Trainees with Problems$^1$

An ANZCA Education Module

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$^1$ Sources of material for this module are:
Janower M. The Problem Resident. Acad Radiol 2000;7:393-4
Kahn N. Dealing with the Problem Learner. Fam Med 2001;33(9):655-7
Shapiro, J. Parallel process in the family medicine system: Issues and challenges for resident training. Fam Med 1990;222:312-9
Steinert Y. & Levitt C. Working with the “Problem” resident: Guidelines for definition and intervention. Fam Med 1993;25:627-32
Yao, D. & Wright. S. National survey of internal medicine residency program directors regarding problem residents. JAMA 2000;284(9):1099-104
Guidelines for Assisting Trainees with Difficulties. ANZCA College Policy Document TE18
All Supervisors of Training (SOTs) will eventually encounter Trainees who are perceived as problematic or “difficult”. Indeed the difficult Trainee is the most common concern reported by most Supervisors within ANZCA and within other specialties (e.g., Janower 2000, Yao & Wright 2000). This module focuses upon problems that arise between teachers and learners. For the purposes of this module the “teacher” is a SOT or other instructor and the “learner” is a Trainee.

**Aim**

The aim of this module is to assist Specialists in their dealings with Trainees with problems.

**Objectives**

Completion of this module will assist Specialists to:

- Identify Trainees with problems.
- Define problems.
- Differentiate problems as being at the Trainee, teacher or system level.
- Design strategies to address problems.
- Implement appropriate interventions to address problems.
- Identify personnel to be involved in the intervention.
- Time the implementation of the intervention.

**Trainee Problems**

Typically problems exist because of a difference between a teacher’s expectations and a learner’s performance. Although the problems that arise from teaching Trainees are many and varied, they may be categorised (see Table 1).

*Table 1. The following table arranges typical Trainee problems into the categories used with In-Training Assessment.*

<table>
<thead>
<tr>
<th>Clinical Skills and Attitudes</th>
</tr>
</thead>
<tbody>
<tr>
<td>The learner may have adequate knowledge yet be technically unskilled.</td>
</tr>
<tr>
<td>The learner may be impaired by mental illness, substance abuse or other condition.</td>
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<tr>
<td>The teacher may be inflexible and unable to accept alternative techniques.</td>
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<table>
<thead>
<tr>
<th>Behavioural Skills and Attitudes</th>
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</thead>
<tbody>
<tr>
<td>The learner may be unskilled and/or inexperienced in relating to people, developing rapport and demonstrating empathy.</td>
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<tr>
<td>The learner may be insecure (perhaps manifested as hostility), overconfident, disorganised, dependent, or overworked.</td>
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<tr>
<td>External issues, such as economic and family concerns, may be manifest as conflict between teacher and learner.</td>
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</tbody>
</table>
Lack of awareness of different social and cultural backgrounds may lead to conflict between teacher and learner.

<table>
<thead>
<tr>
<th>Academic Skills and Attitudes</th>
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<tbody>
<tr>
<td>The teacher may have limited educational skills or teaching experience, despite being an excellent and successful medical practitioner.</td>
</tr>
<tr>
<td>The teacher may have unrealistic expectations of the learner.</td>
</tr>
<tr>
<td>The learner may be under-prepared for what is being taught.</td>
</tr>
<tr>
<td>The learner may acquire skills and knowledge comparatively slowly.</td>
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</tbody>
</table>

**Identifying Trainee Problems**

As with most medical conditions, the early identification of a problem usually minimises the negative impact of the problem and maximises opportunities for successful recovery. Furthermore, as in the effective treatment of medical conditions, establishing an effective intervention depends on accurately diagnosing the problem.

Always define tasks and the desired levels of performance clearly (so that the Trainee knows exactly what is required).

A key process is to identify and analyse carefully any differences which may arise between the defined task and the expected level of performance.

You may become aware that a Trainee is encountering a problem through instinct (e.g., a gut feeling arising from your experience), or by observation, verbal or written reports from office staff, patients, colleagues, an evaluation, or a particular incident.

