Early signs of the trainee in difficulty

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A series of high-profile medical scandals and tragedies has generated increasing interest in the earlier detection of doctors whose health, conduct or performance may pose a risk to themselves or others. The earliest signs of problems often emerge during the training years, when it may be possible to take remedial action to prevent the doctor derailing. This article describes the early signs that have identified doctors in difficulty in a large postgraduate deanery.

INTRODUCTION

Every profession has its fair share of people who struggle to cope with the demands of their job, fall ill, become disillusioned, or have personality disorders. Within medicine there is always the potential for the problems of the individual in difficulty to become an issue affecting clinical performance and patient safety (Yao and Wright, 2001). Following a series of high-profile medical scandals and tragedies in the UK, there is growing interest in developing ways of identifying and helping poor performers.

So far, the evidence that poorly performing doctors can be turned around by remediation is thin. It would be helpful to be able to identify the doctor at risk at a stage early enough for educational or psychological interventions to have some hope of success, or at least before patient care is affected. This article describes the first behavioural signs of problems in doctors in training who were referred to the postgraduate dean for support, remediation or withdrawal from training.

AN EXPERIENCE SHARED

The London Deanery is responsible for managing and quality assuring the postgraduate education and training of over 8000 doctors. The authors take a lead role in advising employers, clinical tutors, consultant supervisors and training programme directors how to deal with trainees whose health, conduct or performance is giving cause for concern (Paice et al, 1999).

The authors also regularly interview and counsel trainees referred to the deanery or seeking help because of problems with their training and careers. The observations below are based on the authors' experience of dealing with the doctors in difficulty who have come to the attention of the deanery over an 8-year period. These represent less than 1% of the trainee population. The examples below are each based on one or more true cases, but the details have been altered in order to preserve the anonymity of the people concerned.

POOR CLINICAL PERFORMANCE

Poor clinical performance in trainees is usually considered an educational issue and is handled locally by intensified training and supervision. Trainees are, after all, there to learn. It is only when performance consistently falls well below the standard expected, or when the trainee refuses to accept criticism or to make efforts to improve, that the deanery becomes involved.

The sorts of performance issues that come up most frequently include:

- Poor note-keeping or prescription writing
- Failure to follow protocols
- Inappropriate investigations
- Failure to recognize or respond to the urgency of a clinical situation
- Problems with practical procedures.

On occasion it has taken a serious critical incident to highlight the fact that a trainee's behaviour or performance has been below standard for some time, whether because of stress, ill health, substance abuse, or poor professional skills, knowledge or attitudes (Paice, 2000). Those responsible for the supervision of trainee doctors need to be alert to early signs of difficulty, so that action can be taken before patient care is put at risk.

UNEXPLAINED ABSENCES

One theme that ran through the cases the authors saw was that the trainees concerned had acquired a reputation for being unavailable at the time and in the place expected. Arriving for work late or leaving early were common features. Excessive poorly-explained sick leave was another. Some had the reputation for being uncontactable even when known to be on-site in the hospital. They seemed especially prone to having malfunctioning bleeps. The unavailability of the doctor sometimes came to light when they were needed in an emergency.

What the authors have come to call 'the disappearing act' may have many reasons, including:

- The early morning effects of depression or hangover
- Attempts to sort out complicated financial or relationship problems while at work
- Loss of confidence in making clinical decisions
- Being at the receiving end of bullying or harassment.

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What the authors have learned is that attempting to tackle punctuality or failure to answer bleeps is too superficial an approach. Trainees exhibiting this behaviour may have a serious underlying problem that needs to be explored in parallel with appropriate disciplinary action.

Case example
A young doctor was given repeated warnings about arriving late for work. His performance when he was there was satisfactory, but his tardiness was disruptive to patient care. When confronted, his lack of emotion or any attempt to explain his behaviour was taken as insolence. His trainer wrote a negative report, recommending withdrawal from the training programme. However, psychological assessment uncovered severe depression with suicidal ideation.

Case example
A trainee anaesthetist who had the reputation of disappearing when on duty did not respond to her bleep when on call one night. Concerned about her welfare, colleagues forced open the locked door of her on-call room to find her unconscious, with a needle and syringe containing a narcotic drug by the side of the bed.

RIGIDITY

Another early feature of the trainee in difficulty is rigidity. The doctor concerned may have difficulty dealing with uncertainty or ambiguity, an unwillingness to compromise in the face of competing priorities, and intolerance of compromise in others. One consequence of rigidity is a slow work-rate that does not accelerate under pressure. This tends to infuriate colleagues, who feel forced to work faster and cut more corners themselves as a result.

Another consequence is the writing of numerous letters of complaint to the management about the failures of others, out of proportion to the significance of the incidents. Features of trainees exhibiting rigidity are self-righteousness, rejection of any criticism and tendency to blame others.

Case example
A senior house officer in dermatology was known for the thoroughness of his clerkings, and the meticulous case notes he made on every patient. Unfortunately this resulted in a very slow work rate in a busy department, and the nursing staff complained to his consultant. He responded by writing a detailed letter enumerating the shortcomings of the nursing staff. Relationships deteriorated to the point where he was moved to another unit, but the same pattern was repeated. An offer of psychological support was resented and rejected, and in the end he left medicine.

