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Featured Article

"I'm on an island": A qualitative study of underperforming surgical trainee perspectives on remediation

Kathryn McLeod [a,b,c,*], Robyn Woodward-Kron [d], Prem Rashid [e], Julian Archer [f], Debra Nestel [c]

[a] Department of Urological Surgery, Barwon Health, University Hospital, Geelong, Australia
[b] School of Medicine, Deakin University, Geelong, Australia
[c] Department of Surgery (Austin), University of Melbourne, Heidelberg, Australia
[d] Department of Medical Education, The University of Melbourne, Melbourne, Australia
[e] Department of Urology, Port Macquarie Base Hospital, Rural Clinical School, The University of New South Wales, Port Macquarie, Australia
[f] School of Medicine and Dentistry, Griffith University, Gold Coast, Australia

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ABSTRACT

Background: There is a significant gap in the literature regarding trainees' perceptions of remediation. This study aims to explore surgical trainees' experiences and perspectives of remediation.
Methods: This qualitative study used semi-structured interviews with 11 doctors who have experienced formal remediation as a surgical trainee. Reflexive thematic analysis was used for data analysis.
Results: In this study, trainees perceived remediation as a harrowing and isolating experience, with long-lasting emotions. There was a perceived lack of clarity regarding explanations of underperformance and subjective goals. Remediation was viewed as a 'performance' and tick-box exercise with superficial plans, with challenging trainee/supervisor dynamics.
Conclusions: These findings about trainees' perspectives on remediation show a need for trainees to be better emotionally supported during remediation and that remediation plans must be improved to address deficits. Integrating the perspectives and experiences of surgical trainees who have undergone remediation should help improve remediation outcomes and patient care.

1. Introduction

Underperformance of surgical trainees is an important issue for trainees, supervisors, and patient safety.[1] Trainees identified with significant performance concerns will usually require formal remediation. Between 5 and 31 % of surgical trainees will require formal remediation at some point throughout training.[2–4] Although there is limited research regarding supervisors' perspectives of remediation[5–7] and suggested frameworks for remediation,[5,8] trainees' perspectives have been neglected. There is a "very apparent gap" [9] in the trainees' lived experiences and perceptions of remediation. Understanding and integrating this perspective in remediation frameworks is integral to improving outcomes for all stakeholders.

Remediation is the "process through which doctors' performance concerns can be addressed to facilitate a return to safe practice".[10] A scoping study on remediation in surgery showed a need to strengthen supports for trainees.[11] A study using focus groups to examine the perspective of peers of 'struggling' residents showed "overwhelming emotions", including guilt and anxiety from recognizing struggling peers. Other themes included: negative stigma; lack of transparency around feedback and remediation; and a need for educators to change their approach to residents who are struggling.[12] In a study involving medical students' experiences of failure, themes centered on emotions including anxiety, fear and guilt; social isolation and external stressors.[13] A scoping review of emotion in remediation showed that it was almost always negative, and included "shame, fear and frustration".[14] Emotions must be identified, acknowledged and managed for meaningful remediation to occur.[15] Emotions can impact insight,[16] motivation, engagement and remediation outcomes.[14,15]

Intertwined with emotions and isolation, is the concept of stigma. Stigma can impact individuals' emotions, reduce self-esteem, create unique stressors, cause psychological distress, limit academic

* Corresponding author. West Coast Urology – Suite1, Level 1, 83 Myers St, Geelong, VIC, 3220, Australia.
E-mail addresses: rzetelski.west@gmail.com, krzetelski@student.unimelb.edu.au (K. McLeod).

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Table 1
Major themes and subthemes.

1. A harrowing experience
• Overwhelming emotions are long-lasting
• Feeling unheard and "*in a vulnerable position*"
• "*Like a leper*" - being "*tarred*" and feeling unsupported
2. Lack of clarity about remediation
•Being "*blindsided*" - a lack of warning
•"*What am I doing wrong*?": lack of clear explanation
3. The 'performance' of remediation
•A "*tick-box exercise*": the superficiality of remediation plans
•Trust issues with a "*Judge, jury and executioner*" relationship
•"*Getting the yips*" - the downward spiral of remediation

performance[14] and reduce the efficacy of remediation.[12,15]

Changing the perception of remediation from a punitive measure to an opportunity that allows transformative learning, may help limit stigma.[16] In Mezirow's[17] Transformative Learning Theory (TLT), individuals experience a 'disorientating dilemma', which occurs after information challenges one's beliefs[18] and results in behavioral change[19] through engaging in critical reflection and review, enabling a productive shift in perspective. This may be of particular use in remediating professionalism and issues involving lack of insight.[16]

The aim of this study was to explore surgical trainees' perspectives and experiences of remediation by interviewing trainees who have undergone remediation. Understanding and integrating this key stakeholder perspective will help training colleges improve remediation outcomes and patient safety.

