

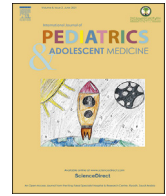
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Managing the ambiguity of the trainee and the trainer

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ABSTRACT

The “trainee in difficulty” (TID) can have multiple causative factors which can impact the delivery of an expected standard of skill sets. The communication and interpersonal skills in Emergency Department (ED) setting are key to any trainee’s performance in an ED environment where team playing is a major factor in achieving safe and holistic care for patients. Trainer or a young faculty member responsible for the training may not have the emotional intelligence or experience to deal with all the issues faced by the TID. This paper talks about the difficulties faced by an experienced trainee in difficulty, who has changed his career from an experienced ED nurse to a trainee registrar in Emergency Medicine. The second case study is about a young emergency medicine residency program director who fails to appropriately address a trainee’s situation and compounds the trainees’ issues. The effect of honest, transparent communication of an educational supervisor and setting clear goals for the TID can have a huge impact on trainees’ performance. A residency program director’s inexperience and poor skills to deal and escalate the trainee’s issues may jeopardize a young physicians’ career.

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1. Introduction

Trainee in difficulty (TID) is a clinician whose performance falls below the required potential of an average trainee (at his level) and he/she is at risk of failing in his performance [1,2]. The trainee has a responsibility to follow the Good Medical Practice Guidelines laid by the General Medical Council, UK or the licensing authority of a country he is working in. The doctor is also contractually accountable within the governance structure of the institution. The trainee’s performance is expected to adhere to a standard, provided he fulfills his clinical and educational commitments [3]. Despite robust educational supervision, some trainees do exhibit difficulty for multiple reasons [4,5]. The trainees are required to be supervised by accredited supervisors who should be approachable, accessible, responsive to the trainees’ needs and able to provide constructive feedback on their performances [6–8]. These trainers should be able to identify the TIDs early and should be able to get appropriate and timely help for them. We will mention two different case scenarios involving TIDs and the approach used by

their trainers to help remedy their problems.

2. Case 1

A complaint was received from a senior nurse. She alleged that a physician became very rude towards her during a clinical discussion and started shouting. They were both working together during a busy time in the ED. The nurse was worried that the patient has been in the department for more than 3 h without a clear management plan. The patient was at risk of breaching the “ED 4-h target” set by the UK Department of Health (DOH).

Another complaint was sent by a speciality consultant about the same physician. The doctor had been very obstructive, rude and dismissive while referring an ED patient to the speciality. He did not provide relevant clinical information about the critical investigation results and transferred the patient to the speciality assessment area. This led to a significant delay in the patient’s further clinical management.

2.1. Urgent “fact finding meeting” with the trainee in difficulty

Complaints from the nurse and the speciality consultant were discussed with the reporting parties within two days after the second event was reported and a fact finding meeting was arranged with the trainee immediately.

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The trainee's background was unlike any other standard trainee. He had been working in ED as a qualified charge nurse for 4 years prior to getting into medical school. After completing his medical degree and two years at foundation year level, he started to work as an emergency doctor (through an agency) for a couple of years. He then took a year off for personal reasons before he entered training for another three years. This was followed by another two years' ad hoc work as a specialty doctor before entering in the specialist training. He wanted to pursue a career in emergency medicine.

These two events happened within a week of him starting in the ED and were both graded as 'moderate severity' according to the institutional protocols. Patient care documentation had been reviewed in detail prior to the meeting. The trainee was advised that the minutes of the meeting will be recorded and he was allowed to bring a representative.

In response to the complaint raised by the nurse he replied that this was his "strict way of speaking" to the nursing staff. He mentioned that nurses are only worried about transferring patients out of the ED within 4 h and the clinical care was not their priority. He reiterated the fact that he has worked as a nurse himself in ED and that's what he has seen the senior ED nurses do.

During his previous job, he had worked in a department where some of the nurses had moved his patients out of the ED before the prescribed treatment had been completed. This had resulted in complaints related to his clinical practice. These incidents resulted in him writing explanatory statements and getting interrogated by the management.

With regards to the second complaint, the trainee felt that the specialty consultant was asking him many irrelevant questions about a straight forward consultation. He apparently wanted to "teach him a lesson early" to prevent any future delays in accepting cases. He also mentioned that during his previous placements he used to send patients directly to medical and surgical assessment areas and verbal communication with the consulting service was not necessary.

He desired to set his rules in the department early to adopt a "no nonsense approach".

