Conceptual Analysis

A remediation in healthcare education: a critical conceptual examination

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Remediation has become a familiar feature of healthcare education, particularly in programs that are accountable for licensure outcomes, clinical competence, retention, and patient safety. Although remediation is frequently framed as a student-centered support strategy, it also functions as a mechanism of institutional accountability, professional gatekeeping, and risk management. This conceptual paper critically examines remediation in healthcare education, with particular attention to nursing education, by drawing on deficit thinking theory, Foucauldian disciplinary power, equity-oriented assessment, asset framing, critical pedagogy, and epistemic justice. The paper argues that remediation is neither inherently harmful nor inherently emancipatory. Rather, its effects depend on how learner difficulty is defined, how remediation is triggered, who is most often identified for remediation, how the process is experienced by learners, and whether programs examine their own curricular, pedagogical, clinical, and assessment conditions. To move the conversation beyond individualized correction, this paper proposes a Critical Remediation Accountability Framework organized around structural reflexivity, equity auditing, asset anchoring, dialogic construction, and outcome accountability. The framework offers healthcare educators and program leaders a conceptual tool for preserving rigor and patient safety while avoiding deficit-based, surveillance-oriented, and inequitable remediation practices.

Keywords: remediation; healthcare education; nursing education; deficit thinking; assessment equity; student success; critical pedagogy; health professions education

Introduction

Remediation has become a familiar and often unquestioned fixture in healthcare education. Across nursing, medicine, pharmacy, and allied health programs, remediation is commonly deployed when learners struggle academically, clinically, or professionally. It is typically framed as a corrective or supportive response designed to promote student success, protect patients, uphold professional standards, and ensure readiness for licensure or certification.[1-4] These aims are legitimate. Healthcare education cannot ignore persistent academic difficulty, unsafe clinical performance, or gaps in professional formation. Programs have ethical obligations to learners, patients, communities, and the professions they serve.

Yet the legitimacy of remediation as a practice does not make it conceptually neutral. Remediation also operates within institutional contexts shaped by accreditation expectations, licensure pass rates, retention pressures, standardized testing cultures, clinical placement constraints, and public accountability.[5-7] In nursing education, remediation is often linked to course progression, standardized examination performance, NCLEX readiness, clinical judgment development, and program outcomes.[1,5,6] In this context, remediation functions not only as a student support strategy but also as a program protection

mechanism. This dual purpose is rarely made explicit; the literature focuses more on implementation than on the assumptions it carries or the effects it produces.[3,4]

This paper does not argue for or against remediation. Instead, it offers a critical conceptual examination of remediation as a social, pedagogical, ethical, and institutional practice. Drawing on the critical lenses developed below, the paper asks what remediation does, for whom it works, who bears its burdens, and what institutional interests it serves. The central argument is that remediation can support learning and preserve standards when it is diagnostic, transparent, developmental, and equity-conscious. However, when remediation is framed primarily as the correction of individual deficiency, it can become a deficit-based surveillance mechanism that pathologizes learners, obscures program responsibility, and reproduces structural inequities.[9-13]

The paper concludes by proposing the Critical Remediation Accountability Framework as an original conceptual contribution. The framework is not a prescriptive remediation protocol. Rather, it is a tool for examining how remediation is defined, triggered, implemented, experienced, and evaluated. It invites healthcare educators to ask not only how a student can be remediated, but also what the need for remediation reveals about curriculum, teaching, assessment, clinical learning environments, advising, and institutional accountability. Because the analysis that follows is critical and conceptual rather than neutral and technical, it is important to name the professional and scholarly standpoint from which the analysis is written.

Positionality Statement

This paper is informed by my standpoint as a nurse educator and academic leader who has participated in the systems through which remediation is assigned, managed, and evaluated. That location matters. It provides direct familiarity with the institutional imperatives that make remediation appear necessary — progression decisions, licensure performance, accreditation accountability, clinical preparedness, and the obligation to protect patient safety. It also creates a responsibility to interrogate how those imperatives shape what counts as student failure, how institutional responses are justified, and which forms of support, correction, or exclusion become thinkable in the first place.

