27 Commentary on Chapter 26: Perspective from the Oman Medical Specialty Board (OMSB)

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The OMSB is the national body responsible for supervising and accrediting residency and fellowship training programs in Oman with over 600 current residents and fellows. It is a sponsoring institution accredited by the Accreditation Council for Graduate Medical Education International (ACGME-I). It has 19 residency and 4 fellowship programs, of which 16 are ACGME-I accredited.

The structure of the OMSB is unique in that it is not a training site or hospital. It is an overseeing body that receives trainees from multiple sponsors/employers and distributes them to multiple training sites depending on clinical specialty. Clinical training occurs at various sites and is managed by assigned faculty contracted by the OMSB. Each program has an education committee which is responsible for managing educational activities at the training sites and reporting progress to the OMSB.

Despite the organizational and structural differences in Oman, we face many of the same issues identified in Chap. 26, reinforcing their commonality across national borders and cultures. Similarities can be categorized into four areas. These include failure to identify struggling trainees, faculty and trainee perceptions about remediation, lack of insight on the part of the trainee, and utilization of nonspecific remediation plans. The few differences are attributable to cultural, social, organizational, and legal issues specific to our region.

The average percentage of residents who undergo remediation in the OMSB programs is approximately 5%, considerably lower than the 18% quoted in Chap. 26. This difference is likely due to failure to identify struggling trainees, grade inflation, lack of willingness to document poor performance, and lack of understanding of resources and processes. We have recently introduced a framework to identify at-risk trainees and diagnose areas of deficiency and have experienced an increase in the number of residents being identified for remediation.

There may be cultural and sociological factors contributing to the low number of struggling trainees identified as needing remediation. Remediation is still generally perceived as a punishment rather than as an educational aid. Therefore, faculty may resist suggesting remediation, as they fear accusation of being overly harsh or having personal reasons influencing their actions. Trainees identified as requiring remediation are likely to feel ashamed and therefore refuse to accept the need for help.

Trainees commonly exhibit poor insight into their performance, especially in instances when medical school and internship scores were comparatively high. We see this most often when remediating for professional issues where, like

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A. Kalet, C. L. Chou (eds.), *Remediation in Medical Education*,
https://doi.org/10.1007/978-3-031-32404-8_27

Dr. P in the described case, trainees assume that since they have been promoted, all is well. They are then surprised when informed that they need help.

The most common deficits we encounter are poor performance in the areas of medical knowledge, patient care, and professionalism. These each require specific remedial interventions; however, historically, our remediation plans have been generic in content and across programs. Similar to those described in Chap. 26, plans have included repeated exposure to the same rotations with no new strategies to target the deficiency and no changes in trainee workload. These nonspecific interventions and delay in producing written remediation plans negatively influence the outcomes of remediation. Inconsistencies seen across programs are likely to reflect differences in the educator skills and experience of the faculty and members of the CCC, including monitoring of and feedback to trainees. We are addressing these issues through faculty training and development.

One of the changes recently introduced to tackle this misconception is changing the title of the plans from "remediation plans" to "academic improvement plans," in hopes that the plans will be perceived more positively. Work still needs to be done to better understand perceptions of remediation and current practices across our various programs. We also need to work with faculty and trainees to "normalize" remediation.

We often encounter inconsistency in implementing remediation and procedures attributable to organizational and legal issues specific to our context. There are marked differences between the probation and dismissal processes in Oman and those described in the chapter. For example, in Oman probation does not follow trainees throughout their career, and only rarely does the OMSB directly communicate about probation during training with future employers.

Historically, trainees had the right to appeal disciplinary decisions and took the matter to court, even when the OMSB's policy on grievances and appeals has been followed. Currently, Omani courts no longer accept academic-related matters and refer them back to their academic institutions. This process parallels the description in the chapter deputizing academic programs to enforce remediation and probation actions fairly.

In conclusion, our remediation and probation issues seem largely similar despite differing structures and geographic locations. Cultural, sociological, and legal factors may affect areas of remediation, probation, dismissal, and appeals. Encouraging international research collaboration in these areas would illuminate the impact of local contextual issues on remediation practices.