**Exercise 1.**

Consider the following situations. Assign each problem to an appropriate category or categories described in Table 1.

a) A Trainee is not successfully demonstrating an understanding of a patient’s concerns.

b) A senior Specialist with many years clinical experience has recently been appointed to your teaching hospital. He is enthusiastic that the Trainees with whom he works are taught the clinical aspects of what he clearly knows so well. However, the Specialist appears to be labouring in his teaching.

c) A third year Trainee has several unexplained absences and a marked reduction in interest at work.

d) Office staff consistently report frustration when dealing with a particular fourth year Trainee.
e) You have received two complaints from patients about a Trainee. The Trainee is not allaying patient concerns about the planned treatment.

f) A highly respected teacher reports frustration with a Trainee because the Trainee is unduly dependent on the teacher to make decisions.

g) A Trainee is in a position where the performance expected is beyond his or her individual experience.

h) A second year Trainee has recently excelled in their Primary Examination, but appears to have a problem with office procedures.

i) A hitherto successful Provisional Fellowship begins displaying changes in behaviour, in particular agitation and mood swings.

j) One of a group of three Trainees does not seem to be able to master appropriate knowledge, skills or attitude as fast as their peers. However, they do eventually learn.

k) A second year Trainee has low levels of productivity despite working very long hours.

In general (Kahn, 2001) problems between teachers and learners may be identified by the teachers’ direct observation (especially for the problems relating to patients or learning). Problematic behaviour may be initially identified by other staff.

Specify the Contributing Factors

Although the Trainee is typically perceived as the “problem”, it may be that the teacher or the system has also contributed to (or even caused) the problem.

**Teachers**

For example, if a teacher cannot attain the expected ability of teaching, then the Trainee may be perceived as the problem. A teacher’s own level of educational experience, assumptions and expectations, personal attitudes, beliefs, stress and reactions to challenging situations (Steinert & Levitt, 1993) may all contribute to or cause problems at the teacher-learner interface.

Remember that the typical “teacher” undergoes many years of tertiary study and post graduate educational experience before becoming an effective teacher. A Specialist may not automatically be a talented teacher, even though they may be a talented clinician.

SOTs and other instructors are encouraged to undertake as much teacher and educational training as possible.

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Trainees are often not the sole source of a problem. The root of a problem may lie with the system or a teacher.
**Systems**
The systems that comprise the administration, procedures and day-to-day running of an organisation are often the source of problems. These can be minimised if a Trainee is provided with a comprehensive introduction and orientation to the systems within a department, hospital and organisation. Orientation should include what is expected of Trainees in terms of professional attitudes, rostering and work ethics as well as initiation in procedures and the workings of equipment.

Apparent training difficulties may be caused by system problems. Indeed, systems may manifest problems as training difficulties. For example, if a system assigns too much work and insufficient time to Trainees then problems will arise. Similarly a system that provides little positive feedback to Trainees, has unclear standards, nebulous responsibilities, or no effective administrative support, will generate problems that may be inappropriately attributed to Trainees.

An intervention will be unlikely to solve any problem that has not been accurately identified. Therefore Trainees, teachers and systems must all be considered as potentially contributing to problems.

**Exercise 2.**
**Scenario:**
Jo is a second year Trainee who has performed well during her previous rotations. You are Jo’s SOT and it has been brought to your attention that she has been skipping tutorials and has failed to see patients preoperatively on several occasions. Jo appears to be lacking in confidence, intense and seeking more reassurance from consultants than she ought to. Her current roster is heavy and two staff members feel that she is not performing as well as she used to.

Consider what aspects of the above scenario could reveal problems stemming from the:

1. Trainee?

2. Trainee’s teacher(s)?

3. System?
Steinert and Levitt (1993, page 628) report a Trainee exhibiting such behaviours. Upon investigation it was found that: “She was awed by her in-hospital responsibilities, and had difficulty balancing her responsibilities at home and at work. She was a mother of two young children, her husband was currently unemployed, and she was generally exhausted and overwhelmed. Her teachers, although sympathetic to her difficulties, felt that they had managed to overcome similar problems in the past, and wanted her to cope. Although they did not want to intrude into her private life, they also did not want to do her work for her, and they quickly seemed to feel as overwhelmed in working with her as she felt in the system. No support system for stressed Trainees was in place. Trainees could not easily change their schedule of rotations and little appreciation for working women was evident”.

Thus a significant component of “Jo’s problems” were in reality “system problems”.