The analysis is further shaped by my scholarly engagement with critical race theory, equity in nursing education, critical pedagogy, and the workings of power in educational discourse, assessment, and policy. From this position, remediation cannot be read solely as a benevolent instructional intervention. It must also be examined as a value-laden institutional practice that may reproduce the very inequities it purports to address when it is detached from questions of curriculum, assessment, pedagogy, race, language, class, disability, and institutional accountability. The paper therefore situates remediation within the current healthcare education landscape before turning to the conceptual assumptions that shape how it is defined and enacted.

The Current Remediation Landscape in Healthcare Education

Remediation has received sustained attention across health professions education, but the field remains conceptually unsettled. Custer's concept analysis defined remediation as instruction that is timely, supplemental, and individualized, delivered in response to an identified learner deficit.[1] This definition captures the most common logic of remediation: a learner is judged to have fallen short of an expected standard, and a supplemental intervention is designed to correct the identified problem. Thilges and Schmer similarly described remediation as a multifaceted concept in nursing education that requires clearer definitions, measurable outcomes, and implementation guidance.[15] Earlier nursing scholarship also noted the increasing use of remediation to improve student performance on faculty-created examinations, standardized assessments, and the NCLEX-RN.[6]

More recent reviews suggest that remediation practices continue to expand faster than the evidence base supporting them. Immonen et al conducted an integrative review of remediation practices for health profession students and clinicians and emphasized that the state of remediation practice across health professions remains incompletely understood.[4] Hughes et al, in a scoping review of clinical practice remediation for student nurses, identified several strategies used in nursing education but concluded that few approaches are well defined or rigorously evaluated.[16] Olsen et al found that standardized examination

remediation in nursing includes a range of strategies and policy approaches, yet best practices remain difficult to establish because of variation in design, implementation, and outcome measurement.[17]

The broader health professions literature mirrors these concerns. A scoping review of reviews by Percival et al concluded that remediation remains inconsistently defined, even though it is resource-intensive, emotionally charged, and culturally complex.[7] The authors found that existing reviews tend to emphasize learner identification, diagnosis of difficulty, and intervention design, while giving less attention to learner involvement, psychological safety, and high-impact educational outcomes. Kalet et al argued that remediation itself needs remediation, particularly through a stronger theoretical basis, a systems-level orientation, and approaches that destigmatize learner difficulty.[18]

These findings matter because remediation does not occur in a vacuum. It is commonly embedded in high-stakes environments where program leaders are responsible for accreditation outcomes, licensure pass rates, public safety, and workforce preparation. The National Academies of Sciences, Engineering, and Medicine called for nursing education to prepare nurses to address health equity, social determinants of health, and the needs of diverse populations.[19] If the health professions are to educate a more diverse workforce while maintaining rigorous standards, remediation must be examined not only as an individual student intervention but also as a program-level practice with equity implications. These patterns suggest that remediation is widely used but not always clearly conceptualized. Before remediation can be critically examined, the concept itself requires clarification.

Conceptual Clarification: What Is Remediation?

The remediation literature defines its central term inconsistently.[17,15,18] Across healthcare education settings, remediation may refer to a punitive corrective measure, a proactive academic support strategy, a clinical performance improvement plan, a standardized test preparation process, a professionalism intervention, or a curriculum-integrated learning tool. This instability is not merely semantic. How we define remediation determines who is labeled as needing it, when the process begins, what forms of evidence justify intervention, how it is documented, and what consequences follow from successful or unsuccessful completion.[7,18]

Three tensions shape the concept. Reactive and proactive approaches offer the first. Reactive remediation identifies learners after they fail an examination, course, competency, or clinical benchmark, consistent with Custer's definition of remediation as supplemental instruction provided after a deficit has been identified.[1] Proactive remediation, by contrast, seeks to identify risk earlier and intervene before failure occurs.[2,6] Although proactive models may be more supportive, they raise questions about prediction, labeling, and surveillance, particularly when risk indicators rest on standardized scores, prior educational history, or faculty judgments that may not be free of bias.[11,20]

Individualized support and standardized protocol form the second tension. Individualized remediation can honor the complexity of learner experiences and tailor interventions to specific needs, but excessive individualization produces inconsistency, unequal access to faculty advocacy, and variable documentation.[4,16] Standardized protocols promote transparency and consistency, yet they may reduce learners to categories such as at risk, deficient, unsafe, or nonprogressing.[17] Programs must balance consistency with contextual responsiveness.

