Managing trainee doctors in difficulty

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When the conduct, performance or health of a doctor in training is called into question, there is often confusion about the roles and responsibilities of the parties involved. Where does training stop and employment begin? When should poor performance trigger intensified training, and when should it lead to dismissal? How much information should be transferred from employer to employer as a trainee moves around a training programme? This article describes one Deanery's approach.

There have been a number of changes to the way in which doctors in training are employed and their education is managed. These changes include the introduction of the specialist registrar grade (with structured training, annual assessments, and national training numbers) in 1995, and the devolution of contracts for higher specialist trainees from regional offices to NHS trusts in April 1996. Following these came the introduction of the General Medical Council (GMC) procedures for poorly performing doctors in 1997.

In order to agree some principles, a series of informal meetings was arranged by the North Thames Deanery involving consultant trainers, medical directors, NHS trust human resources officers, individuals from the British Medical Association (BMA) and GMC. These discussions drew on lessons learned from a series of cases over the past year. This paper describes the problems and principles that emerged.

ROLES AND RESPONSIBILITIES

Doctors in training are employed by NHS trusts, and as such are subject to the trust's disciplinary procedures. They are appointed to training programmes that take them from one employer to the next. Often a disciplinary procedure will not be completed before it is time for the trainee to move to the next NHS trust. Sometimes a trust will be reluctant to receive a trainee who is in the middle of a disciplinary procedure with a previous employer.

The postgraduate dean has responsibility for the trainee throughout the programme, which may last 6 years or more. The postgraduate dean does not employ the trainee, but commissions training from the employing trust through the educational contract. Through this contract the postgraduate dean pays a sum equivalent to 50% of the basic salary for most trainees, and 100% for preregistration house officers, flexible trainees and public health trainees. The postgraduate dean is responsible for ensuring continuity of training through a programme or rotation, and facilitating remedial training where required.

In the past, disciplinary procedures have sometimes been dropped, or never commenced, because the trainee was due to leave soon. Sometimes trainees have been offered the choice between resignation or facing a disciplinary procedure. These approaches are unsatisfactory because they leave the matter unsettled, do nothing to address the problem behaviour, and face the next employer with tackling the same problems from scratch. Now that most posts are part of rotational programmes, a different approach is needed.

PREVENTION OF PROBLEMS

There is little doubt that a number of the conflicts that have arisen could have been prevented by time spent at the beginning of a placement clarifying the expectations of trainer and trainee and going through departmental procedures and policies. This is particularly true for non-UK graduates in their first post in this country. Deaneries often provide orientation literature for overseas doctors, but induction is the responsibility of the employing trust.

FACTORS THAT REDUCE DISPUTES AND MISUNDERSTANDINGS

- Personal introduction to key staff and their roles
- Clearly defined supervisory arrangements
- Responsibility tailored to competence
- Readily available written policies and protocols which are given and explained to all trainees
- Training agreement
- Objective-setting and appraisal
- Regular assessment of competence.

Trainees in difficulty need advice and support, and trusts find it easier to deal with experienced professionals who understand the system. All trainees should be encouraged to join the BMA and a defence organization.

AT THE FIRST SIGN OF TROUBLE

Often it is unclear whether initial concerns are valid and whether they are sufficiently serious to warrant further action. The first decision is whether to investigate, and whether the triggering incident would fall into the category of personal or professional conduct, professional competence, or health. At this

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stage the people involved should include the consultant supervisor, human resources, the clinical tutor and possibly the medical director. If it is decided to proceed with an investigation it should follow the trust's written procedures, depending on the category of the triggering incident.

THE RANGE OF PROBLEMS

Problems that have occurred include trainees' personal conduct (rudeness, poor punctuality, missing induction day), professional conduct (failing to clerk a patient, contacting a patient at home for reasons unconnected with their care), and professional competence (failing to recognize the significance of signs or symptoms, failing to call for help, isolated but serious prescribing errors). Health-related problems have included substance abuse and psychiatric disturbance.

It is important to remember that trainees cannot be expected to be fully competent. The responsibility they are expected to carry must depend on their experience and be made clear by the supervising consultant. The expectations of the trust with regard to their attendance at educational meetings must also be made explicit, ideally in the training agreement.

THERE IS A CASE TO INVESTIGATE

Once it has been decided that there is a case to investigate, the next steps are to set the trust disciplinary procedures in action and to inform the postgraduate dean that this is being done. The postgraduate dean has a legitimate interest in knowing that this is happening, as the commissioner of training for that trainee. The postgraduate dean will not wish to be directly involved, but will wish to be satisfied that matters are being handled in a fair and appropriate manner.

Suspension from clinical duties pending investigation, although a neutral act, may be felt as punitive by the trainee. It is not always necessary. Often it is possible to restrict the range of activities of the trainee to exclude those considered high risk, bearing in mind the nature of the triggering incident. Where it is decided not to suspend, but to restrict activities or working practices, this should be made clear to the trainee, documented in writing, and a copy sent to the trainee detailing the restrictions and the reasons for them.

