Responding to trainee doctors in difficulty

George Ikkos

Appropriate workload, good clinical and educational supervision and rigorous appraisal routines will prevent a number of trainees developing difficulties. When difficulties do occur the presence of such arrangements will facilitate appropriate emotional and practical handling of these problems.

The prevention, recognition and management of poor performance among doctors is a matter of major public concern at present. The Department of Health (1999) has issued a consultation document seeking advice on the matter. The document highlights a national survey of postgraduate deans in the UK, by Dr Elisabeth Paice, North Thames Deanery, which:

'revealed that 30–40 preregistration or senior house officers a year are referred to them for serious behaviour, performance or mental health problems (Department of Health, 1999).'

There are approximately 3500 preregistration house officers (PRHOs) in England. Other trainees present problems but are never referred to postgraduate deans.

The fact that the above refers to PRHOs and senior house officers (SHOs) should not be taken as indication that problems are limited to this level. Similar problems may occur at all levels of training and beyond.

Doctors who perform well some of the time, perhaps most of the time, may perform poorly at other times. The reasons for this fluctuation in performance are many. They include intermittent substance misuse, recurrent depression, burnout, stress, personality clashes, family problems, tiredness and physical illness.

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THE EMOTIONAL FRAMEWORK

Freud (1900) introduced the concept of the 'pleasure principle'. Simply stated, it postulates that the human organism seeks pleasure and, more importantly, seeks to avoid 'unpleasure', i.e. unpleasant feelings. Freud and his daughter, Anna (Freud, 1936), further postulated that the mind or individual employs psychological mechanisms of defense in order to avoid unpleasant feelings. One does not have to concede the validity of all psychoanalytic ideas in order to appreciate the usefulness of these ideas when dealing with trainees with difficulties.

The ordinary human response to identification of one's own shortcomings includes a range of unpleasant feelings such as unease, embarrassment, shame, loss of confidence, anger, despair, panic or hatred. It also includes a range of behavioural responses such as tearfulness, protest, apology or abuse. Simple observation of colleagues, friends and oneself is likely to confirm that the above responses are, at times, as likely to be encountered as the calm, thoughtful and constructive approach that one might ideally hope for.

It is important to note that the above responses will induce any of a range of unpleasant emotional states in the person who has identified and communicated the shortcomings and is bearing the brunt of the trainee's response. Because of this trainees and trainers often avoid addressing the trainee's shortcomings. Although this avoidance is helpful in terms of the pleasure principle, it is not helpful in improving the behaviour and performance of the trainee. It is also not helpful in terms of protecting the public from poorly performing doctors.

Denial

The most common mechanism of defense is that of 'denial'. The trainer may allow other colleagues to cover for the trainee's difficulties, 'until he/she moves on to the next job'. Alternatively the trainee may deny the validity of the trainer's remarks and make unjustified comments alleging personal antipathy on the part of the trainer (*Case 1*). Denial may also be found among service managers and administrators who may act with lack of due haste in clarifying and resolving problems brought to their attention.

CASE 1

An educational supervisor of a senior house officer approached the clinical tutor to express concern during the fifth month of the trainee's current 6-month placement. She said she was 'a little concerned' that the trainee did not seem to accept feedback and advice with respect to diagnosis and treatment. She had not discussed her concerns with the trainee. Further inquiry by the clinical tutor revealed that the trainee often did not answer his bleep, was rude to patients, relatives and staff, performed incomplete assessments of patients and regularly failed to communicate with GPs. The magnitude of the problem appeared to be much greater than his trainer had suggested. When the tutor informed the trainee of the extent of the problem, the trainee accused her of exaggerating minor difficulties.

Reaction formation

Another commonly employed mechanism of defense is that of 'reaction formation'. When employing this mechanism people say or do the opposite of what they mean. For example, the trainer may bring problems to the attention of the trainee but quickly offer inappropriate and premature reassurance. Trainees themselves may use this mechanism. One way it may show is through expression of admiration and praise towards the trainer when, in fact, the trainee's real feelings toward him/her are those of fear, anger and/or intense dislike. This may prevent the trainer from persisting in highlighting the trainee's shortcomings.