Pedagogy and gatekeeping form the third. Remediation is pedagogical when it supports learning, feedback, reflection, and growth. It becomes gatekeeping when it determines whether a learner may progress, graduate, enter clinical practice, or sit for licensure.[6,21] This gatekeeping function cannot be avoided entirely because programs are responsible for public protection. But when remediation is framed only as support while functioning as progression control, students may experience the process as coercive or stigmatizing even when faculty intend it to be developmental.[22] The tension is sharpened by the well-documented “failure to fail” phenomenon, in which clinical educators feel unprepared or unwilling to assign failing grades to underperforming trainees — a pattern Yepes-Rios et al[21] found across medical, nursing, and dental education and that subsequent work has continued to identify in nursing specifically.[16]

Remediation, then, is both an educational intervention and an institutional practice.[11,18] The educational question is what the learner needs in order to develop competence. The institutional question is what the remediation process reveals about program design, assessment validity, teaching practices, clinical learning conditions, student support structures, and the distribution of opportunity. A critical conceptual analysis requires holding both questions together. The next section applies several critical lenses to examine the deeper logics through which remediation operates.

Critical Lenses for Examining Remediation

A critical examination of remediation requires more than describing when and how remediation occurs. It requires attention to the assumptions, power relations, assessment practices, and knowledge hierarchies that shape how learner difficulty is recognized and addressed. Four interrelated lenses are particularly useful for this analysis: deficit thinking (read alongside asset framing as a corrective), disciplinary power, equity-oriented assessment, and critical pedagogy paired with epistemic justice.

Deficit Thinking as Conceptual Architecture

Deficit thinking provides a useful lens for examining the assumptions embedded in remediation. Valencia described deficit thinking as a blame-the-victim orientation that attributes academic struggle to individual, familial, cultural, or community inadequacy rather than to structural conditions or systemic inequities.[13,14] Deficit thinking is powerful because it is often implicit. It can appear as common sense, professional judgment, or neutral academic concern while still locating the source of difficulty primarily within the learner.

Remediation often bears the imprint of deficit thinking because it begins with the identification of what a learner lacks — knowledge, skills, professional judgment, communication, or confidence. Identifying areas for development is not inherently harmful. Feedback is essential to learning, and health professions programs must identify unsafe or insufficient performance. The problem emerges when the diagnostic gaze stays on the learner and never reaches the curricular, instructional, clinical, or assessment conditions that may have produced the difficulty.

Deficit thinking is especially consequential for students from racially minoritized, economically marginalized, first-generation, multilingual, and other historically underrepresented groups. These students may be more likely to encounter learning environments built around norms that reflect dominant cultural, linguistic, and class-based expectations. When remediation is triggered by performance standards that have not been examined for fairness, validity, or contextual meaning, remediation may unintentionally convert structural inequity into individualized deficiency.

Asset framing offers a partial corrective. In health professions assessment and feedback, asset framing shifts attention from what learners lack to the strengths, experiences, commitments, and forms of knowledge they bring to the learning environment.[12] Applied to remediation, asset framing does not mean ignoring gaps or lowering standards. It means asking a different first question. Instead of beginning with, what is wrong with this student?, an asset-informed approach asks, what does this learner bring, what standard must be met, and what conditions have made it difficult for the learner to demonstrate competence in the expected way? This shift preserves rigor while resisting the presumption that difficulty is solely a learner defect. What deficit thinking leaves unaddressed is how institutions monitor and normalize learners once they have been identified as struggling — a dynamic better illuminated by disciplinary power.