2. Background

The Royal Australasian College of Surgeons (RACS) is authorised to conduct surgical training in Australia and New Zealand. The Surgical Education and Training (SET) Program (in nine sub-specialities) is the only accredited training pathway to become a surgeon in these countries.

3. Methods

A qualitative research design was best suited to meet the study aims enabling the focus to remain on trainees' perspectives in remediation. The Consolidated Criteria for Reporting Qualitative Studies (COREQ) checklist was used for reporting (Appendix 1). Ethics approval was obtained by the University of Melbourne Office of Research Ethics and Integrity (Reference No - 022-23310-26597-3).

To be eligible, trainees must have been accredited surgical trainees on the RACS Surgical SET Program when they received an unsatisfactory training assessment and undergone formal remediation. To fulfill inclusion criteria, participants must have been a current trainee, or completed/exited training within five years. The outcome of the remediation did not impact eligibility. Recruitment began with advertising on broad range of social media and direct invites from surgical trainee associations. Purposive sampling ensured a range of gender, surgical specialties, location, and timing of remediation during training. Participants were not compensated.

Semi-structured interviews were conducted via Zoom. All interviews were conducted by researcher (KM) and an interview guide was used (Appendix 2). Interviews were audio-recorded and transcribed by KM. Data was de-identified prior to analysis.

Transcripts were analyzed using reflexive thematic analysis.[20] KM analyzed all transcripts creating preliminary codes. Various measures were implemented to ensure trustworthiness and rigour of analysis. Two researchers (DN, RWK) analyzed two transcripts, independently identifying codes. The three researchers met to discuss these codes and generate candidate themes. KM reviewed the transcripts seeking data to affirm, disconfirm and refine themes. All researchers met to review refined themes against the data. Although 14 participants agreed to participate, it was agreed that data sufficiency[21] was reached after 11 interviews. NVivo software (Release 1.6.2, QSR International Pty Ltd, Australia) was used for data organization.

Authors brought different perspectives to the research. KM and PR are surgeons, and both involved with governance of underperforming trainees within their training college and have been trainee supervisors. DN and RWK are educationalists, JA is an educationalist/physician and head of a medical school.

4. Results

Between April–June 2022, 11 participants were interviewed. Interviews lasted a median of 42 min (Range: 26–72 min). Six participants identified as women and five as men. Their specialties included: Otolaryngology Head and Neck Surgery, Orthopedic Surgery, Pediatric Surgery, General Surgery, Urological Surgery and Neurosurgery. All training regions across Australia and New Zealand and all levels of seniority during training were sampled. At the time of remediation, three participants were first-year trainees, six were in the middle of training, and two were in their final year. At the time of interview, participants included three current trainees, one fellow and seven consultant surgeons. All participants had passed their remediation period.

Themes and subthemes are presented in Table 1.

4.1. A harrowing experience

Participants universally described remediation as an acutely stressful and lonely period in their lives. Recalled emotions were largely focused on the initial feedback conversation, with vivid memories of specific phrases used by supervisors. While the remediation process was described in negative terms, *"shattered"*, 2 "*catastrophic*", 5 "*devastated*", 11 "*destroys you*", 9 "*the hardest*", 10 all participants acknowledged the need and appreciated the role of remediation within training.

> It was the implementation or lack thereof that was the challenge. 10

> I think the process to get to there [to the end] was not positive. 3

> I think I needed to improve. I think the way it was done was completely wrong.11

> I, in theory, genuinely agree and accept the concept of remediation. (…) I'm absolutely all for self-improvement. (…) But the way in which it's done, this is only being done to tick a box. 7

- **Overwhelming emotions are long-lasting:** For many participants this distress continued long after remediation, persisting years after successful remediation and surgical training was completed.

