysis. We redacted names from the transcripts to ensure anonymity.

TABLE
Focus Groups and Participants With Respective Gender Breakdown at 3 Study Institutions

Institution	No. of Focus Groups	No. of Participants	Participants Identifying as Male (%)	Participants Identifying as Female (%)
University of Colorado School of Medicine	2	19	5 (26)	14 (74)
University of Illinois College of Medicine Peoria	3	26	18 (69)	8 (31)
University of Virginia School of Medicine	3	23	9 (39)	14 (61)

Analysis

We pooled the data from all 3 institutions and analyzed it using conventional content analysis.[23] We used the framework approach to conventional content analysis, which includes a procedural analysis of transcription, familiarization, coding, developing a framework, applying a framework, charting the data, and analyzing.[24] As such, investigators first reviewed their own institutional transcripts to gain substantial familiarity with the data. We then held an open discussion with all investigators to advance understanding across institutions. Two investigators (S.W., E.B.) iteratively coded 3 transcripts to create a reliable book of 21 codes with definitions for use as an analytic framework. The research team was subsequently trained to the framework. Each transcript was then independently coded by 2 investigators to assure accuracy of coding until saturation was achieved. The coding process utilized HyperRESEARCH 2.8.3 (Researchware Inc, Randolph, MA) and Microsoft Excel 2013 (Microsoft Corp, Redmond, WA). Investigators discussed the framework application, and there was no desire to expand the framework. The codes with supporting quotes were imported into Microsoft Excel to collate content across the framework from all focus groups and identify emergent themes. Through multiple iterative and interpretive discussions, the team identified dominant emergent themes.

Results

Between February and April 2015, we conducted 8 focus groups (FG) with 68 participants (P) across 3 institutions (TABLE). Participants from PGY-2 through PGY-4 represented 12 distinct medical specialties: emergency medicine, family medicine, internal medicine, medicine-pediatrics, neurology, obstetrics and gynecology, pathology, pediatrics, physical medicine and rehabilitation, psychiatry, surgery, and dermatology. The 3 focus groups at UICOMP were composed of single specialties due to logistical convenience of scheduling these groups after specialty-specific weekly didactics. The focus groups at UVA and CUSOM were mixed specialty. No residents disclosed a history of requiring remediation. We identified 4 major themes related to residents who are struggling and remediation: lack of transparency, negative stigma, overwhelming emotions, and a need for change.

Lack of Transparency

The participants highlighted a lack of transparency around communication about their clinical performance and the process of remediation itself. From a performance standpoint, participants noted that "*Faculty are very hesitant to criticize residents. . . .Everyone's like, 'You did a great job.'*" (FG1, P7), and "*Actionable feedback is important, and. . .that's kind of lacking across the board.*" (FG8, P6) Although educators may hesitate to provide constructive feedback, our participants implored "*We want the feedback. We want to know how we're doing.*" (FG1, P5) Participants believed that receiving infrequent and non-actionable feedback frequently resulted in ambiguity and that "*if you are that struggling resident, you may not even know because no one tells you.*" (FG1, P7) or "*basically, you assume that no news is good news.*" (FG2, P1) The contribution of delinquent and insufficient feedback was also noted:

> "*Remediation and feedback go hand in hand. . .you don't get a lot of feedback so you think you're doing well, and then 6 months down the road, you get told, 'Oh, 3 months ago, there was a comment about this, or 2 months ago, maybe you did that.'*" (FG1, P2)

There was also a lack of transparency about the remediation process, with one participant reporting that "*no knowledge or understanding of what kind of educational steps or constructive steps were being taken to actually improve [a struggling resident's] training.*" (FG1, P4) It was also evident that participants felt ill-informed about the process as a whole, leading to a lack of transparency and skepticism: "*I would be skeptical of [remediation's] effectiveness. . .I don't know what [it] consists of, but I would feel I'm just like repeating second grade, just do it again.*" (FG6, P2)

