

Dealing With Trainees in Difficulty

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Abstract

Doctors are highly valued in every society as they are expected to serve humanity with dedication, commitment and motivation within professional boundaries. Those working within acute specialities are increasingly coming under public microscope. As the public expectations of a quality assured high quality services delivered by the doctors is increasing, so does the pressure on doctors to deliver these services. Our doctors in training are on the front line to deal with the initial assessment of acutely sick women and therefore may be exposed to stressful situations with little support. All doctors in training require support from their trainers and clinical supervisors but more support is needed for trainees who are struggling to cope with the pressure and are in difficulty. This paper examines underlying factors which need to be clearly understood before planning a remedial strategy for this group of doctors. They should be handled sensitively but pro actively.

Key words: Burn out, competence, misconduct, performance, substance abuse, training.

Introduction

Most doctors work very hard in order to achieve high standards to ensure that the patients should receive excellent clinical services.

The practice of doctors irrespective of their grades and seniority should be guided by six core principles of professionalism (NCAS, 2009).

1. Competency
2. Inter-personal relationships
3. Managing professional boundaries
4. Consistency and reliability of practice
5. Reflection and learning
6. Commitment to service

Competency encompasses knowledge, skills and ethics, and their appropriate application in practice. However it is important that each doctor is competent against his own level of responsibilities and area of clinical practice. This demarcation is important especially when assessing doctors in training in order to identify support they would require from their trainers to meet their targets in the post graduate curriculum.

Interpersonal relationships and emotional function relates to failure to communicate properly with other colleagues in a team and deal with the clinical workload, and recognise the ability and contribution of others especially nurses and midwives. It can also manifest when an individual acts just being awkward within a team working environment.

Managing professional boundaries is important in order to deliver a responsive high quality care. However with the agreement of colleagues and supervisors, and with appropriate safeguards in place, boundaries for responsibilities can be crossed to achieve specific goals. However it is the deliberate inadvertent crossing of boundaries through poor awareness which quite often can cause problems. This is illustrated by the facts when doctors in training sometimes undertake procedures where their competencies to carry out these surgical procedures have not been assessed for independent practice.

Consistency and reliability of practice is important. All health professionals make mistakes. It is important that during the formative years, doctors in training are focused towards attaining targets against their post graduate curriculum. Their practice should

reflect a sound evidence base and be delivered following the local guidelines. Any mishap/error should be considered as part of reflective learning. However repeated occurrence of errors and the foreseeability of potential harm to women should not be ignored and addressed through appropriate mechanism within the unit.

Reflection and learning, in all areas of practice are important. A doctor labelled as being a problem may not know how to perform a task as expected. Doctors in training especially should not attempt to undertake a task which they cannot complete to the required standard, neither should supervisors delegate tasks to them without knowing that they have the requisite knowledge and skills to do it and deal with any complications. It is important to learn by reflection about different clinical scenarios especially where adverse outcomes have been reported.

The final domain of professionalism is commitment to service. Professionalism does extend in some respects to an individual's private behaviour; obvious examples here are drug taking and violent behaviour. There are some grey areas and that includes personal beliefs. It is important that personal and religious beliefs should not compromise individual patient care.

Why some doctors perform poorly?

It has been recognised that up to 5% of doctors fail to meet reasonable standards (Paice, 2006) and that begs the question why does this happen? Why should someone who has had the ability and commitment to enter medical school and to qualify as a doctor start underperforming in their clinical practice? The reasons are complex. The issues may not be related to lack of clinical knowledge and skills because performance is affected by a complex interplay of personal and situational factors such as workload, sleep loss and shift patterns, physical environment, team work and leadership. It has been recognised that workload affects physical and mental ability in the form of decision making, attention span, fine motor control and level of motivation. This is further complicated by sleep loss which increases the risk of human error and shift work can cause biological disruption which may lead to impaired health, effect on work life balance and psychological wellbeing, including adoption of risky behaviours such as alcohol or drug misuse (Firth-Cozens and Cording, 2004) .

If there are concerns about a doctor's performance then we must consider the following questions.