**Potential Impact**

Difficulties experienced by a Trainee negatively impact upon the Trainee, teachers and other Trainees. Typical teacher responses to Trainees with problems include:

- Denying existence of any problem.
- Endeavouring to “save” the Trainee.
- Changing teaching patterns (ie, reducing the stress of the training).
- Feeling inadequate or unable to help.
- Feeling irritated or even infuriated.
- “Branding” of registrar as a problem Trainee for the rest of his/her training.

Typical Trainee responses to difficulties experienced include:

- Feeling helpless, anxious, incompetent or stressed.
- Appearing apprehensive, fearful or overwhelmed.
- Experiencing decreased self-confidence, doubt or inadequacy.
- A negative response to a perceived labelling of themselves as “having a problem”.
- Loss of self esteem (especially for those experiencing difficulties with examinations).

If a system or teacher fault has led to apparent inappropriate identifying of a Trainee experiencing difficulties, then typical responses of other Trainees include:

- Increased rostered hours and on call work.
- Decreased attention to their training needs.
- Concern that they may also become a victim of a system or teaching approach they perceive as unfair.
- Unease that a colleague has been arbitrarily branded.
- Counterproductive stress.
- Disquiet about issues of fairness and confidentiality.
Other responses include all those involved:

- Becoming concerned about patient care.
- Becoming focused on the Trainee (often rather than becoming focused on the problem).
- Reducing available attention to other Trainees.
- Experiencing an increased demand on their time.

**Should the Problem be Solved?**

At this stage it is appropriate to pose the question “Is the perceived problem real?” And if real, “Does it need to be fixed?”

Although all good teachers prefer their Trainees to be positive, cheerful and obliging, occasionally an apparent problem may be a perception of the teacher. Typically such perceptions arise because a perceived problem interferes with the teacher’s own goals and expectations. Under these circumstances the problem may not really exist.

Of course, if a problem truly represents a difficulty with a Trainee, teacher or system then it must be addressed.

**Confirmation of Problem**

Once the initial parameters of a problem have been established and a hypothesis formulated, the teacher must confirm initial suspicions by collecting additional information. This is best achieved by:

1. **Discussion with the Trainee.** This discussion should focus upon establishing the Trainee’s:

   a) Perception of the problem.

   b) Perception of his or her strengths and weaknesses.

   c) Relevant life history (including whether the problem has arisen at other times).

Early discussion with a Trainee may be useful in optimising the teacher-learner relationship, identifying and addressing a problem in a timely manner, and preventing development of additional problems.

This discussion with the Trainee should take place with a third party present, such as a staff member whom the Trainee can trust, or another person, preferably nominated by the Trainee. (If your department uses a mentoring system, it would be appropriate for the Trainee’s mentor to be present.)
A conversation with the Trainee is essential to confirm a teacher’s suspicion that a Trainee has a problem. The teacher must determine what difficulties are perceived by the Trainee and his/her perception of the overall situation.

Few Trainees completely lack strengths and the teacher should (if possible) draw on these strengths.

Many teachers may be uncomfortable in eliciting a Trainee’s relevant life history, out of respect for Trainee privacy. Nevertheless, in fairness to the Trainee and to the teacher’s ability to make an accurate diagnosis and develop a treatment plan it may be necessary to inquire about personal issues (Steinert & Levitt, 1993). The inquiry should include:

- Identifying any source(s) of stress the Trainee may be experiencing.
- Establishing if the Trainee is anxious or depressed.
- Determining if drug or alcohol abuse is a contributing factor.
- Determining if similar problems have occurred in the past and, if so, how were these dealt with.
- Establishing an understanding of the Trainee’s support systems, resources and ability to adapt to change.
- Determining the Trainee’s ability to cope with stress.

2. **Considering the teacher’s position.** This consideration should focus upon the teacher’s own:

- Strengths and weaknesses in relation to teaching.
- Strengths and weaknesses in relation to the Trainee’s knowledge, skill or attitude in which the problem is manifested.

This process may be invaluable in creating constructive change in perception or behaviour.

3. **Discussion with other teachers.** This discussion should focus upon establishing:

- Whether other teachers perceive the existence of a problem.
- How the Trainee performs with different teachers.
- How the Trainee performs in different situations and under various circumstances.