Negative Stigma

Remediation was described by participants as being shrouded in negative culture, describing it as "*taboo*." (FG6, P4; FG1, P1) Another participant remarked, "*Remediation is seen as a very dirty word*." (FG1, P6) Participants noted that remediation carries a stigma that "*is really hard to lose once it's there,*" (FG3, P2) which serves as a barrier for residents sounding the alarm when a peer is struggling: "*I think so many people don't want to say something, and so we just keep hoping it gets better for months and months and months because no one wants to say something negative*." (FG8, P9) Further compounding this negative culture is an ensuing level of secrecy and "*a lot of residency-level gossip about what was going on and why this was happening*." (FG2, P4) The relationship between the negative culture of remediation and stigma was summarized as:

> "*The perception of people on remediation is a negative thing overall…people don't talk about it…it's like, 'Oh we can't talk about that.' You don't want them to get embarrassed, and then you don't know the personal struggle*." (FG6, P2)

Participants believed that this negative culture, stigma, and gossip results in remediation "*kind of setting up an attitude or a culture of punishment*." (FG7, P1) A vicious cycle then ensues with participants undergoing remediation feeling "*isolated*" (FG8, P4) as a "*failure*" (FG1, P3), yet becoming increasingly reluctant to seek meaningful feedback for improvement due to the associated stigma. This cycle was described by one resident who remarked, *Obviously, [remediation is] going to create a stigma, and like some people mentioned, part of your social situation is probably contributing to [your struggles] anyway, so it may worsen the underlying problem*." (FG1, P1) Another commented on the isolation: "*The whole thing is no pain, no gain. You carry this on your own, versus trying to share it with your fellow colleagues or your teammates*." (FG1, P3)

Overwhelming Emotions

The discussion of residents who are struggling and remediation unsurfaced deep overwhelming emotions. The residents reported guilt and anxiety that comes from recognizing a peer is struggling and the gravity of a remediation process: "*It's like such a big deal though…if remediation fails…our careers [will be] so different. You work so long and so hard to get to where you are, and to have to decide to end somebody's career is such a horrible, huge thing*." (FG7, P3) The seriousness of this situation disincentivizes residents from speaking up: "*I mean, it would be hard for me to say something to my friends, like if I don't think they are doing well. So I may not be the one…it's not my place to do this*." The impact of an underperforming resident was noted to be "*really difficult on their co-residents, on everybody in the program*." (FG1, P4) Ultimately, however, participants felt loyal to their peers, stating "*You want to give people the benefit of the doubt*." (FG1, P4) "*A lot of it is not wanting to hurt peoples' feelings*." (FG2, P3)

A Need for Change

Participants spoke of a need for change around how educators approach residents who are struggling and remediation. While recognizing the need to protect details of an individual remediation plan, participants reported a desire to understand the process itself. The participants believed that if programs prioritize "*…some type of formalized, better feedback process in general…*" (FG1, P3), residents could better understand where they stand, resulting in a more authentic process. One participant reinforced this sentiment: "*If you know a process exists, then I would feel more comfortable…I can stop worrying, thinking to myself, 'I wonder if this is happening.'*" (FG1, P1)

Despite overwhelming emotions around remediation, residents report wanting to be involved in the process, from giving feedback to implementing a remediation plan. Regarding feedback, residents felt they were often in a better position than faculty to provide feedback: "*I don't think that [attendings] truly spend enough time with the resident, at least on the service month, to know. On inpatient peds month we're doing our thing all day, largely aside from attendings*." (FG8, P4) However residents lamented the lack of structured opportunities and education about how to provide feedback for their peers: "*I feel like I've had interactions with residents where I might be able to say, 'I think this person is struggling in these areas,' but I don't know that I really have the forum to give that feedback very often*." (FG8, P4) Another challenge was that "*residents aren't really good at giving each other very good constructive feedback either, because we are new at this and we're not taught that*." (FG1, P8) Once a resident is identified as struggling, participants suggested involving senior residents: "*Make sure that they talk to the seniors. Make sure that the seniors know how they can support them, because then you set them up for failure also, so to set up a communication, not like the scarlet letter, but like [a] supportive way*." (FG8, P1)