1. Is there a difficulty with clinical knowledge and skills?

2. Do they have a physical illness which was previously unknown or a previously known chronic illness has worsened? Furthermore could their performance be affected by medication they are taking?
3. Is the individual depressed or suffering other mental illness which may or may not be linked to life events but could seriously affect decision making and memory, thus making an individual lose confidence and become irritable?
4. Is there a cognitive problem which may be caused by alcohol abuse?
5. Has there been a recent life event such as separation, family illness, financial worries and even the birth of a child can affect both psychological and physical health? Try to identify work life balance issues as well.
6. Has there been a change in work pattern which means they are losing sleep or working longer hours or with less support? It is equally possible that they are deficient in education; require more intense supervision or indeed workload is excessive. It is equally relevant to explore whether a change in team structure in their new rotation has created interpersonal problems with other team members?
7. Could there be issues relating to equality and diversity as it may disadvantage an individual from a minority group?

Effect of various Confounding factors on performance

Workload, Sleep Loss and Shift Work

Medicine is a 24 hour discipline and work has become more intense, particularly in our speciality. Working time arrangements and their effects on sleep can exacerbate other stressors and have an indirect effect on care, since higher stress levels may adversely affect quality of care.

Workload is not only a matter of long hours, but a combination of the demands of the task, and efforts that need to be made to deliver these tasks. Increased hours of clinical responsibility are related to greater fatigue, which in turn aggravates the effects of other stressors more severely.

The problem of sleep comes with shift work, typically associated with shorter sleep duration and from the exhaustion of higher workload which can cause changed sleep patterns. There are wide individual reactions to sleep deprivation, and although many doctors respond well in crisis situations, sleep loss has been found to cause lower mood and psychological wellbeing as well as poorer attitudes to work performance and safety.

Work life balance issues have led to working in shifts. The goals of duty hour's restrictions are to improve trainees' well being and patient safety (Blanchard, 2012). However, it has also been reported that, shift work is associated with physiological disruption, including sleep cycle, impairment of physical health and wellbeing, lowering of alertness, more sickness/absence and turnover, and interference with social and domestic life. This may even lead to engaging in more risky coping behaviours such as increased smoking, alcohol or other drug abuse, and impaired eating habits, though there are always individual differences in response (Bennet & Donovan, 2001).

Physical Health and Disability

Although doctors suffer from all the illnesses that affect others, the principle studies on their health primarily concern depression, burn out and substance abuse. Studies show excessive mortality for doctors from overdose of prescribed drugs (males), suicide (females) and cirrhosis of the liver (Carpenter et al., 1997). It is well known that doctors appear reluctant to admit to illness and colleagues unknowingly may be playing a part in this. There is evidence of considerable self prescribing and informal referrals to consultants. Treating doctors can be difficult because they are constrained by their knowledge of disease and by their previous professional experience. It is important for the educational supervisors and trainers to know that their trainee may suffer from chronic illnesses (i.e. diabetes, ulcerative colitis, arthritis, etc). A majority can fulfil professional responsibilities; however there is always a potential for problems to occur if the workplace is not suitably adapted to take care of their requirements at work (BMA, 1997).

Mental Health and Performance

Levels of stress in health service professionals, especially in doctors and nurses, are high with around 28% showing above threshold symptoms at any one time compared with 18% of British workers as a whole (Birch et al., 1998). In addition, depression, alcoholism and drug dependency are particular problems for doctors, not only in the UK but also in North America, Europe and Australia. Between 10-20% of UK doctors become depressed at some point and the suicide rate is also raised, particularly for women. Alcoholism affects a higher proportion of doctors compared with other professional groups and is a largely hidden problem that often goes unacknowledged for many years (Alkint, 2004). Stress and depression produce a number of symp-

oms and signs which affect clinical judgement. The most important of these are problems with concentration, attention, memory and decision making and a rise in irritability. There is evidence that errors arise when there are high stress levels in a number of settings, including healthcare (Davidson & Schattner, 2003).

Organisational Culture

Research shows that quite often poor support from supervisors, poor teamwork, a lack of control over how the tasks are performed and supervised; overload and a lack of resources could increase stress. In addition within medicine a major increase in stress includes the fear of making mistakes and of litigation and complaints. An organisational culture which is open and fair and where trust is high is likely to reduce this stress somewhat (Firth-Cozens & Mowbray, 2001). Of late it has been recognised that institutional racism (which may be defined as the collective failure of an organisation to provide appropriate and professional services to people because of their colour, culture or ethnic origin), is an important source of stress for those affected by it and can impact on health and performance (Baldwin et al., 1997).

