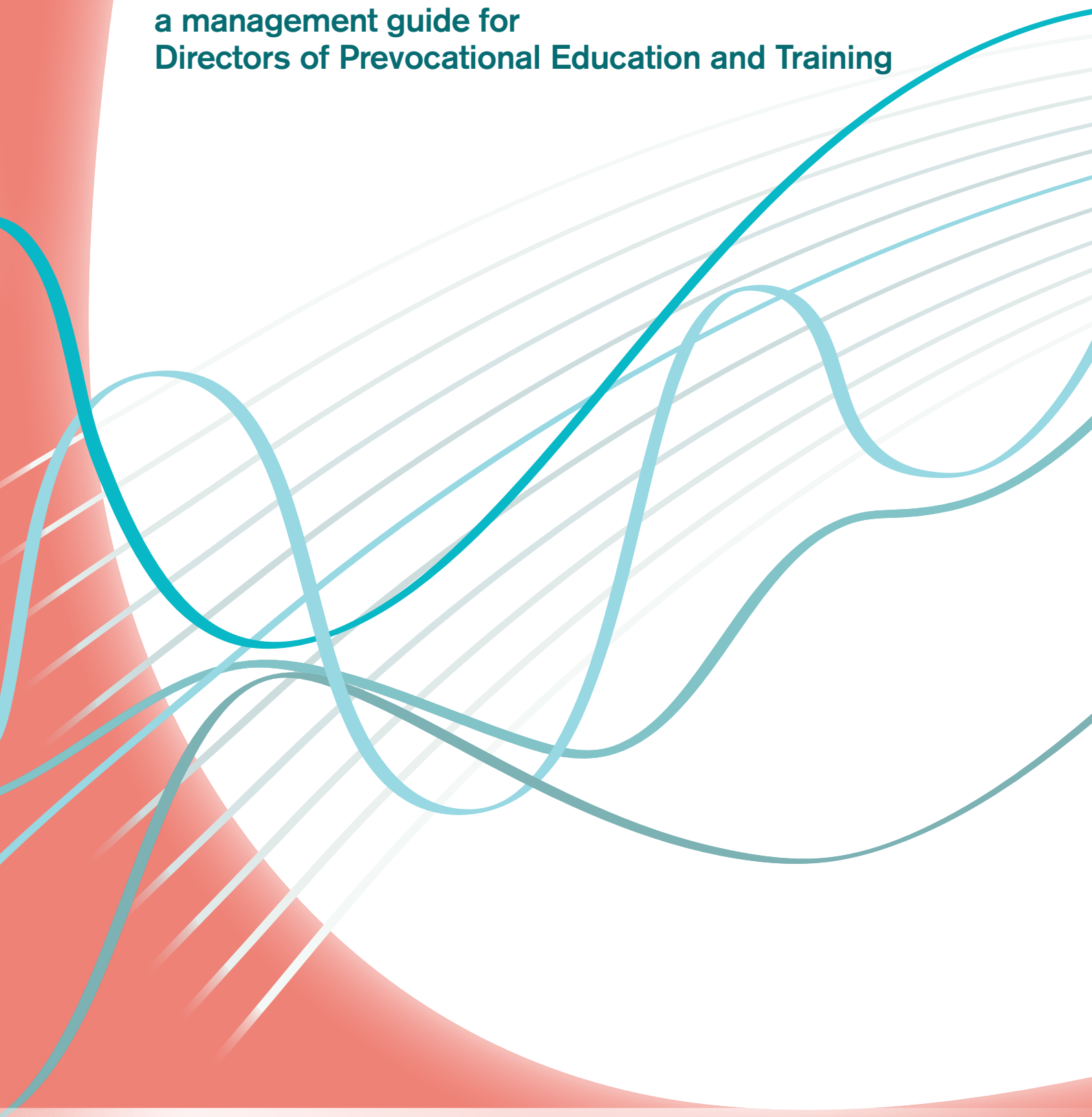
Trainee in difficulty

a management guide for Directors of Prevocational Education and Training



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SECOND EDITION

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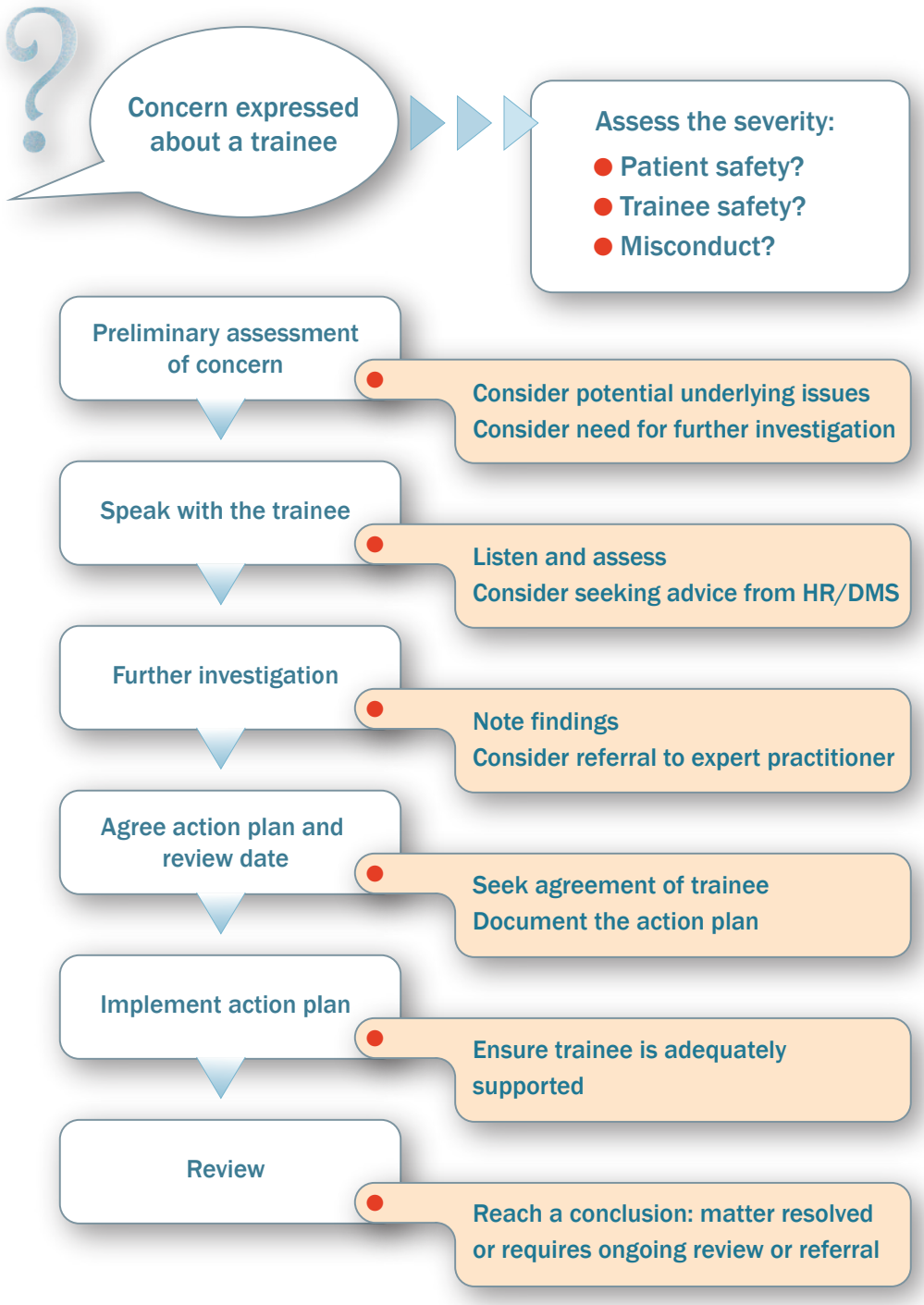
Trainee in difficulty: management outline