3. Case 2

A female resident during the nightshift approached the recently appointed program director (PD) requesting a leave. The trainee requested to drop out of the program for three months. This conversation happened on the ED shop floor with night staff overhearing the conversation. The PD was perceived by other colleagues as very loud and dismissive towards the trainee. Later, the PD took the trainee to his office for further conversation without a chaperone. The trainee felt very uncomfortable with the whole situation and had to be sent home due to extreme anxiety and distress. Following this incident, the trainee filed a complaint against the PD. The trainee also had to be sent on a prolonged sick leave.

3.1. Urgent "fact finding meeting" with the trainee in difficulty

A complaint was filed by the trainee against the PD to the Director of Academic Affairs and also to the Chief Medical Officer of the Hospital, which bypassed the system hierarchy. The respective heads of the departments approached the ED chairman to talk to the trainee and the PD to resolve the issues. A meeting was arranged within two days of the reported incident.

The chairman discussed the content of the complaint with the PD who did not seem concerned about his approach towards the trainee's issue, while his only fear was about a possible sexual harassment allegation by the trainee. He felt that as a PD, he had the right to interrogate the trainee on the shop-floor or in his office.

During the meeting with the trainee, her main concern was that her request was not received sensitively and she was interrogated in front of her colleagues. She denied any inappropriate sexual harassment on part of the program director but felt uncomfortable alone in the office of a male PD. She wanted an apology from the PD for his inappropriate mannerism, when a seemingly simple request was brought to his attention. It was highlighted in the meeting that the trainee was faced with a social issue which needed to be resolved but was never given an adequate opportunity by the PD to discuss her matters.

3.2. Defining & understanding the trainee's problems

When exploring a TID, the following areas have to be explored [9–11].

1. Are there lapses in clinical knowledge and skills?
2. Is physical illness impacting on their performance?
3. Is there an unidentified mental illness, which can seriously affect decisive thinking, create irrationality and irritability?
4. Is there any substance/alcohol abuse?
5. Is there domestic issues and loss of work life balance?
6. Is there any sleep deprivation due to a change in work pattern?
7. Could there be issues relating to equality and diversity which can affect individuals from a minority group?
8. Is there lack of interpersonal skills/personality issues?

In the first case study, the concerns raised pertained to communication and interpersonal skills. In the first complaint, there was an unprofessional communication with a ED nursing colleague. This could be related with the trainee's previous work practice as a ED nurse. He displayed an inhibiting and resentful attitude towards a genuine nursing query. It also came to light that in his role as a nurse, he faced harassment by his senior nursing colleagues, when he failed to avoid patient breaches. There was also a misconception about the ED 4 h' indicators. The second complaint was also related with communication and handover skills. There was a failure to communicate effectively and safely with another clinician. The trainee seemed to apply a practice which was best suited to his personality. The lack of competence in handover skills could also be a factor. This incompetency could be masked by adopting an obstructive attitude.

The second case was a trainee in difficulty due to her domestic issues which she wanted to discuss with the PD. The trainee was so much overtaken by her problems that she approached the PD in the middle of her clinical shift. The PD also compounded the problem by showing lack of empathy and his inability to react proportionately to the sensitivity of the raised concerns. The discussion behind closed doors without a chaperone caused a lot of anxiety for everyone. The trainee got overwhelmed with the situation and took a wrong approach towards getting help. She ended up escalating the issue unnecessarily to hospital management, whilst it could have been amicably resolved within the department.

3.3. Signs of trainee in difficulty

Some pertinent signs raise concerns about a doctor in difficulty. They are warning shots that the doctor needs to be approached by his training supervisor to identify any underlying causative factors [12,13].

1. The disappearing act – not answering pagers; disappearing during the clinical shift; late arrival to work; frequent sick leaves.

2. Low work rate – poor performance during procedures, sub-standard documentation, poor decision making; unable to finish all the tasks.
3. Shop floor rage – burst of temper, low self-esteem, unnecessary argumentation and shouting.
4. Rigid attitude – lack of patience to positive criticism, inability to compromise on reasonable issues, difficulty prioritizing, inappropriate whistle blowing.
5. Bypass syndrome – the doctor is avoided by his junior colleagues and nurses for opinion and help.
6. Career issues - exam failures, unsure as what to choose, disillusionment with medicine.
7. Insight failure – gets defensive and rejects constructive criticism, counter challenge.