Cognition and Performance

A doctor's memory, reasoning, learning, attention, understanding, communication, empathy, decision making and emotional control all involve cognitive functions. It is important to recognise that some medical conditions such as severe depression or some medications such as anticholinergic agents or steroids can affect cognition. This is especially important if a doctor's poor performance represents a change from how he or she was in the past (Dorafshar et al., 2002; Hall et al., 2003).

Personal Characteristics, Behaviour and Performance

It is important to understand that individuals behave in different ways in different circumstances. Personality can have significant effects on the behaviour of individuals. It may not be possible to change underlying personality; however attitudes and behaviours can be adopted. Attitudes have a strong effect on behaviour and have also been shown to affect safety performance, probably via behaviour. For example, the macho style of individuals: as they do not recognise their limitations during stress or emergencies, do not interact with team members well, and are less sensitive to others problems (Baldwin et al., 1997).

What are the Early Signs of Doctors in Difficulty?

There are some signs that may raise concerns that a doctor is getting into difficulty. The signs would suggest the need for an approach to the trainee by a skilled senior doctor or their training supervisor, to identify any underlying factors and to set clear goals for improvement (Paice, 2006).

1. **The disappearing act** – not answering bleeps; disappearing between clinic and ward; lateness; frequent sick leave
2. **Low work rate** – slowness in doing procedures, clerking patients, dictating letters, making decisions; arriving early, leaving late and unable to finish all the tasks.
3. **Ward rage** – burst of temper, shouting matches with other members of team (nurses, midwives, secretaries etc)
4. **Rigidity** – poor tolerance to healthy criticism, inability to compromise, difficulty prioritising, inappropriate whistle blowing.
5. **Bypass syndrome** – junior colleagues and nurses find ways to avoid seeking the doctor’s opinion or help.
6. **Career problems** - difficulty with exams, uncertainty about career choice, disillusionment with medicine
7. **Insight failure** – rejection of constructive criticism, defensiveness, counter challenge.

What are the markers of Doctors in Difficulty?

Table I describes a list of pointers at work place which should raise a suspicion that a given doctor is struggling and his/her cry for help needs to be responded to (Paice, 2006).

Guiding Principles for Dealing with Doctors in Difficulty

Doctors in difficulty should be supported and managed pro-actively to ensure that patient safety is not compromised and the said doctors are not left in a limbo. The concerns reported about the doctor in training should be guided by the following principles (NPSA, 2006):

1. **Ensure patient safety** – if there is a risk to patient safety, alert the Clinical Lead and Director of Education so appropriate arrangements are in place to supervise and support the doctor concerned.
2. **Address problems** when they occur and do not wait until the end of current appointment
3. **Classify problems** in order to develop a focused strategy to address the issues identified

Performance issues can be categorised in three areas:

1. Personal misconduct
2. Professional misconduct
3. Professional competence/educational progression

Personal Misconduct

This may be in the form of bullying, harassment, dishonesty, working under the influence of alcohol or drugs or criminal behaviour. Incidences of personal misconduct should normally be managed in line with the employers’ policies and procedures, therefore advice should be sought from the Clinical Lead and from the Human Resources Department of the hospital.

Table I. — List of markers of doctors in difficulty.

Category	Markers of Difficulty
Work based	Absence from duty, persistent lateness, poor time management, backlog of work, failure to learn and change
Clinical performance	Over and/or under investigating, poor decision making, poor record keeping, complaints, failure to follow guidelines, missed diagnosis
Psychological/ personality	Irritability, unpredictability, forgetfulness, high self criticism/ perfectionism, arrogance, lack of insight/ denial, risky/ impulsive
Social	Isolation, withdrawal, poor personal interactions
Cognitive	Memory problems, poor problem solving/ reasoning, decision making difficulties, poor concentration/ attention, learning problems
Language/culture	Poor verbal fluency, poor understanding

Professional Misconduct

This comprises of the following:

- Neglect or disregard of duty of care to patients
- Any abuse of position or trust
- Unacceptable attitude or behaviour towards patients, relatives or colleagues
- Inappropriate attitude to work

Incidences of professional misconduct depending on the nature/context should be managed at local level and, may be managed in line with the employers' policies and procedures.