Trainee in difficulty

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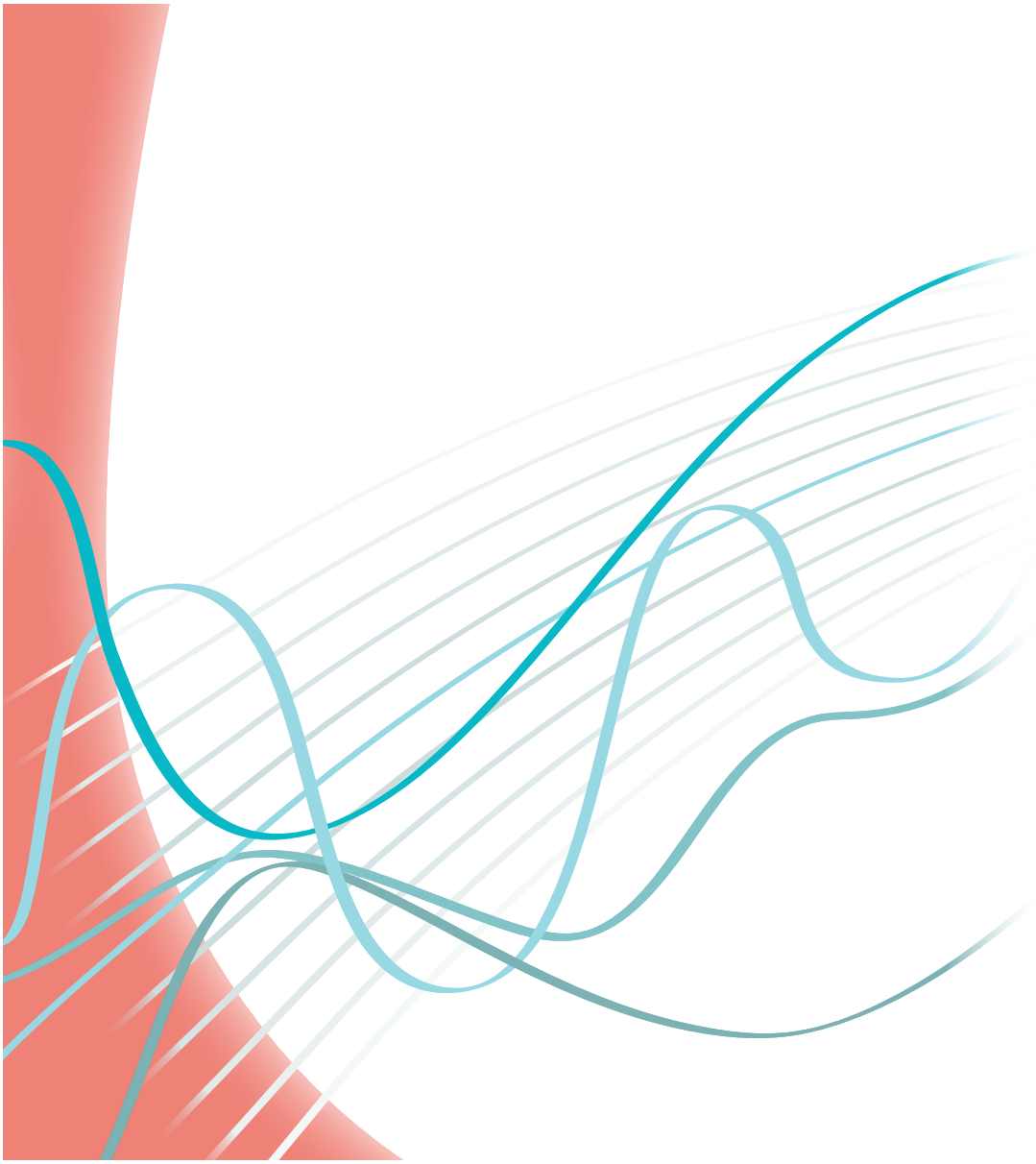
Second edition



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Foreword

Many doctors will encounter difficulties during the first year or two of their medical careers. The transition from student to responsible professional is perhaps the most daunting period in their working lives. Most of them will rise to the challenge, but a small proportion are at risk of failure. They may present a risk of harm to patients or to themselves. This book provides senior clinicians with some simple guidelines to help manage and reduce those risks.

Those experienced in managing and training junior doctors know that when senior clinicians are sensitive to the potential problems of junior doctors and respond supportively, minor difficulties can be prevented from escalating into major problems, and that even serious performance issues can often be ameliorated through quite simple interventions, particularly if these are made early.

Many people have contributed to this handbook, but I particularly want to acknowledge the significant contribution of Dr Jo Burnand, Director of the Medical Appointments and Training Unit, ACT Health. I hope that directors of training and clinical supervisors will use this book. It distills the practical experience of many directors of training and medical administrators into a step-by-step guide to identifying and managing the trainee in difficulty.

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Chair, Prevocational Training Council
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Contents

A short guide to managing a trainee in difficulty

This is a practical handbook designed to help Directors of Prevocational Education and Training (DPETs) deal with prevocational trainees who are experiencing difficulties.

It provides information about:

- how trainees experiencing difficulties present ▶ p6
- assessing the severity of the problem ▶ p8
- the range of underlying issues ▶ p10 and pp15–17
- speaking to the prevocational trainee and other key individuals ▶ p11–14
- formulating, implementing and reviewing an action plan to address identified issues ▶ p25–26.

This handbook is not a policy document, neither does it provide all of the answers for dealing with prevocational trainees who are experiencing difficulties, but it has been written by experienced directors of training and medical administrators to assist others navigate the sometimes complex territory surrounding prevocational trainees in difficulty.

Website: This handbook, updates and other useful resources are available at **www.heti.nsw.gov.au/prevocational**

Three principles

- Patient safety should always be the primary consideration
- Prevocational trainees require supervision and support.
- Prevention, early recognition and early intervention are the preferred approach.

Early signs

- The disappearing act
- Low work rate
- Ward rage
- Rigidity
- Bypass syndrome
- Career problems
- Insight failure

Key messages

- Most trainees in difficulty can be assisted, over time, to become competent clinicians. A supportive approach, with common sense interventions coordinated and monitored by the DPET, usually leads to a satisfying result for the trainees and their clinician supervisors.
- Do not jump to conclusions or decide too early what the actual problem is. Stick to the facts — and get them directly from the source. Be circumspect with the number of people that you gather information from. Discuss the issues with the term supervisor and whoever raised the original concerns. “You can’t unknow what you know” – never accept someone telling you something “off the record”.
- Any risks to patient safety, risks to trainee safety, or allegations of criminal conduct require immediate action and referral.
- The role of the DPET is support and advocacy. The DPET is not the treating doctor, formal counsellor, or disciplinarian. In some instances the DPET will be required to refer the trainee for further assessment or assistance.
- All prevocational trainees should be encouraged to have their own general practitioner and should seek early advice from their GP in the event of emerging health issues.
- There are several individuals within any health care organisation who may become involved when concern is raised about a trainee. It is important to identify local resources (▶ p28–29).

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Role of a Director of Prevocational Education and Training

One of the fundamental roles of the DPET is to facilitate feedback to prevocational trainees about their performance. This extends to identifying prevocational trainees who are experiencing difficulties and implementing effective support systems for them.

Many DPETs report that managing trainees who are experiencing difficulties is one of the most challenging aspects of their work. The reasons for this are numerous and include the following:

1. The legal and industrial frameworks are complex and there are multiple public sector policies to consider.
2. The DPET must negotiate the interface between the junior doctor's role as a trainee and as an employee.
3. Effective communication skills are required to manage trainees who are experiencing difficulties, particularly those who have problematic attitudes and behaviours.

Employers have a legal responsibility to ensure that industrial conditions and legislated requirements pertaining to employment are upheld. This includes responsibility for managing performance and disciplinary matters, and ensuring that performance issues are responded to in a timely, fair and objective way.

Every public health organisation has processes for identifying, investigating, managing and supporting prevocational trainees who are experiencing difficulties. The DPET has a central role, sometimes using the support of medical administration and human resource departments. Further information regarding the roles of others is provided later in this handbook (▶ p28–31).

Most trainees with difficulties can be assisted, over time, to become competent clinicians. A supportive approach, with common sense interventions coordinated and monitored by the DPET, usually leads to a satisfying result for the trainees and their clinician supervisors.

The conceptual framework

A doctor in prevocational training is both a “trainee” (who is by definition on a learning curve) and an “employee” (of a public healthcare organisation which has specific expectations regarding responsibilities and performance).

These two roles may at times conflict, making effective management challenging. Considerable attention has been paid to this issue in the writing of this handbook.

Prevocational trainees face multiple internal and external stressors. Some stress heightens performance, but prolonged stress may lead to distress, and prolonged distress may lead to impairment.

The general approach to dealing with the prevocational trainee experiencing difficulties rests on three principles:

- Patient safety should always be the primary consideration.
- Prevocational trainees require supervision and support.
- Prevention, early recognition and early intervention are always preferred over a punitive approach in dealing with identified issues.

