

Good at medicine, pity about the rest

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What happens when doctors struggle with their communication skills? How can we pick up problems earlier, what help is available? In Cardiff an innovative approach provides support to doctors identified as underperforming. This article describes how the programme fits with other work in this field.

INTRODUCTION

Dr X is a third year specialist registrar (SpR) in anaesthetics and just coming up to his next record of in-house training assessment (RITA). He is good technically, but he is quite abrupt at times, even rude, and nursing staff and relatives have complained. He can be hard to find when he is needed, and when you ask him to do something you are never sure it will be done.

Dr Y is an SpR in renal medicine. She is just coming up to her final RITA. She is always reticent about giving her opinion at a meeting; she lacks confidence in her presentations and likes to be led rather than to lead. The nursing staff seems to have little confidence in her and seems to bypass her. The problem for the RITA panel is, will she ever make consultant grade?

The changing face of medical education and clinical practice presents many challenges to students and clinicians. Following the introduction of *Tomorrow's Doctors* (General Medical Council (GMC), 2001) communication skills teaching has become accepted as an important part of the undergraduate curriculum. The various Royal Colleges' objective structured clinical examination (OSCE) based communication skills assessments indicate that in the postgraduate world communication is now also seen as important and requires training. However, how can we help those who struggle? Over the last 2 years in Cardiff, an individual support programme has been run

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(Cohen et al, 2004) for both undergraduates and postgraduates. More than 40 individuals have been seen during this time.

This article presents a review of the issues and describes some of the help available based upon the authors' experience.

NATIONAL ASSESSMENT

When there are serious concerns about a doctor's competency or behaviour clear routes for assessment are now emerging. Local performance procedures are the first port of call for assessment of poorly performing doctors. The next step is the National Clinical Assessment Authority (NCAA). Here assessment takes a multidisciplinary approach where reports are obtained from a range of clinicians, occupational health doctors and psychologists. A report with advice is then provided to the referring body.

The final port of call is the GMC where further assessments take place. The decision following this process is whether the individual can undergo retraining or whether his/her licence should be withdrawn. Retraining and remediation falls to the referring body and the process then becomes less clear.

CLOSER TO HOME: FRAGMENTATION?

So what is in place for those struggling undergraduates and trainees whose practice may be of concern but which is not serious enough to be taken down one of the formal paths?

Since the introduction of *Tomorrow's Doctors* (GMC, 2001) supervision and evaluation of the preregistration house officer's (PRHO) skills has changed, with more formal assessment during the first year (soon to become 2 years)

of registration. As a result the authors' unit are aware that a small number of PRHOs now require remedial training of some kind (which includes communication skills) before obtaining full registration. Similarly, some SpRs are being required to undergo targeted training in communication skills following a RITA review.

Anecdotal evidence suggests that trainers struggle with knowing when to refer. They are uneasy about raising concerns in such areas as team working, insight or professional development when at present there are no clear assessment methods in place (Newble et al, 1994). In addition they may hesitate to refer because they are concerned about possible disruptions to clinical services, disrupting working relationships and the wider implications this brings. This is compounded by the lack of organized training and support offered to struggling doctors.

Trainers and supervisors are reluctant to raise an issue when there are no remedial services to offer. Just sending someone on a 2-day communication skills course may not get to the heart of the matter. The situation has been described by the President of the Royal College of Psychiatrists:

'...we have nothing between local, early mentoring schemes and national, sick doctor schemes that are only available when it is too late. This will not do. (Shooter, 2002)'

So while assessment routes are now better established, they are not always implemented, and remediation processes are either rudimentary or absent. The medical profession now needs to think carefully about remediation and what resources are needed to offer effective solutions for very real problems.

TOWARDS A MORE CONSTRUCTIVE RESPONSE

Efforts should now be moving towards a more constructive and cohesive approach to earlier assessment and remediation. The authors believe that by developing solutions, the problems themselves will become easier to identify and manage. This is based on experiences in Cardiff where an individual support programme for struggling doctors and undergraduates has now been running for 2 years.

RECOGNIZING A PROBLEM

It is likely that the earlier a problem is recognized, before bad habits have become engrained in practice, the more likely remediation will be effective. Recognizing patterns of behaviour which might be early manifestations of a struggling doctor is therefore important. By ensuring that supervisors and trainers understand these behavioural patterns, the process starts to become more manageable. This process then needs to be set into a framework that is acceptable to both trainee and trainer.