Professional Competence/Educational Progression

Trainees' competence should be measured through clinical, professional and educational performance. The majority of trainees who are failing to meet the required standard can be supported in the workplace by their Clinical and/or Educational Supervisor. If local mechanisms put in place are not sufficient to improve performance and achieve the agreed targets, guidance should be sought from the Programme Director. Such problems might include:

- failure to develop skills and knowledge required,
- failure to work effectively within the healthcare team,
- recognise own limitations,
- consult senior colleagues appropriately
- communicate effectively with patients and relatives.

Collecting Evidence

Gather information regarding concerns raised by using multiple sources to establish facts. Draw on sources of information such as multisource feedback, training portfolio and previous educational supervisors' reports (Paice et al., 1999).

It is important to speak to the trainee as well – remember there are two sides to every story.

Consider whether there is an underlying health problem or any mitigating circumstances influencing the trainee's performance.

Setting up a meeting to meet the doctor in difficulty

Confidentiality should be respected and maintained in line with good medical practice when meeting with the trainee when concerns have been identified:

- All relevant information should have been collected beforehand and all the facts have been re-confirmed with appropriate supporting documents.

- choose a suitable time and place to meet the trainee free from disturbance
- make the meeting as close as possible to the event or complaints that prompted the concern
- invite rather than summon the trainee to a meeting, indicating that you have an area of concern that you would like to discuss
- suggest that the trainee may bring a friend or someone to support them
- be aware that the trainee may be fearful and may not respond in character due to the stress of the situation
- avoid meeting a female trainee alone with two male trainers

Conduct of the meeting

The meeting should be conducted in the following way:

- Ensure the trainee is aware of the purpose and boundaries of this meeting, for example the meeting may or may not be confidential and this needs to be clarified.
- state that the aims of the discussion are to help and support the trainee by establishing whether or not there is an issue
- tell the trainee that notes of the meeting will be kept and shared with them
- emphasise that you wish to hear the trainee's perspective on the situation
- describe the concern in neutral language and outline the evidence you have collected
- be prepared for a negative or defensive response
- if a trainee does not accept the concerns and needs more time to respond, do not attempt to close the issue at this meeting but document next steps and arrange a follow up meeting
- if the trainee is willing to engage listen to their account with an open mind
- establish the core problems to be addressed
- if there is lack of clarity at this point agree how further evidence could be sought
- when it is necessary to speak to other parties this should be done with the full knowledge of the trainee
- if there is agreement about concerns explore the possible causes
- identify any additional support which may be needed
- agree actions to address concerns which might include further referrals, ie to occupational health service
- check actions agreed are smart, specific, measurable, attainable, relevant and time bound
- document arrangements for monitoring and review

- seek help/guidance if unsure how to proceed
- document everything in writing and this should be signed, dated and preferably shared with the trainee
- the remedial action plan may include individualised targeted work place based training and assessment and organising specialist training courses as appropriate.

Remedial Action Plan and Follow up

As suggested earlier on, agreed remedial actions should be fully supported by the programme director and it should also be ensured that the doctor in difficulty will be supported by one named senior colleague.

The Clinical supervisor would ensure that trainees' progress is continuously assessed against the miles stones agreed at the previous meetings.

If there are lingering concerns despite all the support provided by the local team, then it would be prudent to review the strategy with the help of Programme Director/ Head of Department.

Conclusion

Over the past twenty years we have learnt a lot about supporting doctors in training and how sensitively they should be managed. A majority of these doctors eventually pass through their training programme with the support and guidance of their educational supervisors. However there will be a small hard core group who may require individual career guidance at any stage of their career. There should be mechanism in place to provide or arrange guidance for change of career path for this cohort of trainees either within Medicine or a career outside Medicine. I firmly believe that termination of training should only be based on substantial evidence that despite all the remedial actions put in place, patients are at substantial risk.

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