Projection

Perhaps the most commonly used mechanism of defense in these situations is that of 'projection'. The essential feature of this mechanism is the unwarranted attribution of responsibility and feelings to someone else. A common example of this is for the trainer to leave it to the tutor to identify difficulties to the trainee. It may happen that more than one of the people involved (e.g. trainee, trainer, tutor, manager) are using this mechanism at the same time. In this case a dysfunctional group is formed. One way that responsibility may be projected to someone else may be through demands that the postgraduate dean or the local professor 'sack the trainee'. In fact it is unlikely that they will have any power to act in this way.

Omnipotence

One of the most often projected feelings is that of 'omnipotence'. In the example above there appears to be an unwarranted assumption that the dean or professor are omnipotent. The trainee often fears that the trainer or tutor is omnipotent. This may be the reason why they break down in desperate tears when faced with criticism, rather than listen calmly to the points raised. Sometimes the trainer may have unwarranted feelings of omnipotence themselves. They fear that any criticism will damage the trainee beyond repair. They therefore remain quiet rather than face the imagined risk. In cases where they are contemplating action they may lose sleep unnecessarily over their imagined omnipotent power to 'destroy' or 'damage' the trainee.

Reference to mechanisms of defense should not give the false impression that unpleasant feelings can be avoided altogether. In the example above, the trainer who is losing sleep over the trainee's shortcomings may be plagued by feelings of guilt. Sometimes different feelings emerge. The trainer or trainee may experience the situation as a contest or battle. This creates the unhelpful impression that at the end of the process there will be a winner and a loser. Some of those involved may get in touch with feelings of anticipated triumph. Feelings of anticipated triumph or pleasure may or may not reinforce feelings of guilt. It is possible that some may even experience sadistic pleasure at the prospect of the defeated adversary's suffering.

The above descriptions are not intended to condemn the use of mechanisms of defense nor to condone the feelings described. They are inevitable to some extent. It is important to recognize their presence so that they may be put in perspective and the difficulties of the trainee addressed appropriately. Consultation with and supervision by senior and experienced colleagues will often help in this respect.

LEGAL AND ADMINISTRATIVE FRAMEWORK

The legal and administrative framework for dealing with trainees in difficulty has been described in detail elsewhere (Paice et al, 1999; Barbenel and Ikkos, 2000). The main points will be summarized here.

There are three broad legal and administrative arenas in dealing with with trainees presenting with difficulties. These are the courts of law, the General Medical Council (GMC) procedures and the NHS procedures. The function of civil courts of law is to compensate a victim of an offence, whereas that of criminal courts is to punish perpetrators of a crime. The purpose of the GMC is to ensure adequate standards of practice by the profession and to protect the public from malpractice. Happily, the courts of law and GMC procedures are relatively rarely involved with trainees and they will not be discussed further. NHS procedures are more immediately relevant.

NHS procedures

With respect to the NHS there are two kinds of procedure: the complaints procedure and the disciplinary procedure. Complaints procedures ensure adequate standards of service offered by the NHS. A complaint about service provision may or may not lead to application of the disciplinary procedure.

Disciplinary procedures address failures in the behaviour or practice of individual doctors. In considering disciplinary procedures the investigating officer must decide whether the triggering incident would fall into the category of personal conduct, professional conduct, professional competence or health. A not uncommon example of personal misconduct is sexual harassment of colleagues or students by male trainees.

Disciplinary procedures have four stages: verbal warning, first written warning, final written warning and dismissal or other appropriate action. For example, it is emphasized in the Barnet Healthcare NHS Trust Disciplinary Procedure (unpublished) that:

'Poor performance or misconduct issues should be managed initially by informal counselling, support and re-training. The disciplinary procedure should be a last resort that aims to achieve an improvement in conduct/ performance and safeguard the interest of patient/staff.'

It is further stated that:

'any disciplinary action taken should normally be at the lowest possible level within the procedures so that the required level of improvement can be achieved.'

Responsibility for responding to a trainee in difficulty, especially one facing the prospect of disciplinary procedures, is likely to be shared by a number of individuals. The educational supervisor, who is the 'manager' of the trainee, will always be involved, and

the clinical tutor will usually be involved. More than one tutor may also be involved. The service manager and medical director may also be involved. The regional postgraduate dean, or his/her representative, should also be informed early on in the procedure, particularly where there are indications that the trainee is not responding to counselling and remedial action. It is important to maintain good communication and work effectively and proactively as a group. The trainee may also wish to involve other people. These include a 'friend', the local junior doctors' committee chair (or his/her representative) and the British Medical Association. Such involvement must be accepted, indeed encouraged.