OUTBURSTS

Irritability is a common feature of stress, whatever the cause. Occasionally, the first indication of trouble has been an uncontrollable outburst of anger in a clinical setting – what might be called 'ward rage'. These may include flare-ups with medical colleagues, nurses or patients. Sometimes the trigger for the outburst is some real or imagined criticism or slight.

Case example
A registrar was preparing to aspirate a knee effusion. The ward sister was shocked to hear angry shouting from behind the curtains and to see the registrar stalk out, flushed with anger, leaving the patient undressed and untreated. The registrar was reprimanded, but argued that the patient had questioned his competence, and that his response had been entirely appropriate. He was referred to a counsellor who identified that he was under stress for personal reasons and had a long history of outbursts when criticized. He responded to appropriate support and treatment, including anger management.

FAILURE TO GAIN THE TRUST OF OTHERS

When a trainee's competence or reliability is below the expected standard, colleagues or patients may recognize a problem before it comes to the attention of the consultant. Patients may ask to see a different doctor, nursing staff may go over the head of the individual to ask the opinion of more senior colleagues, and peers may attempt to avoid being on duty with the doctor concerned. Supervising consultants should also be alert to the possibility of bullying or harassment when certain trainees are marginalized by colleagues (Quine, 2002).

Whatever the reason, being bypassed or marginalized at work is isolating and saps confidence. Serious attention should be paid if it is discovered that this is happening, and action taken to ensure either that the trainee is enabled to play a full part in the team, or that deficiencies are addressed.

Case example
A consultant surgeon was surprised to be called at home by a preregistration house officer seeking advice about the management of a sick patient. The consultant dealt with the query and then asked why the house officer had not called the registrar on duty. The house officer was evasive until pressed, but finally said there was not much point, since everyone knew the registrar's opinion was not worth having. The consultant was surprised, but made a point of intensifying his supervision of the registrar's work over the next few weeks, and discovered that he did indeed have worrying gaps in his knowledge.

PROBLEMS OF PROBITY

Probity is one of the duties of a doctor, and the sort of casual 'economy with the truth' that might be tolerated in another walk of life should ring alarm bells in a doctor in training. An example is CV writing, where exaggeration of competence or previous experience might be the norm in some careers, but could endanger patient safety if it secured the doctor a post beyond his or her capabilities. Trivial, casual or minor degrees of dishonesty should not be overlooked, as they may lead to more serious breaches.

Case example
An applicant for a specialist registrar programme submitted an impressive

CV and was duly shortlisted. Routine checking of her qualifications revealed that the royal college had no record of her having taken the membership examination she claimed to have passed. When this was brought to her attention at interview, she immediately produced a letter from the college apologizing for an administrative mix-up and confirming that she had indeed passed. Subsequently the college denied having issued such a letter. The applicant's referee was contacted. He was not surprised and cited several instances when she had prevaricated in a clinical setting. However, he had not wished to give her an adverse reference as she was bright and clinically able. The panel took a serious view of the events and referred her to the General Medical Council.

OBSTACLES TO ACTION

It was sometimes difficult, in retrospect, to understand why more active intervention did not occur at an earlier stage in some of the cases referred to the deanery. A number of factors seem to be involved. Since the vast majority of doctors in training are committed, competent and professional, it may be hard to recognize the occasional one who is running into difficulty for whatever reason. It may go against the grain to raise concerns about a fellow doctor when nothing very serious has happened (Firth-Cozens, 2002).

The consultant supervisor may be inhibited by feelings of embarrassment in confronting the trainee or guilt at not being a better trainer, or not being around enough. Since the trainee concerned may have little insight (Kruger and Dunning, 1999), raising concerns is likely to be met by denial, defensiveness and counterclaim. The consultant may feel it easier to hope the problem will resolve itself, especially since the training rotation is likely to move the trainee to another unit before too long.

CONCLUSION

The examples above describe some of the ways in which doctors in training have started to run into difficulty or derail. They are reported with the intention of raising awareness of the behaviours that may be early markers of the doctor in difficulty. The behaviours themselves are not diagnostic of any specific underlying cause, nor do they indicate any specific remedy. What they should do is alert those in a supervisory capacity to the possibility that a doctor is running into trouble, and encourage exploration and support at a stage when help may be effective.

Human resource professionals and occupational health services should be brought into the discussion of how best to investigate and address each case on its merits. Research is needed to explore the factors that lead doctors to derail early in their career, and the interventions that can put them back on track. HM

Conflict of interest: none.

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KEY POINTS

- A small proportion of doctors derail during the training years.
- The problems that cause this are various, and include stress, ill health, substance abuse, and poor professional skills and attitudes.
- Certain behaviours provide early warning signs of the doctor in difficulty.
- These include poor clinical performance, unexplained absences, rigidity, outbursts, inspiring distrust in colleagues and dishonesty.
- Early recognition of problems and appropriate professional intervention may put the derailing doctor back on track.