> I think overall, it was (…) and I'll be honest (…) very difficult, and I'm still going (…) I will never be over it. 7

> I look at the [FRACS] certificate. And I think I don't know if it is worth it. (…)
>
> I have some really dark days from it all. 1

- **Feeling unheard and "in a vulnerable position":** Participants felt isolated, disempowered, and unable to advocate for themselves

without further compounding an already difficult situation. They thought supervisors were uninterested in hearing their version of events and attempts to initiate these conversations were interpreted as adding to their reputation as being difficult.

My own unit haven't even bothered to ask me, what happened? (…) I think that was the thing that upset me. 7

How do I know what to do? I'm on an island. I don't know what to do. 7

… as a SET trainee, you're just in such a vulnerable position … they have all the power, they decide your job, they decide your references. So, it would be quite difficult to think for anybody to take it constructively and like calmly, because so much hangs on it, and the power balance is so big. 5

- **"Like a leper" - being "tarred" and feeling unsupported**

Participants described stigma of being labelled as underperforming and requiring remediation. They described "*shame*", "*hopelessness*", "*embarrassment*", and felt judged as "*substandard*" by supervisors, peers and by themselves. They described *"poor self-esteem"* and feeling "*isolated*" and "*abandoned*", and that support structures "disengaged" from them.

I was treated like a leper (…) I never really fit in. 1

I feel like at that point, that the die was kind of cast and they had made their mind up about me (…) I'm not sure that there was much I could have done to dig myself out. 10

And now I just feel like I feel like I'm very substandard and that my peers see me as very substandard, and I don't know if there's a way forward. 1

4.2. Lack of clarity about remediation

Participants described confusion in understanding their feedback, as well as a lack of understanding of the process itself. They were concerned about the ramifications of the underperformance on future career prospects.

- **Being "*blindsided*" - a lack of warning:** Most participants felt blindsided and that they had been given no warning prior to the implementation of formal remediation. Many believed they were progressing adequately based on formative work-based assessments; however, were then surprised by an unsatisfactory end-of-term assessment. A few participants had reflected on prior supervisor conversations as being too subtle or generic without gravitas.

Anyway, they failed me at that point. And I was flabbergasted, I couldn't quite believe it. 4

I had no other indication, like, it's not like halfway through, they're like, hey, you lift your game. So, it was a big shock and a big surprise (…) you're essentially blindsided. 2

- **"*What am I doing wrong*?": lack of clear explanation:** Participants felt a lack of clear explanation of specific deficits despite having feedback sessions.

I didn't feel like I could have done anything different or better to fix the situation, because I didn't really know what I was doing wrong. 4

The feedback (…) it wasn't really clear to me what I could do to be better other than be better. 10

… my (…) quarterly assessment with my director of training (…) he was like "the unit feeling is (…) we just feel that you need a good kick up the bum." 2

Participants universally commented that their feedback lacked specificity on how they needed to improve. Without having a clear understanding of their deficits, participants had difficulty creating a meaningful remediation plan and having confidence that they would be deemed successful in their remediation.

4.3. The 'performance' of remediation

This theme refers to trainees' perceptions of feeling they needed to "*prove*" that they had remediated to their supervisors. They felt a need to "*stage*" their improvement and "*jump through the hoops*" as opposed to being confident that any authentic improvement would be noticed.

- **A "*tick-box exercise*": the superficiality of remediation plans:** Trainees felt that remediation plans were vague and tokenistic - *"tick what needs to be ticked"*. The plans were described as superficial and that they did not address identified deficits. Plans consisted predominantly of extended training time with additional generic work-based assessments. Concerns included the subjectivity of learning goals, with success difficult to define.

My summary of the whole thing is, we've got a problem with you because you can't do a lap right hemi fluently, we will give you a term of thoracic to fix the problem. And (…) that doesn't add up. 4

I had no idea what I was doing [with creating the remediation plan]. I just copied the assessment for the points that they had said I was underperforming on (…) I just copied the characteristics for (…) the excellent one and then tried to reword it (…) there was no sort of reflective process involved. 3

- **Trust issues with a "Judge, jury and executioner" relationship**: Participants expressed concern that the supervisor who initially identified the underperformance was also the individual to help implement and judge the outcome of the remediation plan. This perceived lack of external and impartial judgement meant that trust between trainee and supervisor was threatened and overlooked any possible role the supervising unit may have contributed to the underperformance.