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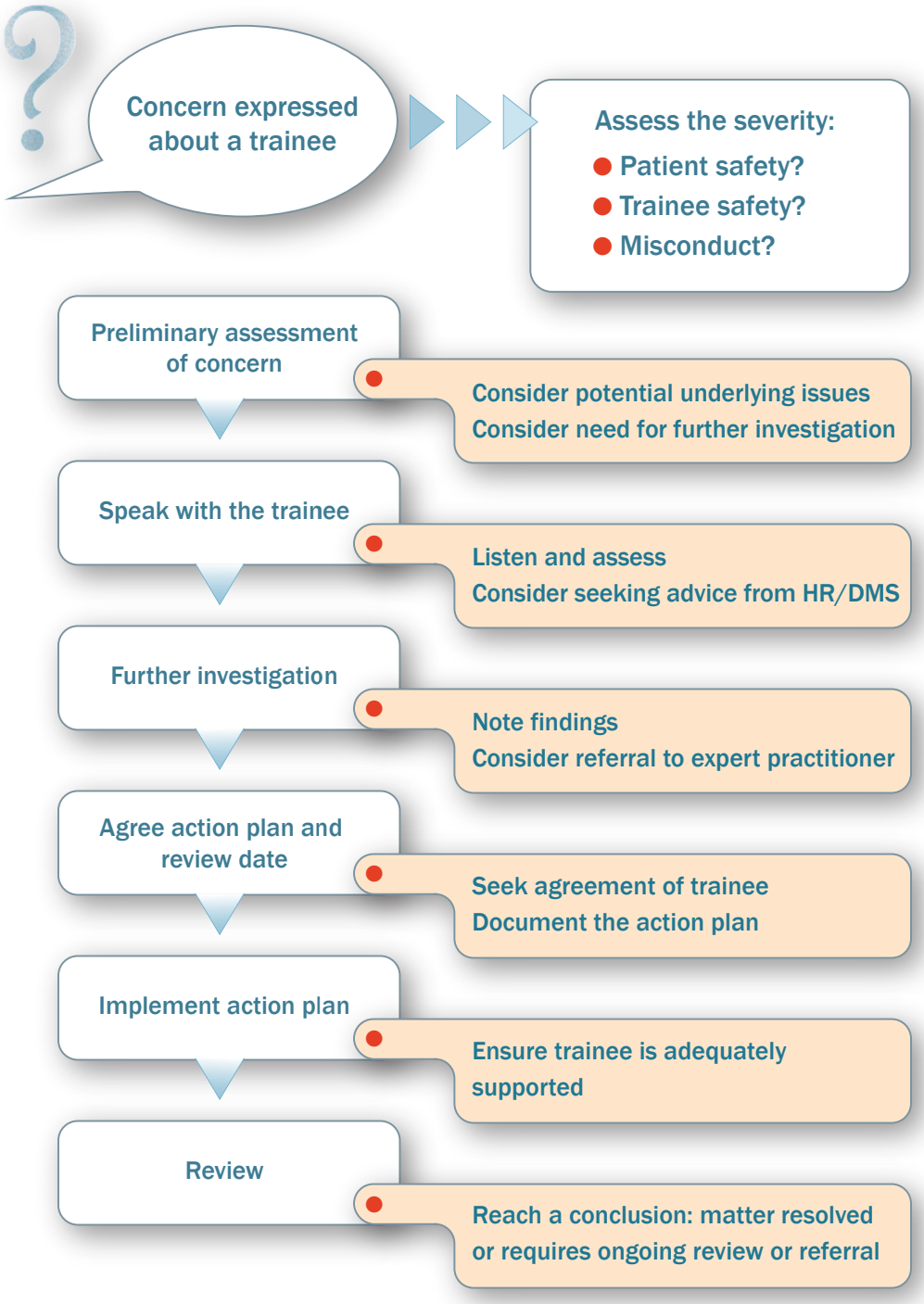
Trainee in difficulty: management outline



Early signs of difficulty

- **The disappearing act:** not answering pagers, disappearing between clinic and the ward, frequent lateness, excessive amounts of sick leave.
- **Low work rate:** slowness at procedures, clerking, completing letters and making decisions; coming early and staying late but still not getting a reasonable workload done.
- **Ward rage:** aggressive or passive aggressive responses when decisions are questioned, shouting matches with colleagues or patients, disrespectful or dismissive speech and behaviour towards other health professionals.
- **Rigidity:** poor tolerance of ambiguity, inability to compromise, difficulty prioritising, inappropriate or vexatious complaints.
- **Bypass syndrome:** junior colleagues or nurses finding ways to avoid seeking their opinion or help.
- **Career problems:** difficulty with exams, uncertainty about career choice, disillusionment with medicine.
- **Insight failure:** rejection of constructive criticism, defensiveness, counter-challenge.

— Adapted from Paice E. The role of education and training. In: Cox J, King J, Hutchinson A, editors. Understanding doctors' performance. Oxford: Radcliffe Publishing, 2006.

A word on social media

Social media, such as Facebook and Twitter, are now part of most people's lives. They can be a valuable vehicle for connecting with others and for expressing oneself, but can also present problems for the user and be a source of stress.

Problems arising from a trainee's use of social media usually result from poor judgement regarding information available in public versus private spheres. Common issues include breaches of patient confidentiality, defaming colleagues, disclosing personal information inappropriately, or blurring boundaries between professional and non-professional relationships.

Social media can also be a means by which JMO managers or DPETs become aware that a trainee is experiencing difficulty. Trainees may post information relating to their emotional state or problems they are currently experiencing, or colleagues may raise concerns from reading posts by the trainee.

Resource: *Social Media and the Medical Profession: A guide to online professionalism for medical practitioners and medical students.* A joint initiative of the Australian Medical Association Council of Doctors-in-Training, the New Zealand Medical Association Doctors-in-Training Council, the New Zealand Medical Students' Association and the Australian Medical Students' Association <ama.com.au/socialmedia>.

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How do prevocational trainees in difficulty present?

It is generally agreed that about 10% of trainees experience some difficulties during the prevocational years. Most problems, when appropriately identified and managed, can be resolved by the DPET working with the trainee.

About 3%–5% of trainees may have ongoing difficulties, requiring further intervention or referral to the human resources manager in the health service. The following list is not all-inclusive but gives some of the common ways in which prevocational trainees experiencing difficulties may present.

Work performance

- not getting through workload compared with peers
- lateness
- absenteeism
- poor clinical skills compared with peers
- poor English language skills
- poor communication skills
- failure to perform tasks as directed
- departure from protocols and safe procedure guidelines
- overworking — working back when not rostered on
- ongoing prescribing errors
- failure to seek advice appropriately

Professional conduct and behaviour

- lack of insight into underperformance
- work avoidance
- aggressive behaviour
- bullying, demeaning or undermining others
- sexual harassment
- unethical or dishonest behaviour
- alcohol or drug abuse
- practising beyond capabilities
- inappropriate interactions with staff and patients

Physical and mental health issues

- excessive tiredness
- physical illness
- weight loss/gain
- eating disorders
- anxiety, irritability or depressed mood
- withdrawal or self-neglect
- disturbed behaviour
- failure to seek advice appropriately
- drug or alcohol dependence
- lack of insight into limitations

Other

- signalling an intention to resign or leave medicine

Referral sources

Many people are potential sources of information about a trainee in difficulty. The initial information you receive and the direction of your initial assessment will depend to some degree on the source of the referral.

Confidentiality should always be maintained — this applies to anybody who gathers information about a trainee in difficulty, before or after a referral.

Where possible get information directly from the source, not by second-hand report.

Term Supervisor

- Many concerns will come directly from the term supervisor, although usually someone else has spoken with the term supervisor first (eg, nurse, registrar).
- Complaints are usually about clinical performance, time management or other professional issues.

Registrar

- Complaints about time management, prioritising work tasks, clinical competence (not recognising or attending to a sick or deteriorating patient), incomplete work (follow up of investigations, consults), poor decision making.
- The registrar has often already approached the trainee informally to address issues by the time they speak with the DPET or term supervisor.

Nurse Manager

- Complaints about incomplete work (admissions, discharge summaries), being dismissive of requests to review patients, not being contactable or responsive to beeper, having poor interactions and communications with nursing staff, not being a “team player”.

Trainee (self)

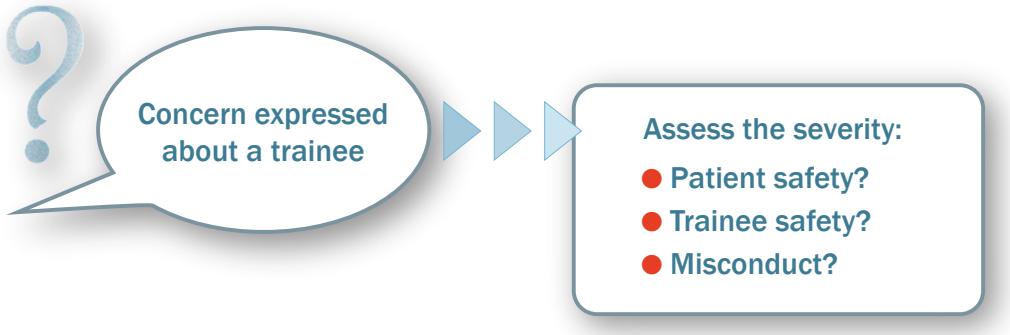
- Trainees who self-refer may have significant distress.
- Many trainees who experience difficulties do not identify themselves as having issues, but may present with a complaint about a related matter, such as workload or supervision by a registrar or term supervisor.