Paice et al (1999) give details of good practice in contemplating, preventing the need for and implementing disciplinary procedures. A good knowledge of local disciplinary procedures, as well as a basic knowledge of the more general legal and administrative framework referred to above, will help the educational supervisor to negotiate the complex feelings involved in dealing with a doctor in difficulty with success. The Department of Health (1999) has issued *Supporting Doctors, Protecting Patients: A Consultation Paper on Preventing and Dealing with Poor Clinical Performance of Doctors in the NHS in England*. This outlines new proposals for dealing with doctors in difficulty, irrespective of whether they are trainees or not.

APPRAISAL AND GOAL SETTING

The trainee's educational supervisor, as the trainee's manager, is responsible for ensuring that trainees have a reasonable workload and working conditions. Every trainee who is new to a particular training post must be provided with an up-to-date job description, with clearly identified time for educational supervision, other relevant educational activities and training objectives. Where service difficulties exist, which may impact adversely in terms of workload and/or training, it is important that the consultant notifies the clinical tutor, clinical director and relevant service manager immediately.

The educational cornerstone in dealing with trainees in difficulty is the process of 'appraisal'. This has been reviewed in detail in relation to specialist registrar training (Jolly and Grant, 1997). The same principles apply at all stages of training and beyond. A robust appraisal system will often prevent trainees finding themselves in difficulty. It will also help negotiate the complex emotional and administrative issues involved in cases where difficulties have not been prevented.

The process of appraisal consists of a series of one to one interviews between the trainer and trainee for the purpose of describing the trainee's current performance and reaching a consensus about the trainee's strengths and weaknesses. Such an interview must always take place at the beginning of each educational placement. At least two such interviews should take place during each placement, and preferably more. More appraisal meetings should take place, in particular when worrying weaknesses have been identified. The normal scheduled educational supervision sessions may be used for appraisal purposes. It is advisable to document in writing the salient points.

The appraisal of strength and weaknesses will guide further training. This is best done by setting specific training objectives. Objectives may be set in relation to personal conduct as well as professional conduct or performance, where necessary. In all cases, including personal conduct, it is best to be precise as to the desired outcome. In the case of personal conduct, precision may help overcome the natural hesitation that some educational supervisors have in making personal comments about the conduct of their trainee (*Case 2*).

THE DIFFICULT TRAINEE

Most trainees with difficulties will readily acknowledge these and accept appropriate help. The conscientious educational supervisor from time to time will be supervising trainees who are not only in difficulty but are difficult themselves. They may not acknowledge difficulties, may not agree objectives, may fail to recognize failure to meet objectives, may be evasive, unreliable, rude or any combination of the above.

The consultant, who has agreed clear educational objectives, offers regular educational and clinical supervision and follows robust appraisal routines, will identify such problems early. He/she should try to establish as clearly as possible whether the problem is one of personal or professional conduct, professional competence or health. It will be helpful to discuss each of these areas explicitly with the trainee and indicate what help may be available. For example counselling may assist

CASE 2

An educational supervisor received persistent complaints from the multidisciplinary team that the new specialist registrar was arrogant. He had had similar complaints about two previous trainees but had not acted on them. Having recently read an article highlighting the importance of the doctor's attitude and conduct in preventing complaints and litigation he was determined to tackle the problem with this trainee. Colleagues in the multidisciplinary team were less prepared to put up with arrogant doctors than they had been some years ago. He hesitated, however, as he felt uncomfortable about telling his trainee that she was 'arrogant'.

He sought the advice of the medical director. In response to this advice he asked members of the team to record and report in detail specific incidents where 'arrogance' was manifested. He also started making his own observations during ward rounds and multidisciplinary team meetings. On the basis of these records and observations he was able to tell the specialist registrar that her habits of looking away when colleagues talked to her and not allowing them to finish their sentences made them feel devalued and angry. The consultant and specialist registrar agreed to set a specific objective to monitor change in the manner and behaviour of the specialist registrar during the following month. The specialist registrar was asked to pay particular attention to her posture and facial expression when talking to colleagues. She was also asked to note how often she interrupted colleagues and try to avoid this. Three weeks later the physiotherapist commented to the consultant that the specialist registrar seemed to be more ready to listen, had stopped interrupting her and was generally less condescending in her manner.

with personal problems, extra training with professional performance and treatment with addiction problems.