Naturally discretion, respect and appropriate rules of confidentiality need to be observed during discussions.

Perhaps surprisingly, teachers’ perceptions of a Trainee with problems frequently do not agree. Identifying such inconsistencies is an invaluable source of information for a teacher wishing to identify a problem.
Frequently differences in personality, attitude and teaching technique adversely influence the accuracy of a perception.

In order to effectively address a problem, it is necessary for a teacher to know:
- The situation(s) where the problem arises.
- How often the problem arises.
- With whom the problem arises.

**Successful Intervention**
A key to successful intervention is accurate diagnosis combined with an appropriate approach. Threatening to sack someone who is uncertain of your commitment to them is unlikely to defuse a problem.

Similarly, failing to adequately establish the source of a problem before designing an implementation will have no more effect on solving a problem than going to one operating theatre when the patient is in another. Obviously the intervention must match the problem.

Failing to identify the problem before designing an intervention will almost certainly guarantee failure.

**Specify the Problem You Wish to Address**
The information you obtained when confirming the problem will help you to accurately specify the problem. Ensure that your perception of the problem at this stage matches with other teachers and the Trainee. If the perceptions of yourself, the teacher(s) and the Trainee do not match, then you will need to undertake further investigation in order to accurately identify the specific problem. This may necessitate involving someone else in the procedure, for example a mentor, or offering the Trainee the option of bringing someone else into the discussions (preferably someone whose objective opinion is respected by the Trainee).

Note that an intervention will almost certainly fail if the Trainee does not agree with the definition of the problem.

**Exercise 3.**
Identify suitable personnel in or near your department to whom you could refer a Trainee who had problems with:

- Anxiety or depression.

- Other mental illness.
- Illness (physical).

- Marital or relationship problems.

- Pregnancy.

- Stress emanating from family relationships (especially relationships with children).

- Financial issues.

- Grieving.

- Chemical abuse.

- Alcohol abuse.

**Addressing the Problem**

Ensure that you include the Trainee in the design of the intervention strategy. This will provide the Trainee with a feeling of ownership and responsibility to ensure the intervention succeeds. Furthermore, factors contributing to many Trainee problems arise from Trainees feeling helpless or out of control during a portion of their training. Enlisting the Trainee in the design of the intervention strategy should significantly alleviate this concern. Failure to include the Trainee in the design of the intervention may well exacerbate the problem.

It is possible that more than one problem arises concurrently with a Trainee. Although appearing disparate, typically these problems have a common cause and a skilful intervention will address this cause.

A teacher may consider several alternative interventions. These include:
• **Arrange Meetings**
  A beneficial strategy is to arrange one-on-one meetings with the Trainee. Not only does this allow an opportunity for the teacher and learner to consider specific problems, review clinical issues, discuss pre-assigned reading, or enhance clinical reasoning, it may also foster the essential relationship between teacher and learner. Some departments may wish to consider establishing a mentor. If the learner desires a support person to be present, allow this.

• **Increased Observation**
  A clinical problem can often be addressed successfully by increasing the quality and/or quantity of observation and appropriate feedback. The teacher may undertake this role or assign other instructors to facilitate the process. It is best if this is scheduled during normal clinical hours.

• **Decreasing Schedule Intensity**
  Effective detailed feedback and discussion can be facilitated by temporarily decreasing the Trainee’s clinical commitments (and reinstating the normal schedule once the problem is solved). Though this may initially increase the workload of other registrars, this temporary measure may ultimately result in less additional workload than allowing the problem to develop further. If a problem continues to deteriorate then it will often require greater intervention and more time to rectify. Thus the burden on other registrars may become greater and last for a longer time.

• **Role Modelling**
  Humans learn by direct observation. Trainees with clinical, communicative or attitudinal problems can usually benefit from observing skilled Specialists. Role-modelling can be supplemented by the Trainee practicing the problematic situation through the use of role-play, where correct behaviour can be learnt in a non-threatening environment.

• **Skill Training**
  Trainees with deficient skills may quickly improve through training. This training may occur within a clinical environment, or within a simulated environment, such as a skills station or simulation centre.