Disciplinary Power and the Surveillance Function of Remediation

Foucauldian analyses of disciplinary power offer a second conceptual lens. Foucault distinguished forms of power that operate through overt punishment from disciplinary power, which works through observation, normalization, examination, documentation, and self-regulation. In educational institutions, disciplinary power is not limited to punishment.[8] It functions through seemingly ordinary practices such as grading, monitoring, ranking, documenting, and requiring learners to demonstrate conformity to institutional norms.

Remediation in healthcare education exhibits the features of disciplinary power. A student placed on a remediation plan becomes newly visible within the institutional gaze. They are identified, documented, monitored, reassessed, and required to demonstrate improvement before progression is permitted. Their plan may prescribe required meetings, standardized assignments, reflective writing, practice examinations, skills check-offs, simulation performance, clinical observation, and documentation of professional behavior. Any one of these activities may be educationally valuable. Collectively, they constitute a regime of monitoring that marks the student as a subject in need of correction.

A Foucauldian critique does not imply that monitoring, documentation, or evaluation are inherently wrong. Healthcare education has a legitimate obligation to ensure safe and competent practice. The critical insight is that monitoring is never neutral. The standards against which students are judged, the language used to describe performance, the instruments used to measure competence, and the consequences attached to remediation are all embedded in power relations. When these dynamics are not examined, remediation may train learners to perform compliance with dominant norms rather than support deeper professional formation.

This surveillance function can also reshape learner identity. A student who receives remediation may begin to see themselves through the institutional label of at risk, deficient, unsafe, or underperforming, which can produce shame, silence, self-doubt, and reluctance to seek help. Kalet et al and Guerrasio emphasized the importance of structured remediation and early support for struggling medical learners.[2,23] Yet the emotional and identity-related effects of being remediated remain underdeveloped in the broader literature. Percival et al began to address this gap, showing how epistemic injustice and power imbalances shape the experience of remediation in graduate medical education — a finding directly relevant to nursing and other health professions, where students often navigate unequal power relations with faculty, preceptors, clinical agencies, and institutions.[22]

Assessment, Race, and Equity

Because remediation is often triggered by assessment results, it cannot be separated from assessment equity. Nursing and health professions programs frequently rely on course examinations, standardized predictor tests, clinical evaluations, simulation performance, medication calculation tests, skills check-offs, and professionalism assessments to determine whether remediation is needed. These measures may be important indicators of learning, but they are not self-interpreting or automatically neutral.

Fair testing principles are especially important when assessment results lead to high-stakes consequences. The *Standards for Educational and Psychological Testing* emphasize that test scores should be interpreted for specific purposes and supported by validity evidence.[24] The National League for Nursing (NLN) has similarly argued that faculty have an ethical obligation to ensure that tests and decisions based on tests are valid, reliable, consistent, and fair to all test takers.[25] In the context of remediation, this means that programs should not treat every score as a complete diagnosis of learner deficiency. Scores require interpretation, triangulation, and contextual analysis.

Scholarship on equity in assessment shows that these systems can reproduce inequity even when individual educators intend to be fair. Lucey et al described equity in assessment as a wicked problem because learner evaluation is shaped by institutional culture, assessment design, faculty judgment, opportunity structures, and advancement systems.[11] Studies in medical education have documented racial and ethnic disparities in clinical grading and educational outcomes.[20,26] Although the specific mechanisms may vary across disciplines, the implication for healthcare education is direct: if the assessment systems that trigger remediation are unfair, the remediation systems built on them inherit that unfairness.

This concern does not make standardized testing inherently inappropriate, nor does it negate the need for objective evidence of competence. Rather, it requires programs to ask more rigorous questions about how assessment data are used. Are remediation referrals disproportionately associated with particular demographic groups, courses, faculty evaluators, clinical sites, question types, or standardized testing thresholds? Are decisions based on a single data point or multiple sources of evidence? Are faculty trained to write and interpret test items, evaluate clinical performance, and provide feedback using fair and valid

processes? Are students given meaningful opportunities to understand expectations before they are judged against them?