Trainees found difficulty in discussing and thereby confirming deficits during remediation. Any affirmation of difficulty was accompanied by fear of an unsuccessful remediation outcome.

What I remember is that there was no (…) I had no feeling of security (…) the only full-time consultant that was there was the head of unit who was also the person to pull the trigger. So, I had no trust in that relationship. 11

Despite the [required] training [for supervisors],[22] people [supervisors] are still unclear what to do with the underperforming trainee, no one really knows how to treat you, or what to do with you (…) 6

- **"Getting the yips" - the downward spiral of remediation:** "*Getting the yips*" was described by one participant, but conceptually echoed by many. It is a golfing metaphor, where one experiences sudden and

unexplained loss of fine motor skills,[23] and is possibly related to performance anxiety, with trouble performing previously subconscious skills. Once a trainee is under the microscope after being labelled as underperforming, they start to underperform in other domains.

This underperformance issue reportedly compounded itself, spiraled; and was exacerbated by increased supervisor surveillance. The participants described becoming paralyzed by fear of making mistakes, which threatened their engagement and learning during remediation.

I think once you mark someone, fairly or unfairly, people start to notice all sorts of things that they otherwise wouldn't have (…) Sometimes it's totally irrelevant. 4

"I tried to push myself and all the wheels fell off. And then, I was staring down the barrel of remediation." 1

5. Discussion

Formal remediation during surgical training is experienced as "harrowing", often with overwhelming and long-lasting emotions. Trainees reported vulnerability, social isolation and generally feeling unsupported. They described a lack of clarity about remediation, in part because it was unexpected and often remained unaware of what needed remediation. Trainees also experienced remediation as a "performance" that often felt superficial. Trust issues between trainees and supervisors complicated their relationship and that entering remediation could trigger a downward spiral of their practice.

Mills' (14) scoping review of emotions in remediation categorized timing of emotions as: before identification, at identification, and during remediation. We found that the intensity of the emotions was greatest 'at identification'; and subsequently limited the ability of trainees to reflect upon their feedback and develop a remediation plan. Our findings describing the longevity of those emotions has not been previously reported. We found that emotions persisted years after remediation had ended, even after surgical training was successfully completed. In literature on emotions, it has been shown that "intensity of emotions is more strongly determined by the general adversity of the precipitating event, whereas duration depends more strongly on how negative the event is for one's self-image".[24]

Although it is acknowledged that trainees undergoing remediation may experience stigma, it has primarily been portrayed in the literature as "external to the learner".[14] In addition to this public stigma, our study found significant self-stigmatization. Self-stigma occurs when an "individual applies the elements of stereotype, discrimination and prejudice to themselves".[25] Self-stigma contributes to shame, depression, anxiety and self-isolation.[26] Stigmatized individuals may utilize rumination to overcome such emotions, where they passively and repetitively focus on their distress and related circumstances.[27] This subsequently exacerbates and sustains psychological distress.[27] Other strategies to overcome stigma include cognitive reappraisal, where one reinterprets the situation to alter its emotional impact; or suppression with inhibition of emotionally expressive behaviors.[28] These may be useful concepts to consider when reflecting on trainees labelled as 'lacking insight'.

Trainees reported adequate progression on prior formative work-based assessments but then felt "blind-sided" on the failed term. The use of 'shadow systems' may help explain this phenomenon. Castanelli[29] showed that supervisors tend to make holistic decisions about performance at the time of assessment rather than basing them on a collation of singular episodes of performance data. However, often the trainee is unaware of the decision-making process behind this subjective outcome until too late to rectify any deficits. Many participants thought the feedback regarding the cause of underperformance was non-specific, and not clearly communicated or understood. This dissatisfaction by trainees with feedback has been echoed previously.[30] Current supervisors are not adequately trained in dealing with underperformance[3,31] and remediation requires more time, expertise and resources than most can currently provide.[32,33] Documentation required at summative assessment is recorded against core competencies.[34] However, the discrepancy between how supervisors conceptualize trainee's deficits against the language of these competencies can be vague, difficult to document[7] and communicate.

