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'This trainee makes me feel angry': It's time to validate the reality and role of trainer emotions

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1 | INTRODUCTION

It is widely accepted that being a doctor involves a range of skills and modalities beyond the purely rational, including the emotional.[1] Even in the diagnostic process itself, clinician gut feelings ('an uneasy feeling about a possible adverse outcome even though specific indications are lacking'[2]) have proven valuable.[3] Gingerich et al.'s[4] work on supervisors' reactions to failing trainees sends a clear message that recognising a failing trainee also has a strong emotional component. While burdensome, these affective reactions may provide an important signal. Much has been written about the emotional burden of caring for patients[5] and, more recently, the emotional welfare of those learning medicine.[6] The unique focus of this paper, the emotional burden of training learners, resonated with our context: in the United Kingdom around 50% of clinical supervisors say their work is highly emotionally exhausting.[7]

Gingerich et al.'s work on supervisors' reactions to failing trainees shows that recognising failing trainees has a strong emotional component.

2 | ANGER AS A SIGNAL

Earlier work in this journal has discussed the 'failure to fail'[8]: a well-known reluctance to fail underperforming students.[9] The current paper addresses situations where supervisors reached a 'tipping point', recognising that a trainee needs to be failed. Gingerich et al. demonstrate how this realisation by supervisors is characterised by anger. We would like to know from where this anger comes. Doctors regularly treat 'failing' patients (ones who seem impossible to help, for example, due to lifestyle or behavioural factors), yet such patients do not typically make doctors feel angry. We must ask, therefore, what implications reactions of anger have for supervisors' professional development and practice?

Gingerich et al. suggest that negative trainer feelings may be useful, perhaps signalling to the trainer something is happening, helping them to recognise that a trainee is failing. That begs the question of how trainer emotions play a role in helping to identify failing trainees Further, while trainers' emotions may alert them to a problem, without adequate supported reflection is there a risk that they undermine objectivity and enhance bias, while adding to supervisors' stress and lack of wellbeing?

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3 | PERSONAL OR CULTURAL INTOLERANCE OF FAILURE?

As the paper points out, the consequences of failing to fail trainees are fundamental. It is essential, however, for future patient care. The anger signal suggests to us, therefore, that the tipping point may involve a shift from supervisory responsibilities to an overwhelming

accountability to future patients. The desire to protect is a manifestation of caring; indeed an emotional reaction to perceived threat to patients is understandable. However, it is not always a helpful way of professionally addressing a situation that will inevitably occur, even if only occasionally, during training.

We think anger may also represent a mismatch between a system/culture and practitioners' real experiences within it. Research has identified concern that failing a trainee suggests a failure of the teacher.[8] However, aversion to failure is arguably a wider characteristic of healthcare systems. While desirable with regards to patient care, failure-aversion is less helpful for supporting the learning and development of students, trainees and faculty. Research on medical training has revealed a highly risk-averse culture which, in its avoidance of patient care failures, often fails to articulate or support failure in the context of training. This can lead to limited recognition of failure as an inevitable part of learning.[10] Hence, balancing intolerance of risk of clinical failure with tolerance of trainees exiting training, represents a challenge for doctors who are also educators.

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4 | SHIFTING CULTURES

In our research on clinical leadership development, we found that in relation to other aspects of medical practice (e.g., service improvement, team leadership or interprofessional teamwork), the idea that failures might be inevitable, and a productive source of learning and professional development, was novel to most of the doctors interviewed.[10] They experienced such failures as painful, even where they did not directly affect patients, and had rarely explicitly addressed them. Without the opportunity and culture to address learning opportunities arising from educational failures, these doctors may not be able to examine failures explicitly as supervisors. This raises questions about how the system supports supervisors in dealing with failing trainees. Is it acceptable for supervisors to discuss their negative emotions in relation to trainees? Are explicit discursive tools available to raise student failure among colleagues in a dispassionate manner that acknowledges emotions while interrogating possible bias? Are there systemic practices that help supervisors address the challenges and emotions they encounter or are they considered something that experienced supervisors should just 'get on with'?

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Cultural shifts towards the supportive practices implied by these questions will not happen on their own: they require collective work within wider and local healthcare systems to ensure systematic individual and organisational learning from failures.[11] Support can be absent from the current system due to high workloads and low prioritisation of wellbeing.[6,12] In fact, medicine is notorious for failing to provide a regular space for practitioners to process their thoughts and feelings. Several different group reflection formats exist (e.g., Balint groups[13] and Schwarz rounds[14]), but time is rarely included within job planning. Consequently they add to workloads or take place at the expense of the supervisor's already-squeezed leisure time.[12] Hence, interventions designed to provide such backing for healthcare workers are often not utilised by those most in need of them.

5 | CARING FOR EDUCATORS

In sum, we believe there to be a journey we need to go on, caring for educators, acknowledging the emotional burden of workplace supervision, and validating the role of the emotions (when suitably processed) in alerting us to something amiss. This calls for a system-wide approach. Narratives around workplace-based assessment need to encompass this, spaces need to be created and organisations need to provide meaningful support to enable their busiest clinical supervisors to engage. To fail to do so will not only risk losing educational supervisors but will also fail to utilise the benefits of supervisors' emotions and prevent them from causing harm.

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