Race also enters remediation through the content and assumptions of health professions curricula. Tsai et al challenged medical educators to rethink how race is portrayed in preclinical education, arguing that current portrayals often reinforce problematic assumptions about race.[27] In nursing and healthcare education, similar concerns arise when clinical reasoning, communication, professionalism, or cultural expectations are treated as universal rather than as historically and socially situated. When remediation is used to correct students toward norms that have not been examined, it may function as normalization rather than learning support. These concerns about assessment equity point toward the need for a more dialogic and justice-oriented approach to remediation, one that recognizes learners not simply as objects of evaluation but as credible participants in interpreting their own educational experiences.

Critical Pedagogy and Epistemic Justice

Critical pedagogy offers a third pathway for reimagining remediation. Freire critiqued banking models of education in which learners are treated as passive recipients of expert knowledge.[9] Remediation can become an intensified form of banking education when students who have already been marked as deficient are assigned additional content, testing, or compliance tasks without meaningful dialogue about how the difficulty emerged or what learning support would be most effective.

A critical pedagogical approach positions remediation as a dialogic process rather than a unilateral prescription. Faculty still name performance concerns clearly and uphold standards, but the learner is engaged as a participant in diagnosing the difficulty, identifying strengths, setting goals, selecting strategies, and evaluating progress. This approach is consistent with Onuoha et al, who described critical pedagogy as a useful approach for advancing antiracism and health equity in health professions education.[28] It also aligns with epistemic justice, which attends to whether learners are recognized as credible knowers of their own experiences.[10]

Epistemic justice is especially relevant to remediation because students in remediation occupy a vulnerable position, as Percival et al's analysis of epistemic injustice in graduate medical education suggested earlier.[22] Their credibility may already be diminished by the institutional label attached to them. If a student attributes their difficulty to unclear instructions, financial or caregiving pressures, racialized or language-based classroom dynamics, disability barriers, or inadequate feedback and clinical supervision, programs must have processes for taking such claims seriously. A remediation system that listens only to institutional interpretations of failure while dismissing learner testimony risks becoming both pedagogically ineffective and ethically compromised. These four lenses, taken together, reveal remediation as a practice marked by unresolved tensions — tensions that are not reasons to abandon remediation, but that must be named if remediation is to become more ethical, equitable, and educationally defensible.

Critical Tensions in Remediation

Remediation forces educators and program leaders to navigate several tensions that have no clean resolution but should at least be made visible.

Support and surveillance sit uneasily together. Remediation may provide meaningful help, but it also increases monitoring and documentation in ways that can leave students feeling exposed and controlled. A process described as support may be experienced as surveillance when students have little agency or when remediation records follow them through progression decisions.

Patient safety and exclusion form a second tension. Health professions programs must prevent unsafe practice, and patient safety cannot be compromised. At the same time, the language of safety can be stretched so broadly that it justifies exclusion without adequate attention to whether the learner was taught, supervised, assessed, and supported fairly. Programs should distinguish between remediable learning needs, serious unsafe practice, and structural conditions that impede performance.

Standardization and equity pull in different directions. Standardized policies reduce arbitrary decision-making and promote consistency. But equity requires more than identical treatment. Programs must

consider whether students have had comparable access to information, resources, faculty support, clinical opportunity, feedback, and psychological safety before judging them against the same remediation pathway.

Individual correction and institutional accountability ask different questions of the same situation. Remediation typically asks what the student must do differently; a critical approach also asks what the program must learn. When many students require remediation after the same course, examination, clinical rotation, or faculty evaluation process, the pattern should trigger program review. Remediation data are curriculum and assessment data, not only student performance data.

Compassion and documentation are the final pairing. Healthcare programs need clear documentation for fairness, accreditation, due process, and progression decisions, but documentation can become punitive when it uses stigmatizing language, overstates risk, or records learner difficulty without context.