Trainee colleague

- Peers are often very adept at identifying colleagues who are experiencing difficulties.
- Colleagues may complain about a trainee leaving routine work for other doctors, poor clinical handover, or increased sick leave absences.

Patient or patient’s relatives

- It is reasonably infrequent that a patient or relative directly complains about a trainee, so consider it a red flag if it occurs.
- Local complaints usually involve poor communication skills or professional behaviours.
- Complaints to the Medical Board and Health Care Complaints Commission by patients and relatives usually reflect concerns about clinical management. These complaints often also involve inadequate communication.



Assessing the severity of the situation

Assessing the severity of the situation will guide important decisions on:

- timeliness of intervention (today, within the next few days, within a week)
- need for external advice (from medical administration, human resources)
- need for referral (for example: general practitioner, psychiatrist, psychologist)
- level of documentation required.

Most situations involving trainees will be of low level concern and may only require discussion with the term supervisor and the trainee, but any risks to patient safety, risks to trainee safety, or allegations of criminal conduct require immediate action and referral.

Flags for immediate action and referral

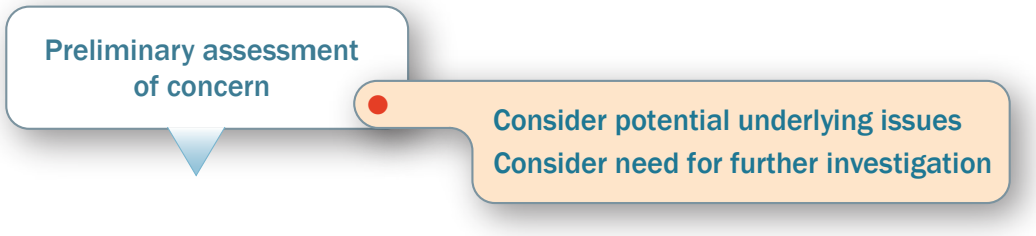
- ! Patient safety (actual act or near miss involving trainee)
- ! Trainee safety (suicide risk or significant impairment)
- ! Allegations of criminal conduct (eg assault) or professional misconduct

Some questions to ask

- Has the trainee's behaviour caused serious harm? (Patient safety)
- Is the trainee at risk? (Trainee safety)
- Have allegations been raised that might represent a criminal act or misconduct? (Sexual harassment, working while intoxicated)

Remember

- In high risks situations involving harm to patients or trainees, JMO managers and DPETs may also need support and the opportunity to debrief.



Underlying causes

A former DPET provided this gem for thinking about underlying causes:

Remember the "Bs"

Blues

Booze

Birds/Blokes

Banks

Bilingual

Babies

Bonkers

Websites

- The student and junior doctor in distress <www.mja.com.au>
- Healping a trainee in difficulty. A five point plan for medical educators <www.oxforddeaneryedu.org.uk/edsuphelpingtid.pdf>
- Doctors' health and wellbeing <www.bma.org.uk>
- Are you OK? A website to promote the health and wellbeing of junior doctors <jmohealth.org.au>

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What are the potential underlying issues? (trainee, supervisor, system)

Competence

- deficient knowledge
- poor communication
- poor time management
- poor record-keeping or documentation

Lifestyle issues

- ill health
- poor general health
- fatigue
- unhealthy lifestyle — poor nutrition, lack of exercise, lack of relaxation and recreation

Extrinsic factors

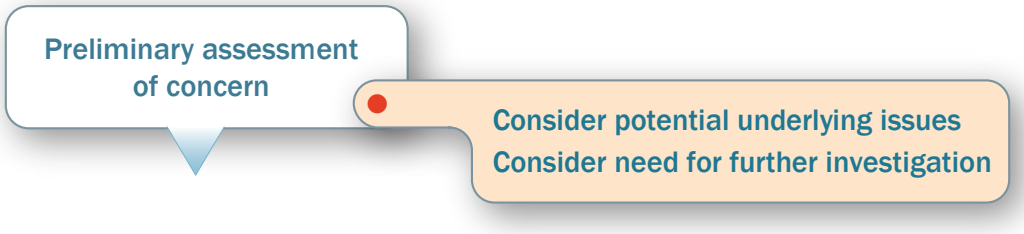
- relationship issues
- accommodation and transport difficulties
- pregnancy and parenting
- financial issues
- visa and migration issues
- language and cultural issues

Psychological issues

- heightened stress reaction or burnout
- lack of self confidence
- highly self critical
- perfectionist or obsessive tendencies
- heightened distress over patient death
- detachment, loss of empathy
- poor attitude
- lack of insight
- lack of motivation
- emerging or existent mental illness (anxiety, depression, bipolar disorder, anorexia)
- alcohol or drug abuse
- difficult personality traits

Work environment

- unfamiliar discipline of being a hospital employee, not a student
- junior status: having to respond to the immediate demands of other staff
- frequent transitions to new work environments
- interpersonal conflict within the team
- excessive workload
- inadequate support for medical and administrative tasks
- inadequate supervision and support
- inadequate role definition/orientation
- bullying or harassment
- sexual harassment



Preliminary assessment of concern

First you will need to decide whether or not there is a problem. This will involve gathering some information and making some assessment of required actions.

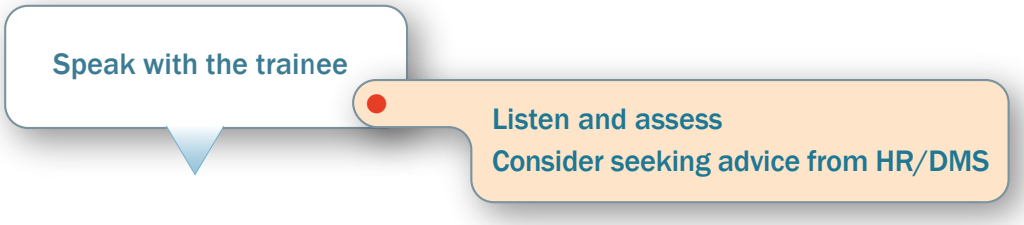
- Do not jump to conclusions or decide too early what the actual problem is.
- Stick to the facts — and get them directly from the source.
- Be circumspect with the number of people that you gather information from. Recognise that interviewing people will heighten their awareness of the trainee, which in turn could influence future interactions and perceptions. Information should always be collected and provided on a need-to-know basis.
- At the very least, discuss the issues with the term supervisor and whoever raised the original concerns.
- "You can't unknow what you know" — whenever you are gathering information, never accept someone telling you something "off the record". Accepting "off the record" advice may place you in the difficult position of not being able to act on critical information. One way of avoiding this is by stating the purpose of the discussion and making it clear that in your role as DPET you have a responsibility to ensure that concerns about trainees are followed up appropriately.

Gathering initial information: some basic principles

- Most of the concerns that are raised with DPETs can be managed without involving anyone beyond the trainee and the original referral source.
- Information needs to be gathered with due regard to confidentiality, fairness and natural justice.
- The principle of fairness is that all parties involved in the process should be given the opportunity to provide their side of the story to an impartial person.
- The principle of natural justice is that the person investigating the incident should have no investment in or bias towards achieving a particular outcome.
- Always speak directly with the person who made the complaint (eg, if the term supervisor reports that the Nursing Unit Manager has complained about the trainee, then speak directly with the Nursing Unit Manager — never rely on information collected second or third hand).
- When the complaint is of poor work performance, determine specifically which aspects of performance are unsatisfactory (eg, time management, application of knowledge, communication).
- If calling a trainee to a formal meeting to discuss performance, 24 hours notice is appropriate.
- If a serious mental health issue is apparent on initial investigation, immediate action will be required (eg, referral to family physician or psychiatrist).
- If the situation is assessed as severe with regard to patient safety or conduct issues, a more formal process is required from the outset and you should seek advice from the Director of Medical Services and your Human Resources department.
- The trainee must have the opportunity to be accompanied by a support person during formal investigative processes.

Resources

- NSW Health website: <www.health.nsw.gov.au>
  NSW Health Policy Directive: Complaint or Concern about a Clinician — Principles for Action (PD2006_007)
- ACT Health website: <health.act.gov.au>
  ACT Health Central Policy and Plan Register
- NSW Ombudsman Factsheets: <www.ombo.nsw.gov.au>
  - Investigation of complaints
  - Natural justice/procedural fairness



Speaking with the trainee

Speaking with the trainee at an early stage is essential:

1. To act in accord with the principles of natural justice and procedural fairness.
2. To help you gather the information you need to make an assessment.
3. To give the trainee the opportunity to respond to and resolve the issue before it progresses any further. In most cases, speaking with the trainee will be the most effective intervention that you will undertake in resolving the problem.

