

# Managing the trainee in difficulty

**Trainees may encounter a range of difficulties during their training period. Supporting a trainee in difficulty can be extremely challenging, yet immensely rewarding.**

This article considers how a supervisor can make a significant difference to the educational outcome for a struggling trainee. It starts by identifying different types of difficulties and linked ‘signs and symptoms’. A range of possible intervention and support strategies are then explored. The article emphasizes the role of clinical and educational supervisors in supporting trainees.

## Introduction

Supervisors of trainees facing difficulties should make themselves aware of local and regional resources and be able to access and use these appropriately when required (Table 1). This is seldom a role to undertake single-handedly: deaneries and local education providers can offer expert advice, guidance and support.

## Diagnosing difficulties

Supporting a trainee in difficulty starts with recognizing common signs and symp-

toms, followed by a triage process to help distinguish trainees with difficulties, and those in difficulty from those who may be just ‘difficult trainees’:

1. Trainees in difficulty – a trainee who is failing to make satisfactory progress overall or has areas of specific difficulty with his/her training
2. Trainees with difficulties of a transient nature who, for a certain period of time, need particular support
3. Trainees who many trainers find ‘difficult’ (the so-called difficult trainee) because of conduct issues.

It is often easier to manage the first two situations than the third. It is helpful to distinguish problems that arise from current circumstances (Figure 1) from problems that are related specifically to the personality and behaviour patterns of a trainee. Careful ‘diagnosis’ will guide your choice of intervention strategy, as discussed later in this article.

## Recognizing signs and symptoms

Paice (2006) described seven key early warning signs of a trainee in difficulty, in terms of observed behavioural patterns (Figure 2). If any early warning signs are observed, a first step is to discuss the behaviour with the trainee, being careful to focus on observable behaviours rather than personal characteristics or traits. This may rapidly identify possible cause(s) of

the trainee’s difficulty which can be dealt with immediately. Some trainees may readily disclose information to a supervisor who clearly indicates his/her willingness to listen and support. Others may have concerns about revealing information to those whom they perceive to be in a position of power.

## Supporting trainees in difficulty

Trainees in difficulty are those who are not making sufficient progress in training or who are experiencing difficulties with certain elements of training. Failure to progress educationally as a doctor usually relates to a failure in learning within the workplace.

**Figure 1. Common circumstantial problems for trainees.**

Educational challenges, exams, revision
Anxiety concerning career decisions
Pressure of work, lack of team support
Unfamiliarity, inexperience
Changes in team dynamics
Personal health problems
Sickness within the family,
Personal relationship difficulties
Cultural isolation, culture shock (e.g. overseas graduates)
Domestic responsibilities or pressures

**Figure 2. Seven key early warning signs. Adapted from Paice (2006).**

<b>The ‘disappearing act’:</b> not answering bleeps, disappearing, lateness, frequent sick leave
<b>Low work rate:</b> slowness in various aspects of work, poor productivity
<b>‘Ward rage’:</b> bursts of temper
<b>Rigidity:</b> poor tolerance of ambiguity, inability to compromise, difficulty prioritizing, inappropriate ‘whistle blowing’
<b>‘Bypass syndrome’:</b> nurses and others avoid seeking the doctor’s help
<b>Career problems:</b> difficulty with exams and career choice, disillusionment with medicine
<b>Insight failure:</b> rejection of constructive criticism, defensiveness, counter-challenge

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Trainee	Holds a contractual relationship with employer which reflects local and national terms and conditions of employment
Employing local education provider	Is responsible for management of performance and disciplinary matters, with support from human resources when needed. Should keep deanery advised of any issues arising. Educational and clinical supervisors are likely to be involved in the identification, management and support of trainee in difficulty. Those with more senior educational roles and responsibilities (e.g. clinical or college tutors, training programme directors, director of medical education and, ultimately, the medical director) may become involved depending on nature and severity of difficulties faced
Deanery	Is responsible for all doctors in training and problems which arise that prevent normal progression. They also quality manage training programmes
General Medical Council	May be involved where there are concerns about fitness to practice

adapted from National Association of Clinical Tutors (2008)

Swanwick (2005) describes the role of the trainer as that of ‘structuring experiences, rather than transmitting knowledge’, underlining the importance of experiences themselves as the vehicle for learning, rather than the knowledge of the trainer. Trainees in difficulty may need help in identifying the learning opportunities that arise in the workplace and encouragement to value and seize the opportunities for learning that they offer. Supervisors can help in making learning opportunities explicit and encouraging engagement. Trainees in difficulty need more experience rather than less, and the supervisor’s role in ‘safety netting’ is important.

**Interventions and strategies**

The now familiar structured training curriculum and workplace-based assessments can furnish a range of helpful ‘diagnostic data’ and indicate the type(s) of learning experiences trainees may need to make progress. Personal development plans can help trainees recognize gaps in their experience, skills or knowledge and be used to set goals for future development. The facilitation by the educational supervisor of ‘developmental conversations’, which highlight ways of addressing areas of difficulty, are vital. Multi-source feedback is particularly useful, with careful interpretation of data to identify areas of underperformance. Trainees who consistently overrate their own performance may be a cause for concern.