Participants acknowledged that "*…everybody [struggles] in residency to some degree…*" (FG6, P2) In order to minimize the negative culture around remediation, the participants advocated for an approach to "*…normalize it, talk about it, get it out there…*" (FG6, P1) One participant suggested renaming remediation "*learning reinforcement*." (FG6, P1) Another proposal was to highlight that struggling is an expected part of the learning process: "*… if we made it like, 'Hey, everybody struggles at one point or another, and that's OK. We'll help you through it.' I think…that would make the whole process seem just a little less, scary, evil!*" (FG1, P6)

Discussion

This study on resident perspectives on peers who are struggling and the remediation process provides new insight into the unique perspective of one of our most important stakeholders in GME—the residents themselves. A cycle of overwhelming emotions, lack of transparency, and stigma all feed a negative remediation culture (FIGURE). As a result, learners are reluctant to seek help while faculty and peers are reluctant to raise concerns.

Overall, resident perspectives mirrored those of educators[11] in the recognition that remediation is associated with heightened emotions and stigma which must be addressed for a remediation effort to be successful. It is also clear that the call for training around providing constructive feedback does not apply just to faculty; residents also feel unprepared to provide feedback to their peers. However, the residents provided additional insight into the consequence of lack of transparency around remediation processes and its contribution to the negative stigma and uncertainty about what it means to struggle during training. The results of this study allow us to recommend 4 areas where action is needed to improve our remediation processes: educational culture, peer feedback, negative culture around remediation, and normalizing the concept of struggling.

GME leaders have a duty to develop an educational culture where residents understand their performance, the educational process, and the means to improve if they are struggling. A psychologically safe learning environment empowers residents to admit uncertainty and voice concerns. The development of such an environment must incorporate unique institutional factors and be informed by resident perspectives to truly make it learner-centered and maximally effective.[25,26] Another strategy in creating a learning-oriented environment is to adopt a feedback culture that encourages a growth mindset, in which deficits are seen as opportunities for learning and success

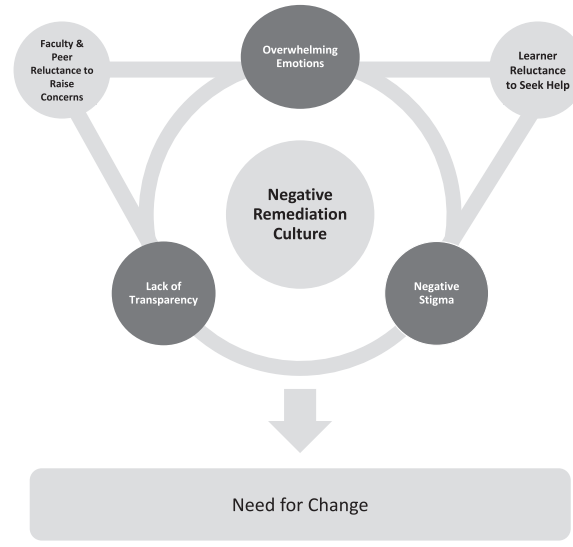

FIGURE
Remediation Culture Cycle

Note: This model illustrates the factors influencing the negative culture around remediation and the need for change. Shaded circles with white text represent major themes emerging from the focus group discussions.

results from hard work and training.[27] Educators must form an educational alliance with their learners[28] and engage in feedback discussions that are dynamic and co-constructive in order to support growth.[29] When delivering feedback, supervisors should utilize an evidence-based approach such as the R2C2 (relationship, reaction, content, coaching) model.[30] This model provides a structure for feedback conversations and has been well-received by both residents and supervisors providing feedback.[31] The messaging that all residents will receive growth-directed feedback in areas where they struggle must be delivered from the start of training and be consistent across faculty and departments. This represents an opportunity for GME-led faculty and program development.