• **Change the Teaching Schedule**
  Persevering with an unsuccessful teaching schedule will likely compound any problem(s) experienced by a Trainee. A teaching schedule that is unsuitable for a Trainee after six months may create six-fold as many problems as a schedule that is successfully modified after one month.

• **Introduce Remedial Instruction**
  Specific deficits in Trainee knowledge, skills or ability may be successfully addressed by introducing remedial instruction designed to focus on the Trainee’s specific shortcoming(s). If the deficit is minor, then the remedial instruction may run concurrently to normal instruction. However, substantial deficits may need to be addressed by considerable remedial instruction that
can only occur once the Trainee is removed from their normal teaching-learning schedule. This may be necessary in extreme cases.

Remedial instruction may include:

- Increased opportunity for rehearsal.
- Additional clinical experience.
- Introduction of protected time for supervision, observation and feedback, or study.

Supplemental teaching techniques that are often useful for remedial teaching include:

- Role-playing.
- Videotape reviews.
- Videotaping and analysis of Trainee performance.
- Self analysis by the Trainee.
- Mini tutorials.
- Reviews of patient management issues.

Many Trainees may benefit from:

- Instruction and supervised practice in adult learning.
- Learning to study effectively with groups of other similar Trainees.

- **Counsellor/Psychiatric/Psychological Intervention**
  Behavioural problems such as aggression, depression, mood swings, poor attention, etc. are often indicative of problems requiring intervention beyond the ability of the teacher. Under such circumstances professional counselling advice may be appropriate for the Trainee. If this is the case the teacher may need to allay inappropriate fears of negative connotations associated with seeking psychiatric or psychological counselling. Similarly a treatment for alcohol or chemical dependency may be necessary and this is beyond the scope of most teachers.

- **Allow Time**
  A Trainee may be able to overcome a problem over time. For example, it is possible that a Trainee will acquire greater confidence over time, enhance a problematic skill with continued normal exposure to the training program, solve a personality conflict when a person leaves a situation, or progress on from a highly demanding rotation.

- **Change in Schedule**
  Under extreme circumstances it may be necessary to institute a leave of absence or probationary period for the Trainee.

- **System Intervention**
  Allowing the teacher to increase observation, monitoring, teaching or supervision of a Trainee is often beneficial. Similarly, incorporating another
teacher (or mentor) into the instructional schedule may be useful. However, the potential benefits of this form of intervention need to be weighed against the additional workload incurred by the department/teachers.

- **Teacher Training**
  Diplomacy and tact are extremely important when addressing problem(s) arising from, or contributed to by, a teacher. However, these problems must be addressed. This can often best be achieved by facilitating self-reflection by the teacher, discussion with other teachers and staff. Teachers may need to be encouraged to attend teacher training or undertake instruction specific to a particular shortcoming. Such training or instruction is extremely valuable and usually has multiple benefits throughout the department.

- **Choice of Personnel**
  In addition to the SOT and Trainee it is often appropriate to have input from other teachers or staff in the design of the intervention.

  The design may require an intervention to be influenced by one or more people. This may or may not include the SOT.

  It is essential to consider the:
  - Nature of the intervention.
  - Resources required.
  - Resources available.
  - Suitability of any proposed material.
  - Number of personnel to be involved (it is often beneficial to have more than one person work with the Trainee).
  - Personnel to be involved (it is essential that these be selected in consultation with the Trainee).

  It is necessary to ensure that all personnel involved in the intervention are:
  - Fully aware of all aspects of the problem.
  - Committed to solving the problem.
  - Appropriately experienced and/or qualified to play their part in the intervention.
  - Comfortable working with the Trainee in their assigned intervention role.
  - Capable of devoting the necessary time.

**Timely Intervention**

Another key to successful intervention is effective timing. Moreover, one of the reasons Trainees with problems are such a concern to SOTs is the time intensive nature of dealing with them. Identifying problems early will minimise the extent of the problem and its negative impacts on the Trainee, teacher, other Trainees,
the hospital and the public. Thus it is well worth the effort to identify and rectify problems early.

The intervention design must specify the:

- Intended implementation date.
- Anticipated duration of the intervention.
- Estimate of when change should reasonably be expected.
- Dates for reviewing the progress of the intervention.

Depending on the type of problem, there may be a call for universal watchfulness and supervision from numerous staff.