Ensuring natural justice and procedural fairness:

- The trainee has a right to know within a reasonable timeframe that a concern has been raised. Most matters should be raised within a day or so of the matter coming to your attention. Delaying the initial conversation with the trainee for too long significantly affects the capacity to effectively resolve issues. Timeliness is very important.
- The trainee has a right to know the details, including who has raised the concern. For most matters this is reasonable and will enable you to have a meaningful conversation with the trainee.
- The trainee has a right to respond to any concerns raised and present their side of the story. For this reason they require as much detail as possible about the concerns raised.
- The person responsible for the assessment or investigation should not have reached any conclusions regarding causation or outcome before speaking with the trainee and giving them an opportunity to explain their side of the story.
- The person responsible for the assessment or investigation should identify any potential conflicts of interest or sources of bias before commencing an assessment or investigation. Human Resources advice should be sought in cases where a conflict of interest is identified.

Resource

- A “Record of meeting with prevocational trainee” form is available on page 36.

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The quiet chat*

*Adapted from the *Teaching on the Run: Junior Doctor in Difficulty* module.

Plan

- Pick an appropriate place and time (private and planned).
- Decide what needs to be covered at the initial meeting.
- Have relevant information handy.
- Think about possible solutions before the meeting.

The interaction

- Put the person at ease. Establish rapport.
- Explain the purpose of the meeting — provide details of the concerns raised.
- Listen to the trainee's side of the story.
- Gather information and clarify any uncertainties.
- Focus on communication.
- Use open ended questions. Encourage the other person to talk.
- Actively listen. Listen for any underlying needs. Give verbal and non-verbal feedback indicating comprehension.
- Look for disparity between verbal and body language.
- Be aware of your body language. Maintain appropriate eye contact.
- Acknowledge the trainee's thoughts and feelings: "You are frustrated", "That's another way to look at it". You can validate feelings without agreeing with the viewpoint.
- Be willing to give praise where it is due.
- Clarify issues — repeat back and/or paraphrase. "It sounds like what you are saying is … Is that what you mean?"
- Be prepared to negotiate on some difficult issues.
- Be honest with feedback. Be direct and constructive with observations and suggestions.
- Set short term, achievable, measurable goals.
- If the need for referral to an expert mental health practitioner is immediately evident, assess the urgency.
- Document the important aspects of the discussion and outcome.
- Agree on a time and place for the next meeting.
- End the meeting on a positive note.
- Maintain confidentiality.

Avoid

Avoid responding to emotional cues with the following behaviours, which may block further disclosure:

- Offering advice and reassurance before the main problems have been identified.
- Ignoring psychological or emotional distress.
- Explaining away distress as normal.
- Switching the topic.
- "Jollying" someone along.

Identifying the problem and the potential solution

Problems relating to the prevocational trainee can be grouped into four broad categories:

1. Clinical performance problems

- Knowledge deficit
- Difficulty with procedural skills
- Time management issues
- Clinical decision making
- Global underperformance.

2. Behaviour and attitudinal problems

- Behavioural issues and unprofessional conduct
- Lack of insight frequently compounds issues and hampers effective management.

Derailing personality traits are described on page 17 and in the case studies that follow.

3. Communication problems

- General interaction with patients and families
- Non-English speaking background (English as a second language)
- Clinical communication — case presentations
- Clinical communication — telephone consultations
- Clinical communication — clinical handover
- Written communication — medical record
- Special skills requiring development.

4. Health problems

- Acute or chronic physical health problems
- Emerging or chronic mental health problems
- Substance dependence/abuse.

Other extrinsic issues

In some cases, the issue may be related to the training position or the broader system (see the list “Work environment” on page 10). As a DPET you will have a role in addressing environmental and systemic factors that affect the ability of trainees to do their work, usually with the advice and support of the General Clinical Training Committee or Network Committee for Prevocational Training.

Hints

The general approach rests on three principles:

1. Patient safety comes first.
2. Trainees require supervision and support — they are not registered to practice unsupervised, nor do they have the skills and experience required.
3. Prevention, early recognition and early intervention are the preferred approach.

Punitive approaches are rarely indicated and only when intentional violations have occurred. See the section on disciplinary processes (▶ p32).

Think about the basic self-care issues:

- Nutrition
- Rest
- Exercise
- Work–Life balance

All prevocational trainees should be encouraged to have their own general practitioner and should seek early advice from their GP in the event of emerging health issues.

! Suicide is a real problem — early intervention and referral are critical if you are concerned about the trainee's safety.)

Resources

- Australian Curriculum Framework for Junior Doctors <curriculum.cpmec.org.au>
- The following resources were developed by the UK National Health Service for the UK context, but still provide a useful overview of the management of trainees in difficulty:
  - Healping a trainee in difficulty. A five point plan for medical educators <www.oxforddeanerycdu.org.uk/edsuphelpingtid.pdf>
  - National Clinical Assessment Service (NCAS) NHS UK <www.ncas.npsa.nhs.uk>.
- *Further reading:* Hays BC, Jolly BC, Caldon LJ, McCrorie P, et al. Is insight important? Measuring capacity to change performance. *Medical Education* 2002; 36 (10): 965-971.

Derailing personalities

Initial differential diagnosis involves dissecting extrinsic factors in the term itself from intrinsic personality factors:

- The Bs: Blues, Booze, Birds/Blokes, Banks, Bilingual, Babies, Bonkers
- Workplace systems or individuals
- Perception or reality?

Some common patterns emerge:

Emotional instability: reduced emotional resilience

Underlying issues:

- Sick or depressed
- Oversensitive to criticism
- Poor perception of work place
- Disengagement or avoidance
- Fearful or anxious
- "Unable to manage"
- Poor job fit.

Action:

- Consider providing a mentor or referral to a psychologist
- Provide support but do not reward "sick role"
- Provide defined time-out then re-challenge
- Offer career counselling.

Poor teamwork and poor insight

Underlying issues:

- No self-awareness
- Often perceived as arrogant
- Cultural medical model
- Blames others
- Disruptive to the team
- Reluctant to participate outside "usual" duties
- Dishonest
- Manipulative
- Highly intelligent.

Action:

- Needs insight into own performance
- Provide evidence of their effect on performance of others
- Demonstrate advantages of modifying approach
- Specific behaviours may need performance management
- Document issues.

Perfectionism

The perfectionist group has a common group of personality traits in medicine.

Underlying issues:

- Overwhelmed and overworked
- Time management difficult: have to do everything perfectly
- Anxious
- Self-blaming
- Very compliant
- Dependent on approval of others.

Action:

- Reality check: the perfect is the enemy of the good
- Set boundaries
- Promote self care
- Give permission to switch off
- Structure lifestyle — leave work at work
- Consider referral for cognitive behavioural therapy with a psychologist.

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Case study 1: Depressed intern

Concern expressed about a trainee

JMO Manager rings you (the DPET) concerned about a trainee in a busy vascular surgery term who "goes missing" during the day. She has rung in sick several times, but now at times is not attending without alerting the JMO Unit or the clinical team.

Preliminary assessment of concern

Registrar confirms instances where he did not realise that the intern was off sick until the nursing staff rang him directly for advice.

After further discussion, you establish that the intern has good clinical and technical skills but her work practice features staying late, starting early and an inability to complete most of the tasks assigned to her at the morning ward round: she seems unable to make decisions on even trivial matters.

Speak with the trainee

When initially spoken to, the trainee states that she was going to come and see you as she had decided to defer the rest of her intern year until she felt more "on top of things".

She tells you that she frequently feels flat and immobilised and even finds it difficult to get up to go to work or to notify work when not attending. She has sought help from her GP but is reluctant to seek psychiatric referral. However, she would like you to speak to her GP. No external factors apart from new work responsibilities are identified.

Further investigation

You confirm dates where she did not attend and align with medical certificates and calls to the team re illness. With permission, you liaise with her GP, then discuss with JMO Manager and Director of Medical Services how to keep her on her team without putting patients at risk (increase supervision in this term and next term allocations).

Agree action plan and review date

Implement action plan

Vascular surgical team is rearranged so that there is more involvement of the second RMO in the team.

Trainee agrees to weekly meeting with the DPET and also to weekly review by the GP. If there is no improvement in clinical performance over the next two weeks under care then further action is required. Psychiatric consultation is again recommended.

Review

At review, the need for psychiatric guidance and sick leave is discussed. You recommend appropriate care and advise her to self-report to the Medical Council of NSW to ensure a supportive response (see page 31).

Case study 2: Tearful trainee

Concern expressed about a trainee

A PGY2 trainee presents to you (the DPET) for the third time, tearful and stating that she has been slighted by nursing staff on ward, then treated dismissively by radiology staff and now by the JMO management unit. You seek permission to discuss the issue initially with the JMO management unit.

Preliminary assessment of concern

You phone the JMO Manager, who states that trainee has been taking frequent sick leave. Some of her colleagues have complained to the JMO Manager that while she has been ringing in sick, she has refused to do a replacement shift for the trainee called in to relieve her.