Opportunities to discuss matters in confidence with others must be highlighted, for example local confidential employee counselling schemes, BMA Counselling Service for Doctors, or the Sick Doctors' Trust For Alcohol and Drug Addicted Doctors. Opportunities for review of workload should be offered and appropriate adjustments made where objectively indicated. Extra supervision should be offered in all cases.

The clinical tutor must be informed at the earliest indication that the consultant is dealing with a difficult trainee. The tutor may want to interview the trainee individually or jointly with the consultant. If the consultant has not previously taken the steps advocated above, the tutor may advise the consultant to take these before further involvement. The tutor must approach each case with an open mind and take care to allow both the trainee and the trainer to present their point of view. Both the consultant and tutor will need to inform the clinical/medical director and service manager if there is significant risk to patients. In cases where risk to patients (or others) appears to be high, suspension may be indicated. The correct disciplinary procedure must be followed. Suspension does not automatically imply termination of training. In some cases, it may provide an opportunity to address weaknesses thoroughly and provide a basis for further remedial action. Whether it will do will depend on the outcome of the relevant enquiry and the attitude of the trainee (*Case 3*).

CASE 3

Dr X was due to take up his second post as specialist registrar. He had previously been a medical student and senior house officer in the same hospital. The consultant remembered him as a quiet doctor who lacked initiative but was happy to carry out instructions and contributed to the safe delivery of care in the hospital. The consultant was, therefore, pleasantly surprised when the trainee turned up appearing bright and more energetic than during his previous stint in the hospital 3 years previously.

Their initial goal setting meeting was short because Dr X was clearly confident in his skills and knowledge and appeared to be keen to go back to the ward. The consultant was pleased to hear from the nurses that the doctor had stayed back late the first 2 nights to do his work. Pleasure turned to worry the following week, when he started hearing that the trainee was highly irritable and appeared to have been drinking. After a serious 'near miss' clinical incident the consultant communicated his concerns to the trainee. The trainee refused to accept the validity of the concerns. He responded by complaining that everyone was against him, that he had powers that made training unnecessary and that he was in direct communication with God. He refused to see the local psychiatrist or his GP.

After his family and friends failed to persuade him to go on sick leave he was suspended on health grounds. Two days later he was persuaded to accept psychiatric admission. A first episode of mania was diagnosed. After discharge from hospital and a period of further stability in the community he contacted his clinical tutor. He apologized for his previous conduct and indicated a wish to explore the possibility of return to clinical work and training. An appointment with the tutor was arranged.

KEY POINTS

- Deficient performance and inappropriate conduct is a significant problem among trainee doctors in the NHS and a major source of concern to the general public.
- It is important for the educational supervisor to identify and deal with emotional reactions (e.g. denial, reaction formation) in the trainee or the supervisor that may interfere with prompt and constructive feedback to the trainee in difficulty.
- Reasonable workload, regular educational supervision, setting of educational objectives, regular appraisal and goal setting are the foundations necessary for responding to trainees in difficulty.
- Poor performance or misconduct should be managed initially by counselling. The use of disciplinary procedures, however, may be necessary in a number of trainees, if counselling, remedial action and goal setting are not effective.

CONCLUSIONS

A small but significant number of trainees will present with persistent or serious problems or both. Appropriate workload, good clinical and educational supervision, appraisal, goal setting and remedial action will help prevent a number of cases. They will also help in dealing efficiently with those cases that have not been prevented.

Dealing with doctors in difficulty presents a number of complex administrative and educational issues. Knowledge of current NHS disciplinary procedures and support from the clinical tutor (and clinical director and service manager, where appropriate) will ensure that the educational supervisor is able to complete the necessary tasks while maintaining an attitude of respect and support to the trainee throughout. The supervising consultant must attend to his/her emotions during this process and seek advice and support where necessary.

It is good practice for clinical tutors to inform consultants when trainees who have had problems are due to join their clinical teams. The threshold before such disclosure occurs is a matter for the individual tutor. This judgment should take into account the attitude of the receiving consultant as well as the facts about the trainee's problems. In cases of doubt the tutor may seek advice from an appropriate colleague. **HM**

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