For transformational learning to occur, trainees must be willing to be vulnerable and have their decision-making challenged.[19] For this, trainees need to feel psychologically safe. However, the lack of separation between the supervisors' roles endangers this trust and compromises the 'educational alliance' [35] of this relationship. To generate valuable feedback from a supervisor the trainee "must feel safe to fail".[36] Currently, the supervisor is also the judge of the remediation plan, which is in tension with educational guidelines recommending separation of supervisors who conduct the remediation process from those involved in determining the outcome.[37]

There was a contrast between the trainee's appreciation for the need and goals of remediation in general, and the negative feelings of their lived experience. Possibly contributing to this disconnect between intent and execution, is the lack of data in regard to outcome measures of remediation, and program evaluations[11] in which the key stakeholders active input is usually paramount but often missing.[38]

Findings from this study support that future practice should prioritize additional emotional support for trainees during remediation by supervisors and training colleges. Strategies embedded within training programs to help destigmatize underperformance are also needed. Engaging a mediating psychologist and remediation coach would prove useful to both trainee and supervisor and help alleviate issues related to the conflicting roles of the supervisor.

To et al.[11] identified the absence of theory-informed remediation plans. The participants in this study confirm that transformative learning theory (TLT) offers promise with the design of remediation plans. Trainees clearly experienced a 'disorienting dilemma'. However, despite all successfully completing remediation, the long-lasting emotional impact and continuing lack of clarity suggests that trainees did not adopt meaningful perspectival shifts that characterize learning in TLT.

Future research should look to further elucidating other stakeholder perspectives in remediation such as college educational managers. Current remediation processes also need to be critically analyzed against best practice guidelines to ensure optimization of outcomes.

Potential limitations of this study include the applicability and generalizability to other cohorts as participants were limited to surgical trainees in Australia and New Zealand. It is also possible that in the time since participants underwent remediation, processes have improved within some training programs. Another aspect to consider is that participants in this study may have been more heavily predisposed towards a particular view of remediation.

6. Conclusion

Being identified as underperforming and undergoing remediation is a very emotionally fraught process. There is a need for trainees to be better supported emotionally within remediation. From the trainee perspective, feedback and remediation processes are poorly communicated, lacking clarity and remediation plans are superficial with subjective goals. Integrating the perspectives and experiences of surgical trainees who have undergone remediation should help improve outcomes.

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Intellectual property

We confirm that we have given due consideration to the protection of intellectual property associated with this work and that there are no impediments to publication, including the timing of publication, with respect to intellectual property. In so doing we confirm that we have followed the regulations of our institutions concerning intellectual property.

Research ethics

We further confirm that any aspect of the work covered in this manuscript that has involved human patients has been conducted with the ethical approval of all relevant bodies and that such approvals are acknowledged within the manuscript.

IRB approval was obtained (required for studies and series of 3 or more cases).

N/A - Written consent to publish potentially identifying information, such as details or the case and photographs, was obtained from the patient(s) or their legal guardian(s).

Authorship

All listed authors meet the ICMJE criteria.
We attest that all authors contributed significantly to the creation of this manuscript, each having fulfilled criteria as established by the ICMJE.

We believe these individuals should be listed as authors because:

Concept and design: McLeod, Nestel; *Acquisition of data:* McLeod; *Data Analysis:* McLeod, Woodward-Kron, Nestel, Rashid, Archer; *Drafting of the manuscript:* McLeod *Critical revision of the manuscript for important intellectual content:* McLeod, Woodward-Kron, Nestel, Rashid, Archer; *Administrative, technical, or material support:* McLeod, Nestel; *Supervision:* Woodward-Kron, Nestel, Rashid, Archer.

CRediT authorship contribution statement

Kathryn McLeod: Conceptualization, Data curation, Formal analysis, Methodology, Project administration, Validation, Writing – original draft, Writing – review & editing. **Robyn Woodward-Kron:** Formal analysis, Methodology, Supervision, Writing – review & editing. **Prem Rashid:** Formal analysis, Supervision, Writing – review & editing. **Julian Archer:** Formal analysis, Supervision, Writing – review & editing. **Debra Nestel:** Conceptualization, Formal analysis, Methodology, Project administration, Supervision, Writing – review & editing.

Declaration of competing interest

Potential conflict of interest exists.

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Appendix A. Supplementary data

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