The trainee has also requested additional leave to travel overseas on short notice, suggesting indirectly that she will resign if leave not granted, saying “locum shifts are much more profitable”. Trainee has already been promised a training position in her specialty of choice.

JMO management staff report that the trainee has some difficulties getting along with colleagues, who are becoming unwilling to assist her, claiming that she frequently spends time in RMO quarters speaking to friends and family on her mobile, and that she frequently leaves early after passing on work to evening JMOs.

Speak with the trainee

You gently explore reasons for sick leave to exclude extrinsic causes of coping difficulties, then discuss more functional ways of smoothing relations with colleagues and staff.

The trainee is referred for psychological therapy as her distress is evident.

Further investigation

You explore the truthfulness of comments relating to professional behaviour and ensure clinical competency and patient safety. You judiciously seek the views of supervisors, senior resident and registrar and find polarised opinions. Senior clinicians are impressed by the trainee’s clinical performance. Senior resident and registrar find difficulty managing her emotional state.

Agree action plan and review date

You arrange a follow-up appointment with the trainee for two weeks after her visit to a clinical psychologist and when her mid-term assessment will have been completed.

Review

On review, the trainee acknowledges that some of her difficulties involve issues that she is working through with her psychologist. You discuss her professional behaviour and develop a performance plan to be monitored with the assistance of term supervisors.

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Case study 3: Global deficits, lacking insight

Concern expressed about a trainee

You meet one of the surgeons in the car park who insists that his new intern hasn't got a clue and that he would be better off without him on the team. He tells you that his unit is too busy, the patients too sick and that he should only have the best trainees allocated to his team. He expects you to do something immediately.

Preliminary assessment of concern

You speak with the surgical registrar and the Nursing Unit Manager of the ward. They confirm that the intern frequently leaves procedures to the after-hours residents, cannot prioritise clerical tasks, and has failed to detect significant changes of condition in his patients by not noting nursing staff observations. He seems slow with placing IV cannulas and prescribing medications.

Speak with the trainee

The trainee started mid-year, in Term 3, due to delayed graduation. He feels that he is doing a "paperwork" clerkship, but that he is applying the diligence he feels is necessary to the task and cites the fact that he works back every night as clear evidence of his performance.

He blames others on the team/ward for constant interruptions slowing him down and poor hospital systems in place for routine tasks. He is dismissive of the skills of the other staff and dismissive of your attempt to tease out the problems. He has no insight into the shortcomings described.

Further investigation

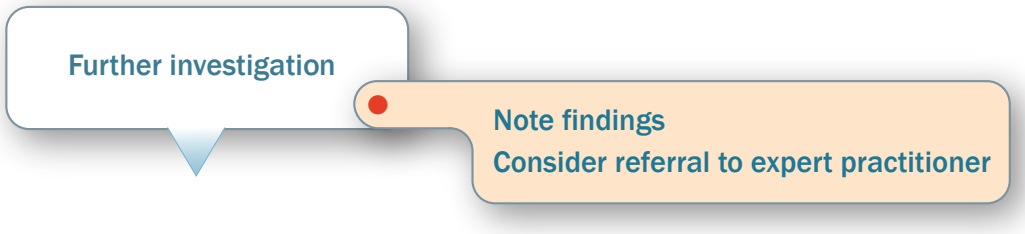
In your assessment you consider whether the unit is geared to support a PGY1 trainee. You have another discussion with the term supervisor and the surgical registrar. It emerges that the intern did not receive an appropriate orientation, particularly with regards to term expectations and resources available to assist, access to appropriate protocols or local practices.

When you have further discussion with the trainee, he confirms that he did not have orientation, nor indeed an appropriate hospital orientation. He did not have much experience before internship in cannulation or prescribing.

▶▶▶

▶▶▶ Case study 3: Global deficits, lacking insight (continued)

Agree action plan and review date	Discussion/reality check with realignment of short term goals. You arrange one-to-one reorientation with term supervisor, including providing the trainee with key review articles, protocols and brief higher level discussion of service goals and key indicators. One-to-one additional session with RMO who had previously done the term to give some additional handy hints and contacts. Access to instant coaching per phone agreed to by previous RMO whose current term will allow some interruption.
Implement action plan	Additional tutorial on prescribing issues (focusing on analgesia, gentamicin and insulin). The trainee is directed to review ECG online tutorials and RMO handbook chapters, with open book Q and A follow up with you. Sessions arranged in ED after hours to improve cannulation skills.
Review	Two weeks after interventions, feedback from the team is that his performance is improving. RMO reports that he is now acknowledging that perhaps he was not performing as well as he could and can see that he has made some improvement, largely attributed by RMO to successful term reorientation.



Principles of documentation

Only a minority of difficulties with prevocational trainees escalate to formal disciplinary processes, but effective management requires appropriate documentation from the earliest stages. Documentation improves continuity of management when the trainee changes rotations, avoiding duplication of effort and helping to ensure that problems are adequately addressed at an early point in the trainee's career.

Triage your documentation — with some adaptation, this is the same skill set as making a clinical record.

Low level concerns

These will be by far the majority of the issues that you deal with on a day-to-day basis.

- Diary entry
- Always record date, time and individuals involved
- Record telephone calls
- Record main discussion points
- Record agreed actions.

Medium level concerns

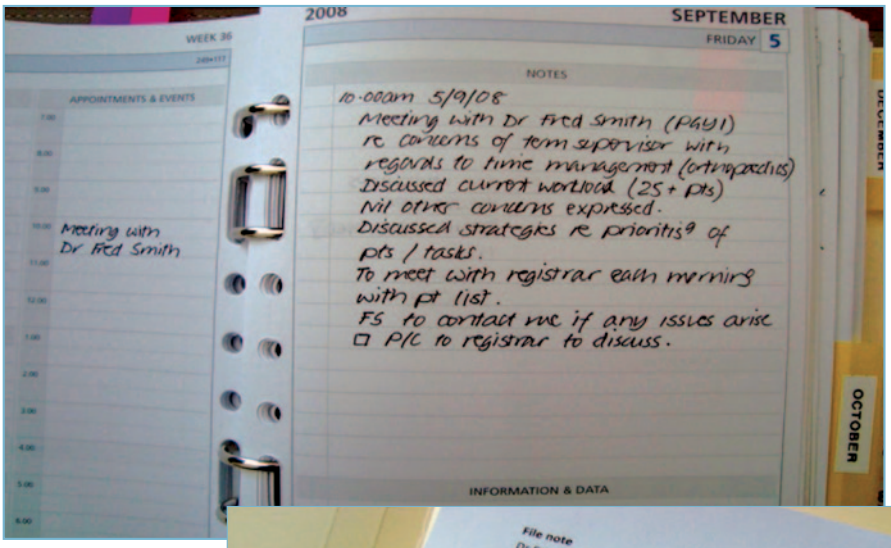
- File notes: required if you believe that the complexity of the situation requires more detailed notes or if there is a high chance of the matter proceeding down a more formal pathway
- Always record date, time and individuals involved
- Stick to facts and include a balanced account of meeting or telephone call
- Hint: use a Dictaphone to facilitate contemporaneous and accurate notes.

High level concerns

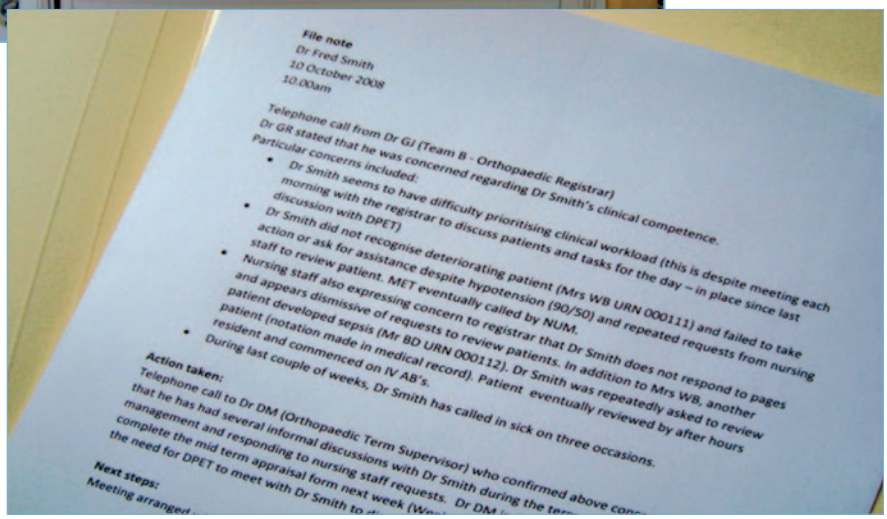
These are for serious allegations that from the outset may result in disciplinary or other formal action (eg, allegation of sexual harassment, misconduct, emerging severe psychiatric disturbance in the trainee).