Because these tensions cannot be resolved through procedural remediation policies alone, healthcare education needs a conceptual framework that holds learner support and institutional accountability together. The Critical Remediation Accountability Framework is proposed as one way to organize that work.

The Critical Remediation Accountability Framework

Building from the preceding analysis, this paper proposes the Critical Remediation Accountability Framework as an original conceptual tool for healthcare education. The framework is not intended to replace existing remediation policies, academic progression procedures, clinical evaluation systems, or licensure standards. Instead, it offers a set of accountability principles that can be used to examine whether remediation practices are pedagogically sound, ethically grounded, equity-conscious, and program-responsive.

Table 1. Critical Remediation Accountability Framework

Principle	Guiding question	Programmatic implication
Structural reflexivity	What curricular, pedagogical, clinical, advising, or assessment conditions may have contributed to the learner difficulty?	Review course design, exam construction, clinical placement conditions, faculty feedback practices, sequencing, workload, and access to support before locating the concern only within the learner.
Equity auditing	Who is referred to remediation, through which triggers, and with what outcomes?	Disaggregate remediation referral, completion, progression, dismissal, and licensure outcome data by relevant demographic and program variables while protecting student privacy.
Asset anchoring	What strengths, prior knowledge, commitments, and forms of expertise does the learner bring?	Write remediation plans that identify learner assets as well as growth areas. Use strengths to design support rather than documenting only deficiency.
Dialogic construction	Is the learner a co-participant in interpreting the concern and designing the plan?	Invite the student into the diagnostic conversation. Clarify expectations, listen to contextual explanations, negotiate strategies when possible, and preserve dignity throughout the process.
Outcome accountability	How will the program know whether remediation worked for the learner and for the program?	Evaluate outcomes beyond completion of assigned tasks, including demonstrated competence, progression, learner experience, psychological safety, retention, licensure readiness, and program-level improvement.

The framework is organized around five principles: structural reflexivity, equity auditing, asset anchoring, dialogic construction, and outcome accountability. Together, these principles shift remediation from a narrow process of correcting individual deficiency to a broader process of examining learner support,

institutional responsibility, assessment fairness, and program learning. Each principle is described in Table 1.

The value of the framework lies not in replacing existing remediation processes but in changing the questions programs ask when remediation is triggered. Its practical significance becomes clearer when applied to policy, assessment, documentation, faculty development, and program evaluation.

Implications for Healthcare Education Practice

The Critical Remediation Accountability Framework has several implications for nursing and broader healthcare education. First, programs should distinguish routine academic support from formal remediation. Not every learner who seeks help should be labeled as requiring remediation. When support is conflated with remediation, students may delay help-seeking because support becomes associated with failure, risk, or stigma. Programs should build robust cultures of early support while reserving formal remediation for clearly defined circumstances that require structured documentation and follow-up.

Second, remediation should be based on multiple sources of evidence. A single examination score, clinical comment, or standardized testing result should rarely function as a complete diagnosis of learner deficiency. Especially in high-stakes contexts, programs should triangulate evidence from course performance, item analysis, clinical observation, learner self-assessment, faculty feedback, simulation data, and advising conversations. This approach aligns with fair testing principles and reduces the risk of overinterpreting one data point.

Third, remediation plans should be written in language that is specific, respectful, and developmentally oriented. Documentation should identify observable concerns, required standards, support strategies, timelines, evidence of progress, and consequences. However, it should avoid vague or stigmatizing language such as poor attitude, not a good fit, lacks professionalism, or cannot think like a nurse unless such claims are clearly operationalized and supported by evidence. In racially and culturally diverse learning environments, vague professionalism language can carry particular risk because it may reflect unexamined norms related to communication style, affect, deference, accent, confidence, or perceived belonging.

Fourth, remediation data should be reviewed as part of program evaluation. If remediation is concentrated in particular courses, clinical sites, testing points, faculty sections, or student populations, the program should examine the pattern. A high rate of remediation may indicate student need, but it may also signal misalignment between instruction and assessment, unclear expectations, curricular overload, inadequate advising, inequitable clinical learning conditions, or poor assessment design. Remediation should therefore generate program learning, not only student correction.