The authors' experience in Cardiff is that this can be done using the RITA process (*Table 1*). For instance, poor note keeping, failure to follow guidelines or never to be found in a crisis can be classified as performance issues. Those doctors who have recurrent flare ups with colleagues, those who have received repeated complaints or those who seem arrogant or flippant and have inappropriate confrontations with patients can be classified as having personality problems which affect their non-technical skills. Inadequate research development, presentation skills or team leadership skills can be seen as failures in professional development.

Once a problem has been recognized and a framework constructed the difficulty then lies with how to manage the problem.

IMPROVING MENTORING AND SUPERVISION

Strengthening mentoring and supervision is an important part of the provision of a good remedial service. It is one thing to recognize a doctor or

undergraduate in difficulty but quite another to feel comfortable addressing the problem with the individual. Discussions with struggling doctors and trainers often reveal frustrations and misunderstandings. Trainees often complain that they cannot understand exactly what aspect of their performance is seen as being inadequate, while trainers often comment on the trainee's lack of insight.

These types of encounters are often not straightforward. It takes time and skill for one person to move between the roles of coach, mentor, trainer and assessor. Programme directors and specialist training committee chairs in Wales are able to discuss areas of concern in confidence with the authors' unit before referral, and advanced GP trainers undergo regular training sessions looking at management of the trainee in difficulty.

Once raised, the problems need effective management. The issues are often complex and the authors' experience is that a comprehensive service offering support and interventions can be of benefit (Cohen et al, 2004).

REFERRAL AND REMEDIATION

These are high stake problems for the doctor or undergraduate in difficulty. The trainee's career may be in question and the trainer may feel ill-equipped to manage such complex issues. Often the individual's perception (whether it is correct or not) is that no-one is on his/her side. In Cardiff the unit provides support for doctors and undergraduates who are seen to be struggling. It has been found that giving the individual the time and opportunity to air his/her concerns in a protected environment allows him/her to unburden often complex problems.

There are many anecdotal accounts of both undergraduates and qualified doctors feeling that their progress will be tarnished if they acknowledge problems connected to stress, distress and communication. Therefore by maintaining an independent and confidential status and confirming this with the use of written consent where appropriate, it has been possible for the authors' unit to create an environment of openness.

TABLE 1.
Categories used for assessing problem behaviour

RITA performance category	Problem behaviours
Performance	Poor notes or prescription writing
	Poor decision making
	Poor practical procedural skills
	Failure to follow guidelines
	Never found in a crisis
	Poor time keeping
	Complaints
Personality	Flippant
	Arrogant
	Attitude towards patients or staff inappropriate
	Rows with colleagues and/or patients
	Complaints
	Lack of insight
Professional development	Lack of concentration
	Poor team leadership
	Poor research development
	Presentation skills
	Investigates inappropriately

These signs may be significant in more than one box, e.g. Investigates inappropriately may lie within performance and/or professional development depending on the individual's level of training.
RITA = record of in-house training assessment

The remediation process itself needs flexibility and the use of a diverse range of communication skills. Merely to adopt the role of an expert counsellor is not enough. Listening skills are undoubtedly important for establishing trust, demonstrating respect and exploring issues. However, the authors' unit also works in a coaching capacity when encouraging individuals to develop specific strategies to overcome challenges in their everyday practice.

Negotiation skills then become important when dealing with sensitive interprofessional problems. The more complex the problem, the more flexible the remediation process needed. In reviewing the cases the authors have encountered over 2 years, mental health, personality and language problems have emerged as common underlying reasons for communication and performance issues (Cohen et al, 2004). Therefore other services such as expert language support, psychiatric support and psychologists form part of the remediation process.

CONCLUSIONS

As a profession we need to think not only about improving assessment but also about developing a more proactive approach to the struggling doctor and undergraduate. Providing educators with frameworks to recognize problems and then the tools to manage them seem important steps forward. By intervening sensitively early on, more serious outcomes can be prevented. An individual support programme of the kind outlined in this article, properly evaluated, can serve as a useful link between national schemes like the NCAA and local services and support systems. These services are then integrated with the use of simulated

patients, video and workplace activities. The aim is to provide a programme tailored to the specific needs of the individual. **HM**

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KEY POINTS

- Clear assessment paths are now available, and effective remediation services are needed.
- The independence of the remediation service is important for engagement of the doctor.
- Problems are complex and may require a multidisciplinary approach.
- Providing a clear framework for referrals enables problems to be picked up early.
- Careful documentation of all contacts is essential.