3.4. Resolutions of cases

A discussion with the trainee around the DOH targets showed a complete lack of understanding and misconceptions in that area. An evidence based insight was given to the trainee by showing him the weekly departmental breach reviews and how its analysis of causative factors helped improve patients' flow to appropriate clinical areas.

It was explained that ED nursing staff are accountable for the patients' journey in the department and communication with physicians for any delays in decision making was a part of normal operational work. The departmental operational policy was shared with the trainee.

The TID was explicitly reminded of General Medical Council (GMC) domains of good medical practice [14], which entails robust communication with colleagues to ensure safe patient handovers. The already written departmental handover policy was explained. The highly validated SBAR (Situation, Background, Assessment, Recommendations) tool [15] was advocated for communication, which he found user friendly. The goal was to address the trainee's

misconceptions, develop a clear insight and give him the needed support for success.

A future meeting was arranged after setting a monitoring period of 6 weeks. The feedback about the trainees' performance from the ED shop floor and specialty colleagues was carefully monitored. There was a consistent positive approach adopted by the trainee during the observation period and his performance steadily achieved an acceptable standard. The trainee successfully completed his placement without any further hiccups.

Regarding the second TID, meetings were held between the departmental chairman, trainee and the PD. The trainee had partner and child issues which were impacting on her work pattern. The department offered her a flexible pattern of working, which she happily accepted. When approached for her concerns, she denied any issues except lack of consideration and empathy from the PD. The trainee was also explained the institutional employees' grievance policy. The trainee was informed that the PD will be counselled for his actions. However, she was advised to follow the right chain of command in future for any other concerns.

The PD was given the trainee's feedback. He acknowledged the shortcomings in his approach and agreed to participate in a mentorship program to help him improve his dealings with the issues in the future.

4. Discussion

The practice of doctors irrespective of grade and seniority should be guided by six main domains i.e. proficiency in skills, professional mannerisms, working within clinical boundaries, trustworthy practice, learning from mistakes, and dedication to work [16].

The problems with difficult trainees can be due to knowledge deficit, attitude or distressing behaviour. In one study, insufficient knowledge and attitude problems scored highest in the problem trainees, followed by interpersonal conflicts, family stress and psychiatric illnesses [16]. The percentage of trainees in difficulty is

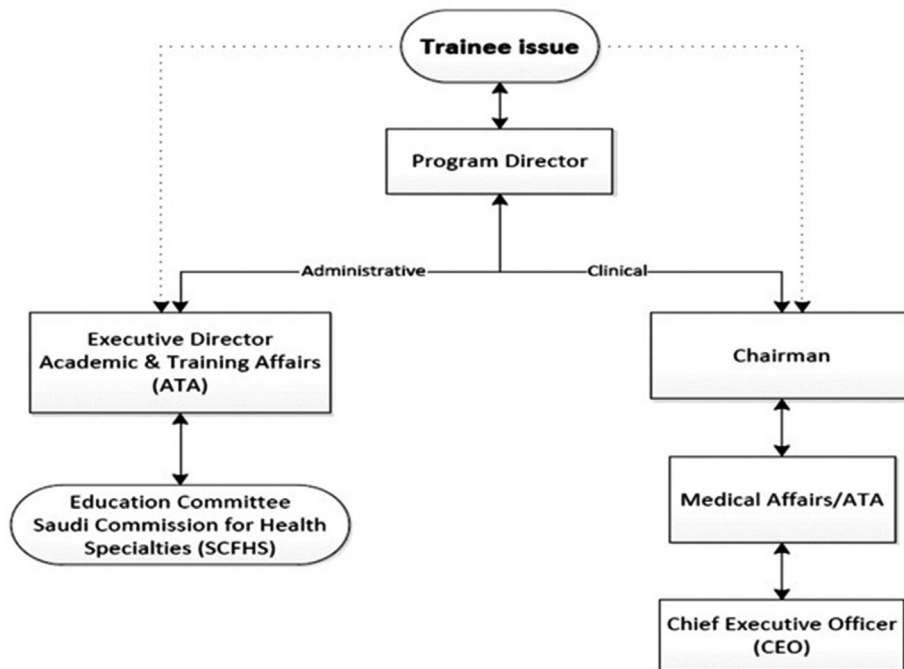


Fig. 1.

RESULTS OF KSA trainees survey:

Sixty Emergency Medicine trainees were surveyed with the designed questionnaire. Response was received from 40 trainees.