- Documentation is very important because it becomes the evidence justifying actions taken in managing the situation.
- In all serious cases you will be seeking early advice from the Director of Medical Services and/or Human Resources. This will include advice regarding both the format and content of documentation, as well as where the documentation should be kept and for how long.

Notes and records



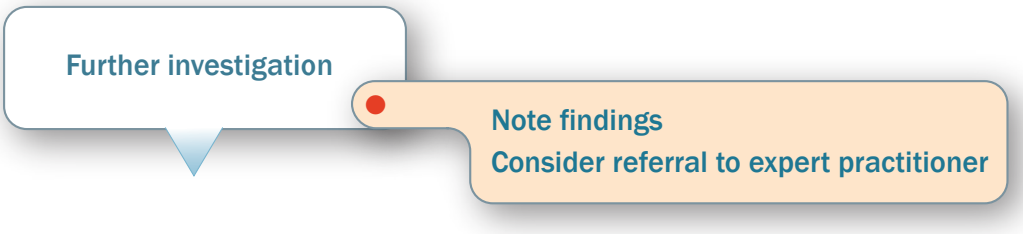
Use a diary entry for low level concerns.



Use a file note for medium level concerns.

Resources

- A ‘Record of meeting with prevocational trainee’ form is on page 36.
- A ‘Prevocational trainee action plan’ form is on the inside back cover.



Referring the trainee

The role of the DPET is support and advocacy. The DPET is not the treating doctor, formal counsellor, or disciplinarian. In some instances, the DPET will be required to refer the trainee for further assessment or assistance.

All prevocational trainees, as with all doctors, should be encouraged to have their own general practitioners and to seek early advice should health or stress issues arise.

Referrals to GPs and psychiatrists:

- Not all doctors are comfortable treating other doctors and it may be useful to develop a list of local GPs and psychiatrists who are willing to treat doctors.
- They will need to have a capacity and willingness to review trainees urgently. This generally means being able to see them during lunchtime, after hours or at short notice.

Referral to psychologists:

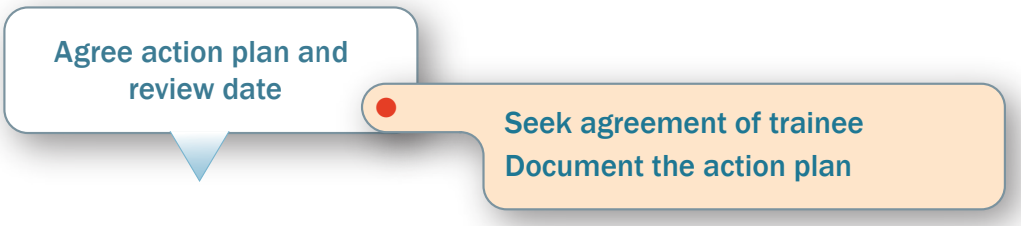
- Establish a list of contacts of local psychologists and counsellors who are experienced in treating doctors.

Employee Assistance Program (EAP):

- All employees, including prevocational trainees, are able to access confidential counselling through the EAP provided by NSW Health. For further information refer to your local human resources department.

Resources

- A form for recording your local referral contacts is on page 35.



Developing and implementing an action plan

Once concerns regarding a prevocational trainee have been raised and investigated, the DPET will generally be responsible for coordinating an action plan to address identified issues. Early identification of a trainee in difficulty and effective intervention at this stage may well prevent issues from escalating.

The primary aim is to provide support to the prevocational trainee and remedial action to re-establish appropriate levels of performance.

One means of support is providing a clearly articulated action plan. A suggested proforma of an action plan is provided on page 36.

A documented action plan is intended to support the prevocational trainee and address the issues that have been raised by providing clear expectations regarding actions, responsibilities, expected outcomes and review dates. Such an action plan should be developed in consultation and agreement with the prevocational trainee and a copy should be provided for them.

When developing an action plan, include review dates to ensure that appropriate assessment of progress is made and that any other required actions are identified.

Action plan: commonly used strategies

- Quick fixes:
  - a more thorough orientation to the term can repair a number of difficulties by realigning the expectations of supervisor, registrar and trainee
  - a quiet chat by the DPET with the term supervisor or the registrar about increased support and supervision can alleviate distress
  - providing a helpful term description and practical manual
  - discussion with a recent successful trainee can identify tips for success in the term, such as efficient practices or good uses of information technology.
- Frequent, thorough and immediate feedback on tasks including medical record charting, prescribing, letters, handover communications.
- Action to correct knowledge deficits:
  - recommending specific texts and review articles
  - ensuring easy access to helpful tools, including handbooks, protocols and the clinical information access portal (CIAP) (particularly for safe prescribing).
- Targeted supervision:
  - direct assistance with time management, such as prioritising of tasks with the registrar
  - prompting the trainee to carry their patient list and details and relevant referral forms and prescribing guidelines with them
  - prescribing review (usually with registrar), ECG review, chest CXR review.
- Regular review with DPET to ensure these interventions are taking place and are effective.
- Reduction in overtime or rostered hours.
- Buddy system.
- External courses.
- Allocation to specific terms (with a supportive Term Supervisor who has capacity to assist).
- Supernumerary position in specific terms, whenever patient safety is potentially an issue.
- Other support strategies
  - communications workshops
  - psychological support or counselling
  - referral (GP, psychiatrist, physician)
  - career counselling or assessment by an occupational psychologist.

Review

An action plan for managing a trainee in difficulty must include a plan for reviewing the success of the intervention. The action plan should state the intended outcomes, which should be *Specific, Measurable, Achievable, Relevant and Timeframed* (SMART). On the review dates set in the action plan, progress towards the intended outcomes should be assessed. On review, the action plan might need to be amended or extended.

If a trainee in difficulty cannot be managed successfully by the DPET with the cooperation of the trainee, further referral may be required.

Roles and responsibilities of others

There are processes and procedures for dealing with trainees in difficulty within every hospital and local health district.

There are several individuals who may become involved when concern is raised about a trainee. Given the variation in organisational structures, it is important that each DPET identify local resources. There is always someone to ask, even about low level concerns.

Medical administration

There is usually a senior doctor responsible for the line management of medical practitioners within the organisation. Generally named Director of Medical Services or Director of Clinical Services, this doctor has responsibility for managing performance issues of medical staff.

Most hospitals have a General Manager. General Managers are usually non-medical, but have a good understanding of local policies and procedures and can provide advice.

When a trainee is experiencing difficulties that significantly affect their work performance, the DPET will need to contact medical administration who will provide assistance by detailing the process to be followed. Possible pathways include sending the trainee to Employee Assistance Program advisors or following through on a disciplinary pathway.

If there is a concern for patient safety, the doctor can be stood down while claims are being investigated.

Human resources

All public health organisations have a workforce development unit which includes human resources (HR) staff. HR personnel can provide advice on industrial and other legal matters relating to employment. They should always be consulted in disciplinary matters or if you are unsure how to proceed. Any allegations of bullying, sexual harassment, or breach of code of conduct should be referred to HR for advice.

When seeking advice from HR, record the information as you would in any consultation; the person, their position, the date and time of the discussion and the main discussion points. It helps to identify the seniority of the person you are dealing with. If you are not comfortable with the advice given, seek advice from a more senior person. Given the intersection between “trainee” and “employee”, some of the issues can be quite complex and you will need advice from someone who is experienced in dealing with medical staff.

Network Committee for Prevocational Training

All prevocational training networks in New South Wales and the Australian Capital Territory have a network committee responsible for issues across the network, including managing trainees in difficulty. Membership is made up of the Director of Medical Services, DPETs and others involved in education and training.

Generally, issues should be dealt with on a need-to-know basis. Most trainee matters can be discussed in a de-identified way, but remember that if a trainee in difficulty is being rotated to another hospital, that hospital needs to be aware of ongoing issues. Similarly, a new term supervisor needs to be aware of any ongoing issues.

Deciding when to inform others is always difficult. Patient safety is the paramount consideration. Committee members need to be mindful of confidentiality requirements and the sensitive nature of the discussions. Wisdom and experience are critical to effective intervention. Seek advice from an experienced DPET in the network or beyond.

Clinical Governance Unit

All local health districts have Clinical Governance Units responsible for managing (among other things) complaints and concerns about clinical performance. The Director of Clinical Governance (usually a medical practitioner) can also be a source of advice — usually through the senior medical manager.

Refer to the medical management model developed by NSW Health Quality and Safety Branch, and see the NSW Health guidelines *Complaint or concern about a clinician* <www.health.nsw.gov.au/policies/gl/2006/GL2006_002.html>.

Role of Medical Board and AHPRA

The Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Board of Australia (MBA) have as their primary objectives protection of the public and maintenance of the highest possible standards of medical care.