Observation of trainees’ practice in the workplace, formally or informally, can contextualize behaviour reported by others in the team. For example, direct observation of a consenting procedure may simultaneously give insight into weaknesses in communication skills (behavioural characteristic) and technical understanding (knowledge base).

Table 2 summarizes common areas of difficulty and how to approach them.

**Creating an environment for learning**

Trainees need a ‘safe’ learning environment in order to learn effectively. Maslow (1943) argued that in order for individuals to achieve self-actualization, i.e. to reach their full potential, a range of basic needs have first to be met. Self esteem, confidence and a sense of safety are prerequi-

sites for the ‘higher’ activities of learning and problem solving to be realized.

Trainees who face difficulties may well struggle to achieve what they are capable of achieving. The need to attend to the emotional dimensions of learning is evident in these situations. Learning in the workplace is about learning with and from others.

**‘...we learn to collaborate, influence, negotiate, motivate, and achieve results through our interaction with others, all of which can be highly charged with emotion.’ (Turnbull, 2000)**

Times of uncertainty and insecurity in new jobs are familiar for most doctors, and trainees face these challenges regularly. It is important to ensure that the workplace culture is one which welcomes trainees as part of a team. Trainees in difficulty may need longer than most to recognize and adopt tacit rules of behaviour. Supervisors should also remember the value of positive emotions in educational experiences

and correct approaches to learning which exploit fear and humiliation as key ‘motivators’ – negative approaches to education have little evidence of their effectiveness.

Moore and Kuol (2007) identified interest, intense positive affect, humour, fun, enjoyment, enthusiasm, commitment, dedication and compassion in students’ recollections of excellent teaching, and noted that a teacher’s attributes were invoked more frequently than his/her actions by students when recalling positive learning experiences. They concluded that ‘who a teacher is with their students’ was more relevant in the recollection of good learning experiences than ‘what a teacher does with his/her subject’. Almost certainly this will prove to be true for trainees in difficulty.

**Supporting trainees with difficulties**

The supervisor’s role with the trainee with difficulties may be limited to the recognition of early warning signs and ‘referral’ to

**Table 2. Common areas of difficulty and how to approach them**

Area of difficulty	Approaches to identification	Possible educational interventions
Practical skills/procedures	DoPs and observed practice Feedback from colleagues Errors reported	Specific feedback and guidance Purposeful observation by those skilled in the procedure Simulation Close supervision, opportunities to practice
Communication skills	Mini-Cex, multi-source feedback, observation. Feedback from patients, carers, colleagues	Specific feedback and guidance Video recording with self review Formal training
Clinical reasoning	CbD, clinical teaching (on rounds, in clinic) Over-reliance on investigations Diagnostic errors	Developing knowledge base Use socratic questioning techniques in supervision Case-based discussion with a focus on rationale for choices, with consideration of alternatives Increased clinical exposure and requirement to present cases
Insight into performance MSF, self ratings	Multi-source feedback Self ratings Evidence in feedback (capacity to self evaluate) and supervision sessions	Encourage independent review of performance in all feedback sessions Encourage trainee to self rate assessments before sharing your ratings and discuss differences. Develop competence through increased opportunities to practice (being able to recognize a competent performance is key step to developing insight) Regular feedback
Team working	MSF, feedback from colleagues and observed behaviour	Shadowing team members – develop awareness of their roles and contributions Case-based discussion to explore who else to involve in patient management (and why)

CBD = case-based discussion; DOPS = direct observation of procedural skills; mini-CEX = mini clinical evaluation exercise; MSF = multi-source feedback

colleagues able to provide specific and/or specialist advice or support. Respect for the supervisory boundary is important – the supervisor is neither the trainee's doctor nor his/her counsellor.

Typical difficulties trainees may face are summarized in *Figure 1*.

### Health issues

Physical and/or mental health issues (e.g. diabetes, depression, epilepsy) may arise during training or be long-standing, and be disclosed to the employer but not to individual supervisors. Subtle health issues may be difficult to discern, and it is helpful to seek input from a range of sources – medical, senior nursing, clerical and secretarial staff – in order to gain a rounded and balanced picture. Some additional support, changes to duties or time out may be sufficient for the trainee to regain health.

Mental health issues, alcohol and drug misuse are more often not disclosed, but where there is cause for concern and patient care or safety may be compromised, advice should be sought from occupational health and human resources immediately. Certain health difficulties may raise issues concerning fitness to practice: the General Medical Council provides guidance in these cases. Whatever the health issues faced, it is important to ensure that trainees are treated fairly. This will be discussed in a future article on diversity, equal opportunities and human rights.

### Personal issues

Trainees may experience difficulties with personal relationships or may have carer responsibilities which detract from full engagement with training. Human resources colleagues can advise the trainee of rights to carer or parental leave. Where disruption to training is significant, the deanery may advise on options for time out, flexible training or an extension to the training period.

### Career development issues

Recent reform of postgraduate training, and changes in selection procedures have undoubtedly been a cause of anxiety and stress for many trainees. Elton (2009) gives structured guidance on how to help trainees facing difficult decisions with regards to their careers, and those whose career aspirations appear unrealistic.