Question 1: 39(98%) (Program Director (PD)). 1(2%) (Senior Colleagues (SC))

Question 2: 20 (50%) (Saudi commission for health (SCH)) 10 (25%) (Chief Medical Officer (CMO)) 10(25%) (Departmental Chairman. (DC))

Question 3: 40 (100%) (Rethink of alternate plan (RAP))

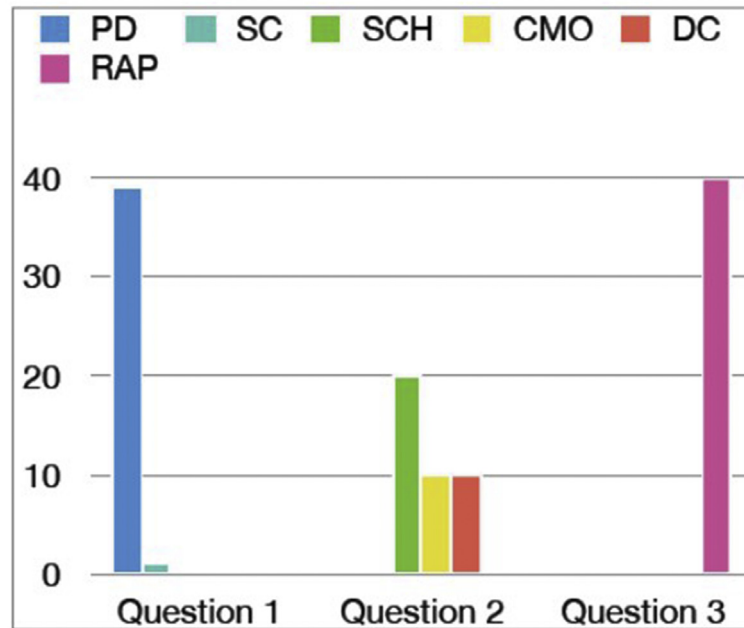


Fig. 2.

highest in psychiatry (9.8%) while emergency medicine falls somewhere in the middle of other specialties [16]. Sometimes the trainee might be completely unaware of his own problems impacting his performance. The specialties which demand high standards of team work, communication and multidisciplinary interactivity can expose a TID very quickly.

The trainee in our first case study displayed symptoms of a problem learner due to a lack of adaptability in his new clinical role. Trainee's temporary placements in various emergency departments had impacted on his style of working. This was due to lack of teaching and supervision, excessive workloads, unclear standards and no feedback on performance. He had a stressful transition in his career, from a nurse to a physician. His signs of distress were recognized quite early and in a timely manner. Appropriate interventions were carried out which helped modify his work-practice and behaviour. The trainee also had a desire to change and took all the recommendations seriously. This reflected in his performance with successful completion of the placement.

The trainers can be an equally possible reason for the trainees to be in difficulty. The second case was the prime example where a straightforward issue was unnecessarily heightened. There was careless attitude on part of the trainer, who should have approached the trainee with professionalism. The inexperience and lack of emotional sensitivity of the trainer escalated the problems of the trainee.

An unbiased information gathering and documentation are the first steps toward analyzing the difficulties faced by the trainees [15,16]. Trainee's previous assessments should also be thoroughly reviewed. A systematic interventional approach should be adopted after careful consideration of available evidence (see Fig. 1).

A brief survey of 40 emergency medicine trainees in our facility indicated that majority would escalate a problem first to the program director (Fig. 2). In case of lack of resolution, the next step in the hierarchy of the chain of command was unclear to the most of the trainees. A comprehensive trainee orientation inclusive of conflict resolution pathways, understanding of the training program hierarchy and assigning mentors will help streamline and support the trainees.

Majority of trainees will successfully complete their training without significant problems [13,14,16]. In few cases, persistence of difficulties with the trainees can occur which may lead to restriction in clinical practice or expulsion from the training program [17].

5. Conclusions

Early identification of problems will reduce the risk to the trainee. The reasons behind a problematic trainee can be multifactorial. A trainee with career breaks can pose a significant challenge to his trainers. Trainees' understanding and effective utilization of the management structure can help address their problems. The trainer should exhibit empathy toward the genuine trainee issues and approach them with high degree of professionalism.

Ethical statement

This study has been approved by the hospital's Research Advisory Counsel (RAC). All ethical considerations have been taken into account.

Author agreement

The author agrees to publish the contents of this paper. There are no other issues or conflicts of interest involved.

Declaration of competing interest

The case studies regarding trainee in difficulty have been written solely for educational purposes and there has been no other reason, intention or conflict of interest.

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