The investigation should take into account the supervision and training provided to the trainee, organizational factors which may have contributed, and the health of the trainee.

Once the investigation is complete, the outcome should be communicated to the postgraduate dean.

AN ISOLATED SERIOUS MEDICAL MISTAKE

This should normally be the subject of an inquiry. There will be pressure from the patient, relatives, or other members of staff to find out what went wrong and why. Sometimes the inquiry will reveal organizational safeguards that could be introduced to prevent a repetition of the incident.

Statements from trainee doctors involved should be collected without delay, before they move on to other posts.

DOCTORS IN TRAINING AND THE GMC

Poorly performing trainees are normally managed within the deanery's educational procedures rather than through the GMC. Referral to the GMC may occasionally be appropriate if educational procedures have been exhausted and the trainee's performance is not considered compatible with good medical practice. It will also be appropriate where a poorly performing junior doctor is not part of a training programme (e.g. a locum).

Doctors found to be abusing alcohol or drugs or behaving unprofessionally should be referred to the GMC.

Doctors suffering from ill health should be referred appropriately depending on the problem. The GMC should be advised of any doctor whose fitness to practise is impaired by a physical or mental condition. There are confidential counselling services available to doctors suffering from stress, and the trainees in difficulty should be offered a referral or contact number.

TRANSFER OF INFORMATION FROM TRUST TO TRUST

Patient safety takes precedence over an employee's right to confidentiality. The trainee has a right to know what is being transferred and an opportunity to challenge the accuracy, but not to prevent information being transferred.

The information transferred should be written and factual. Where a disciplinary hearing has been held, the information should include a brief statement of the nature of the triggering incident, the allegations which were upheld, but not those which were dismissed, and the outcome.

If the outcome was a final written warning, a formal assessment of competence should be carried out at the end of the first 3 months in the new post, and a report sent to the postgraduate dean, copied to the trainee. The trainee has a right to know whether performance is now adequate or not, and the postgraduate dean needs to consider the trainee's ability to progress through the programme. Otherwise frequent change of employer might prevent appropriate action being taken if there were a repetition of the behaviour which triggered the final written warning in the previous trust.

Any special educational or supervisory needs are best transferred via the postgraduate dean, to the receiving clinical tutor or other educational lead.

UNFINISHED BUSINESS

The trainee will be encouraged to continue to cooperate from the new post, if necessary by personal counselling from the postgraduate dean. The recipient trust should be informed of the ongoing action and asked to allow time for attendance at the inquiry.

If there is no identified new employer, and the trainee does not agree to cooperate, it may be appropriate depending on the nature of the case to contact the regional director of public health about issuing an alert letter.

REMEDIAL TRAINING

Poorly performing trainees are usually managed within the deanery procedures, and their deficiencies are tack-

led by remedial training within established posts. It will normally be necessary to move trainees from the environment in which they were performing poorly. The training relationship is likely to have broken down, and it will be difficult for the trainee to improve in an environment where other staff have lost respect or confidence in their colleague's competence.

Where a trainee is moved for educational reasons, it is appropriate for the receiving trainer to have information about areas of concern. This information may be necessary to protect patient safety, and is necessary to ensure optimum educational supervision. This information is probably best transferred in writing and via the postgraduate dean. A distinction should be made between disciplinary procedures, which are rightly expunged from the employment record after a given time, and a training history. Subsequent trainers have a legitimate interest in the training history, in the interests of safeguarding patient care as well as tailoring future training to the needs of the trainee.

Funding for remedial training will normally come within the educational contract between the deanery and the trust. It must be accepted that all trusts in a training programme take their fair share of training the less competent as well as the more talented trainees.

Exceptionally, it will be necessary to arrange remedial training in a supernumerary post, in which case the postgraduate dean may be prepared to provide more than 50% of the basic salary. The chief executive of the trust should be consulted before arrangements are made to place a supernumerary trainee for remedial training.

AND FINALLY

Where remedial training is recommended, it must be accepted that the outcome may be that the trainee is found to be untrainable in the specialty concerned, or even in medicine generally. Such decisions should not be made lightly, or by a single trainer or unit. The training of doctors represents a considerable investment of public money. Every effort should be made to help trainee doctors in difficulty to correct their performance or behaviour. On the other hand, patient safety is paramount and must never be compromised in the interests of training. HM

KEY POINTS

- Changes to the education and employment of trainee doctors have caused uncertainty about roles and responsibilities when problems arise.
- The range of problems includes personal and professional conduct, poor performance, ill health, and substance abuse.
- While disciplinary matters are the responsibility of the NHS trust, the postgraduate dean has responsibility for continuity of education through a training programme and should be kept informed.
- Transfer of information from one employer to another must take into account both the right to confidentiality of the trainee and the interests of patient safety.