Fifth, faculty development is essential. Educators who design and implement remediation need preparation in fair assessment, clinical evaluation, documentation, bias mitigation, and trauma-informed and culturally responsive communication. Without it, remediation depends too heavily on individual instincts, and variation, inconsistency, and inequity follow. Faculty also need support in holding compassion, rigor, due process, and public protection together.

Finally, programs should protect patient safety while resisting the false assumption that equity and rigor are competing goals. Equity-conscious remediation does not lower standards. It makes standards clearer, examines whether students have had fair opportunities to meet them, and ensures that the process used to support or remove a learner is evidence-based, transparent, and just. These practice implications also point to an important scholarly agenda. If remediation is to be understood as both a learner-level intervention and a program-level accountability mechanism, future research must examine not only whether remediation works, but how it works, for whom, and at what cost.

Implications for Scholarship

This conceptual analysis points to several areas for future research. First, nursing and health professions education need empirical studies that examine who is referred to remediation, why, and with what outcomes. Disaggregated data are necessary to determine whether referral, completion, progression,

and dismissal outcomes vary across student demographic and background characteristics, including race, ethnicity, language, disability, and socioeconomic status. Without such data, claims that remediation is fair or equitable remain largely assumptive.

Second, qualitative research is needed to examine the lived experience of remediated learners. Existing literature often privileges faculty, program, or institutional perspectives. Learner narratives could illuminate how remediation is experienced emotionally, relationally, culturally, and professionally. Such research should attend to shame, belonging, psychological safety, help-seeking, trust, and identity formation.

Third, intervention studies should compare remediation models that differ in theoretical orientation. For example, researchers could examine whether asset-informed, dialogic remediation produces different outcomes than deficit-oriented, compliance-based remediation. Outcomes should include not only examination performance or course progression, but also clinical judgment development, student confidence, retention, psychological safety, licensure readiness, and program-level change.

Fourth, scholarship should examine remediation as a programmatic signal. Rather than studying remediation only at the learner level, researchers should investigate patterns across courses, clinical settings, cohorts, faculty evaluators, and assessment systems. This would reframe remediation as a source of curriculum and assessment data. It would also help programs identify upstream causes of difficulty instead of repeatedly treating downstream symptoms.

Finally, conceptual scholarship should continue to examine the ethics of remediation. Healthcare education must preserve standards and public trust, but it must also avoid practices that stigmatize learners, obscure institutional responsibility, or reproduce inequity. Future work can deepen the connections among remediation, assessment validity, critical pedagogy, epistemic justice, disability justice, linguistic justice, and anti-racist educational practice.

Conclusion

Remediation is not a neutral intervention. It is a social practice that reflects and reinforces the assumptions, power relations, and normative standards of the institutions that deploy it. In healthcare education, remediation may promote learning, protect patients, and support progression. It may also function as a deficit-based surveillance mechanism that individualizes student struggle, stigmatizes learners, and obscures the structural conditions that produce academic and clinical difficulty.

The purpose of this paper is not to eliminate remediation. Healthcare programs need mechanisms for responding to learner difficulty, unsafe practice, and gaps in competence. The purpose is to disrupt the unexamined certainty with which remediation is often applied and to insist that remediation systems be held to the same standards of evidence, fairness, rigor, and accountability that programs require of students.

The Critical Remediation Accountability Framework offers one way to move the conversation forward. By centering the five principles outlined above, the framework reframes remediation as more than a corrective action directed at individual learners. It becomes a mirror held up to the educational system itself. In that sense, the most urgent remediation may not be of students alone, but of the curricular, pedagogical, assessment, and institutional structures that shape their opportunities to succeed.

Ethical Approval Statement

This article is a conceptual analysis that involved no human subjects, animal subjects, or primary data collection. The author's professional experience informs the analytical standpoint described in the Positionality Statement but is not the object of empirical study. Ethical approval was therefore not required.

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