Another important suggestion reflected in our focus groups is the need to develop a structured forum in which residents can provide peer feedback. The literature supports the importance of peer feedback[32–35]; however, it has several limitations that were echoed in our focus groups, including lack of training about how to give feedback and few formal opportunities to provide peer feedback. A program- or institution-led initiative may successfully navigate these challenges through implementation of a formal didactic program on giving feedback and a process by which residents may submit peer feedback. By empowering residents to provide peer feedback and creating space for this feedback to occur, we may achieve earlier identification of learners who are struggling.

There are several ways educators can improve the negative culture around remediation. One step is increased awareness of the language used around remediation. Terms such as "doctor in difficulty" and "incompetence" may increase negative stigma in specific educational climates, further preventing residents from self-identifying as needing remediation[36]; situational awareness to your institution's unique educational culture can help prevent using stigmatizing language. The influence of language also affects educators who may react negatively to stigmatizing language, which in turn impacts the quality and willingness to provide feedback.[37] Educators should also work toward eliminating labels for those who struggle relative to those who do not, as this "othering" language contributes to the negative stigma of remediation.[38,39] Another strategy reflected in our focus groups to improve the remediation culture was to involve peers and clinical faculty in the remediation process. This approach has been advocated by leaders in medical education to engage faculty in the remediation process and provide anticipatory guidance to peers.[17,40] Through increasing residents' engagement with the remediation process, we may also improve transparency around the process and reduce negative stigma, which largely stems from the unknown. A deliberate approach will support a necessary balance between disclosure to supervising residents who can help the struggling resident achieve their goals and respect their privacy.

Lastly, the literature suggests several approaches to achieve our participants' call to normalize the concept of struggling. One is to adopt a shared conceptual model of adaptive learning which starts by identifying a gap or struggle in a resident's practice.[41] This conditions residents to anticipate that performance deficits will be addressed. Another option is a systems-based approach found within the competency-based medical education (CBME) model.[42] One framework within CBME suggests normalizing the experience of struggling during training, with movement of a learner from a "success zone" into a "remediation zone" when there is failure to meet well-defined markers of success.[43] In this framework many learners in the "success zone" will still require *remedial action* to keep them on course. The CBME model also emphasizes the importance of frequent, timely, multisource, and formative feedback,[44,45] which was identified by our participants to be lacking in their educational experience. A shared mental model that normalizes struggles encountered in training can have a marked influence on the stigma that surrounds corrective action and remediation.[6]

There are several limitations to our work. First, focus groups have inherent limitations: some attendees may not participate, there is selection bias among those who volunteer to participate, and groupthink may prevent some participants from voicing an opposing opinion.[46] However, data also support that focus groups composed of peers offer a safe place to share experiences,[21] which is important with a sensitive topic like remediation. Asking participants to recall experiences, perspectives, and feelings around remediation activities that may have happened in the past is limited by recall bias. Second, there is risk for coder and interviewer bias in qualitative research. We attempted to mitigate this by forming a diverse research team and having focus groups moderated by individuals outside of a direct assessment role for participants. Third, we did not require participants to disclose their personal history with remediation. The perspective of residents in shaping remediation efforts is critical, regardless of history of remediation. However, this subgroup represents an important voice that may not be represented in our data and should be explored in further studies. Finally, our exploratory data analysis was not designed to identify differences that arose between institutions, geography, or medical specialties. This is an area ripe for future research.

Conclusions

Understanding the perspective of residents about the remediation process is paramount in the creation of successful remediation programs. The residents in this study made a clear call for change, seeking greater understanding and transparency about what it means to struggle and the process of remediation.

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