### Managing 'difficult trainees'

Trainees with personal conduct and performance issues are likely to be in the minority but may occupy a considerable amount of the supervisor's time and energy.

Trainees are employees and, as such, should demonstrate appropriate professional behaviour with patients, carers and colleagues. The General Medical Council (2006) guidance *Good Medical Practice* applies to all UK doctors, including those in training.

In practical terms, it is important to distinguish between issues of improper personal conduct, subject to local employment regulations, and issues of poor professional performance. Matters of improper conduct – e.g. absence without leave, theft, bullying, sexual harassment – apply equally to all employees. If a trainee's behaviour or conduct has been questioned, the director of medical education should advise on how any allegations should be investigated in accordance with local human resources policy. Conduct issues with implications for the future professional work of the trainee should be reported to the deanery after investigation at local level. National policies, General Medical Council regulations and any obligations under law must be respected.

The supervisor should ensure that accurate, contemporaneous, dated and signed records of feedback, supervision and appraisal sessions are kept.

### Stress and burnout

**'Doctors are exposed constantly to risks, including stress, alienation, over-involvement, automatic behaviour, and burnout.... The medical profession has until now been in the paradoxical position of needing as much... [support] ...as any other group of clinicians (if not more), but generally getting less.'** (Lauer, 2006)

The social implications of pursuing a medical career, as well as the cognitive challenges, need to be considered. Firth-Cozens (2003) emphasized the significant levels of stress among junior doctors – with 28% showing above threshold levels of stress, compared to 18% in the general working population. Differences in perceptions of and responses to stressful cir-

cumstances may be indicative of personality predispositions. McManus et al (2004) suggested that:

**'...stress is not a characteristic of jobs but of doctors, different doctors in the same job being no more similar in their stress and burnout than different doctors in different jobs.'**

Burnout in trainees profoundly impairs their ability to learn, as this description suggests:

**'What started out as important, meaningful and challenging work, becomes unpleasant, unfulfilling and meaningless. Energy turns into exhaustion, involvement turns into cynicism, and efficacy turns into ineffectiveness.'** (Maslach et al, 2001)

McKimm (2009) notes the importance of being sensitive to the support needs arising during periods of change and transition, and allowing a period of free 'talk time' at the end of regular supervision meetings.

### The value of mentoring

**'The role of the mentor is vital for those in and out of training schemes. Good mentors are extraordinary people: they have the ability to turn around failing careers and change failure into success.'** (Lake, 2009)

Ensuring that trainees feel supported in the workplace is a key to the progression of trainees in difficulty. Mentoring was highlighted in a report by the Standing Committee on Postgraduate Medical and Dental Education (1998) as a valuable framework for personal, professional and educational support. It describes mentoring as fundamentally a voluntary relationship, which should be:

**'...positive, facilitative, and developmental...not related to, nor...part of organisational systems of assessment or monitoring of performance.'** (Standing Committee on Postgraduate Medical and Dental Education, 1998)

Fraser (2004) describes mentorship as a relationship akin to that in the apprenticeship model, characterized by its breadth of compass – it is more than a relationship between a junior and an educational supervisor, which may only last 6 months – it may span a much longer period of time – perhaps years – from early postgraduate days to positions of seniority. A mentoring

relationship with a direct clinical supervisor may not be possible. This is partly because of the brevity of contact, but more fundamentally, because the employee–employer relationship may incorporate dynamics that run counter to the essence of the mentoring relationship.

A trainee's formally designated educational supervisor may maintain contact with his/her mentee for a longer period of time, and be a little more remote from the work pressures than the direct clinical supervisor, thus fulfilling some of the preferred benefits of a mentor.

The Standing Committee on Postgraduate Medical and Dental Education recommends that informal mentoring structures be encouraged. Fraser (2004) agrees: the ideal relationship of mentor and mentee happens unusually, is informal, and usually as a result of deliberate choice by the junior of one more senior from whom they are ready to seek counsel. Whether this kind of relationship can be organized by an external agency is debatable, but Fraser suggests that at least, senior doctors should be asked to volunteer as mentors – to fill the role of 'teaching, coaching, supporting, counselling, and sharing information with the protégé.'

## Conclusions

It is important to recognize and respond to potential 'early warning signs' that may suggest difficulties in training. Careful diagnosis can lead to appropriate management planning with the rest of the team. **BJHM**

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## KEY POINTS

- Seek to create an open, trusting relationship with all trainees where the interplay between work and life is acknowledged and respected. Do not underestimate the power of regular 'developmental conversations' with all trainees.
- Know the local educational and human resources structures and use them well. A trainee in difficulty is likely to require advice and guidance from a range of people, as will the supervisor. Remember that trainees in difficulty are also employees in difficulty who may put patient care or safety at risk. Involve appropriate colleagues with specialist skills within the organization and local deanery at an early stage.
- Keep contemporaneous records of all encounters with the trainee, in accordance with employer, deanery and professional body guidelines.
- Use workplace-based assessments diagnostically. Be explicit about causes for concern and set realistic goals for improvement which are monitored.