AHPRA is the responsible authority for granting medical graduates a provisional registration, and for granting general registration at the completion of a satisfactory internship. The MBA has set national standards for internship, which include:

- Evidence of satisfactory completion of at least 47 weeks equivalent full time experience as an intern in supervised clinical practice completed in approved hospital, general practice or ambulatory locations. The 47 weeks of experience must be completed within a period of no more than three years. It excludes annual leave but may include up to two weeks of professional development leave.
- Interns are required to perform satisfactorily under supervision in the following terms:
  - A term of at least 8 weeks that provides experience in emergency medical care. Generally, this is a term in emergency medicine or select general practices with exposure to emergency medicine. Not all general practice posts will meet these requirements. [In NSW, all interns are given a 10-week emergency department training term.]
  - A term of at least 10 weeks that provides experience in medicine.
  - A term of at least 10 weeks that provides experience in surgery.
  - A range of other approved terms to make up 12 months (minimum of 47 weeks full time equivalent service). These terms provide experience in additional areas such as but not limited to aged care, anaesthesia, general practice, medicine, palliative medicine, psychiatry, rehabilitation medicine and surgery.
- Terms must be accredited against approved accreditation standards for intern training positions by an authority approved by the Board. (This is HETI in NSW and the ACT).
- There needs to be written confirmation that the applicant has met the above requirements including:
  - Satisfactory term supervisor reports.
  - An overall satisfactory rating awarded by the Director of Training, Director of Medical Services or other person authorised by the hospital and acceptable to the Board as appropriate to sign off on the satisfactory completion of the internship.

If an intern is underperforming for any reason and his/her progress to registration will be delayed, AHPRA should be informed. This is so that AHPRA is aware of the situation if and when the intern applies for a renewal of provisional registration. The appropriate contact is Kim Ayscough, State Manager, AHPRA, GPO Box 9958, Sydney 2001.

However, AHPRA does not play a role in remediating or counselling interns, or in arbitrating between interns and employers. In this respect, the Medical Board of Australia is unlike the previous Medical Board of New South Wales.

Some of the functions of the Medical Board of New South Wales continue in the Medical Council of New South Wales. If any doctor, including any intern, is impaired (eg, has a mental or physical health issue that affects his or her ability to practice), or if there are issues amounting to professional misconduct, the Medical Council of NSW is the appropriate authority to be informed, and it will investigate and recommend appropriate actions. Contact the Medical Council of New South Wales, PO Box 104, Gladesville NSW 1675, (02) 98792200, mcnsw@mcnsw.org.au.

Sometimes an intern has general performance issues which mean that progress to registration is delayed or unlikely to be achieved, but which do not amount to an impairment or professional misconduct. This is not a matter for the Medical Council of NSW. As far as possible, these underperformance issues should be dealt with by the employer, but the Prevocational Training Council at HETI is available to advise on the appropriate referral body. It can be contacted via the Prevocational Program Coordinator, HETI, Locked Bag 5022, Gladesville 1675; 9844 6551; info@heti.nsw.gov.au.

Performance management may require slower progress through training. An internship is normally for one year, but AHPRA grants provisional registration to interns for two years, and a few trainees may take that long to complete internship. It is worth noting that dismissing an intern before completion of internship will not result in that person losing provisional registration. AHPRA will not normally review provisional registration until the end of two years. Decisions about employment, therefore, are not coupled with decisions about registration.

There cannot be a fixed rule about how much time an underperforming trainee should be given to improve performance. The answer depends on the nature and depth of any difficulties, the contributory circumstances, and the trainee's potential for improvement. It is the employer's responsibility to make employment decisions based on fairness to the trainee, safety for patients and the needs of the health service.

Disciplinary processes

Most problems involving prevocational trainees will be managed effectively through informal processes, but occasionally disciplinary processes will be necessary to address serious or ongoing performance problems, misconduct or inappropriate workplace behaviour. All matters involving prevocational trainees that are likely to result in disciplinary action should be referred to the medical administration and human resources.

Human resources or medical administration will be primarily responsible for most formal disciplinary processes involving prevocational trainees. The DPET's role is generally to provide support or advocacy for the trainee.

An intern who is not performing at a satisfactory level must not be recommended for general registration.

A small number of trainees will be judged incapable of achieving the standard required to continue in medical practice. The progress of trainees and the process of remediation should be thoroughly documented before any decision is taken. The management of a trainee in difficulty involves issues under employment and industrial law and it is critical that the Director of Medical Services and HR department are involved early in the process if there is a possibility of disciplinary measures being required. The decision to terminate lies with the local health district chief executive.

DPETs should therefore be familiar with the Policy Directive *Disciplinary Process in NSW Health — A Framework for Managing — NSW Department of Health* [PD2005_225] and in particular its *Appendix C: Checklist — Key stages in managing the disciplinary process*.

Resources

- A form for recording your local adminstrative contacts is on page 34.

Relevant NSW Health Policies <www.health.nsw.gov.au>:

- Code of Conduct — NSW Health [PD2005_626]
- Disciplinary Process in NSW Health — A Framework for Managing — NSW Department of Health [PD2005_225]
- Bullying — Prevention and Management of Workplace Bullying: Guidelines for NSW Health - NSW Department of Health [GL2007_011]

Relevant ACT Health Policies

- ACT Health Code of Conduct <http://health.act.gov.au>

Further reading

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- Hurwitz TA, Beiser M, Nichol H, et al. Impaired interns and residents. *Can J Psychiatry* 1987; 32: 165-169.
- Lake FR, Ryan E. Teaching on the run tips 11: the junior doctor in difficulty. *Med J Aust* 2005; 183: 475-476. <http://www.mja.com.au/public/issues/183_09_071105/lak10465_fm.html>
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- Postgraduate Medical Education Councils Conference Proceedings. The student and junior doctor in distress — "our duty of care". *Med J Aust* 2002; 177 (Suppl): 1-32.
- Willcock SM, Daly MG, Tennant CC, et al. Burnout and psychiatric morbidity in new medical graduates. *Med J Aust* 2004; 181(7): 357-360.

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Local administrative contacts

- Director of Medical Services (or equivalent):

Name: _____

Number: _____

Mobile: _____

- Human Resources contact:

Name: _____

Number: _____

Mobile: _____

- Chair of the Network Committee for Prevocational Training (NCPT):

Name: _____

Number _____

Mobile _____

- Clinical Governance Unit:

Name _____

Number _____

Mobile _____

- Other local resources:

Name _____

Number _____

Mobile _____

Name _____

Number _____

Mobile _____

Local referral contacts

- General practitioners

Name: _____

Address: _____

Number: _____

Mobile: _____

Name: _____

Address: _____

Number: _____

Mobile: _____

- Psychiatrist

Name: _____

Address _____

Number _____

Mobile _____

- Psychologist

Name _____

Address _____

Number _____

Mobile _____

Employee Assistance Program Contact Details

Name _____

Number: _____

Referral

- Doctors' Health Advisory Service <dhas.org.au>
- NSW HETI <www.heti.nsw.gov.au>
- Medical Council of NSW <mcnsw@mcnsw.org.au>

Record of meeting with prevocational trainee

The principles of fairness, natural justice and confidentiality should apply in all dealings with prevocational trainees experiencing difficulties. Appropriate documentation, made contemporaneously, supports these principles.		
Trainee's name	Level	Date
Current rotation	Term supervisor	
Meeting convened by		
Notes taken by		
Purpose of meeting		
Issues		
Actions		
Follow up		

Prevocational trainee action plan

Trainee name	Level	Current rotation	Term supervisor	
Person completing this action plan			Plan date	Review date

Agreed actions	Expected outcome*	Person responsible	Review date
1			
2			
3			
4			

Referred to network committee:	☐ Yes	☐ No	Referral for specialist assistance:
Involvement of DMS	☐ Yes	☐ No	
Involvement of HR	☐ Yes	☐ No	

Signed:

Trainee	Term supervisor	DPET
Date	Date	Date

** Ensure that planned outcomes are "SMART": Specific, Measurable, Achievable, Relevant, Timeframed.*
Ensure that the trainee has adequate support.

Trainee in difficulty

a management guide for Directors of Prevocational Education and Training 2nd edition

Being a junior doctor in training is challenging. Some will have trouble adjusting to the pressures of the role.

This practical handbook gives advice on managing junior doctors (prevocational trainees) who are experiencing difficulties.

It provides information about:

- how trainees experiencing difficulties present
- the range of underlying issues
- assessing the severity of the problem
- speaking to the trainee and other key individuals
- formulating, implementing and reviewing an action plan to address identified issues.

The handbook includes a guide to relevant public sector policy frameworks, plus readings, websites and other useful resources. The second edition has been updated to consider the role of the Medical Board of Australia in medical registration.

This book has been written by experienced Directors of Prevocational Education and Training and Directors of Medical Services to assist others navigate the complex territory surrounding prevocational trainees in difficulty.

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