**Documentation**

Successful interventions are effectively documented. This documentation should include:

- A description of the problem.
- Discussions/meetings.
- Intervention design.
- Key performance indicators by which the success of the intervention will be evaluated.
- Objective criteria by which the intervention can be assessed.

There may be legal implications relating to problems affecting Trainees. Thus it is essential to ensure:

- The Trainee is involved in the intervention design and evaluation.
- All interactions are appropriately documented.
- Due process is adhered to including the principles of natural justice.

**Exercise 4.**

Consider a Trainee with problems who is currently in your department. (If you do not currently have such a Trainee, consider a Trainee with problems with whom you have had contact in the past.) Design an intervention for the problems by answering the following questions.*

1. What problem are you trying to address?

2. How will you address it?

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* These questions are from a workshop entitled “The Problem Resident: Whose problem is it?” by Yvonne Steinert, 2001.
3. Who should be involved in the intervention?

4. What is your time frame?

5. How will you document your intervention?

6. How will you involve the Trainee?

7. How will you assure confidentiality and follow due process?

Written contracts are often used to address problems in educational settings. These contracts specify the problem(s), intervention, personnel involved, time frame, evaluation procedure and assessment criteria. Such contracts offer the powerful advantage of emphasising the Trainee’s responsibility to ensure a successful intervention. In extreme cases consideration may be given to having a highly formal contract drawn up with legal assistance.

**Evaluation of Intervention**

Once an intervention has been implemented it must be monitored and eventually evaluated. The criteria for evaluation must be specified in advance (ideally during the intervention design) and in agreement with the Trainee.

As an example, if the purpose of the intervention is to improve a specific clinical skill of a Trainee, then this skill must be clearly identified and described prior to commencement of the intervention. In addition the expected level of performance must be specified, as should objective criteria by which any improvement of the skill can be assessed.

Ongoing evaluation of the intervention is essential. This is best achieved by scheduling feedback and evaluation meetings between the appropriate personnel in order to monitor the intervention’s progress towards achieving its stated goals. It is important to prearrange these meetings prior to intervention implementation.
so those involved perceive the meetings as a component of the intervention and not as a form of crisis management.

If an intervention is unsuccessful then additional actions need to be considered. These include:

- Redefining the problem.
- Altering the intervention.
- Extending the intervention.
- Expanding the intervention.
- Considering probation or dismissal.

**Exercise 5.**
Consider the intervention you designed in Exercise 4. Describe how you could appropriately evaluate the intervention.

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Shapiro (1990) stresses that it is essential to employ the most important aspects of a doctor-patient relationship when dealing with Trainees. This includes the provision of a safe environment for learning and teaching, provision of non-judgemental support, focus on behaviour rather than the individual, and interacting with Trainees in a demonstrably caring manner.

Steinert and Levitt (1993) emphasise the importance of:

- Involving the Trainee in every step of the process, and
- Considering both teacher and system factors rather than assuming a problem resides solely with the Trainee.
Questions and Answers from the Supervisor of Training Workshop  
“Trainees with Problems”

The following questions were asked by one or more SOTs at the 2002 ASM workshop for Supervisors of Training: Trainees with problems. Many of these questions and their answers may be of interest to those SOTs who were unable to attend the workshop.

Q. Can the Trainee keep the detailed copy (date, content, signature of SOT) of the feedback appraisal documentation?
A. Yes, this is the ITA-2 form. The Trainee should keep this in their Learning Portfolio.

Q. What is remedial instruction?
A. Specific deficits in Trainee knowledge, skill or ability are often successfully addressed by introducing remedial instruction designed to focus on the Trainee’s specific shortcoming(s). If the deficit is minor, then the remedial instruction may run concurrently to normal instruction. Substantial deficits may need to be addressed by considerable remedial instruction that can only occur once the Trainee is removed from their normal work schedule. This may be necessary in extreme cases.

Q. What remedial activities can be given to Trainees?
A. Remedial instruction may include:
   - Specific skills training.
   - A period of continuous supervision by one or more Specialists.
   - Experience in a simulation and/or skills lab.

Supplemental teaching techniques that are often useful for remedial teaching include a combination of:
   - Self-analysis by the Trainee.
   - Detailed analysis and debriefing by Specialists.
   - Mini tutorials.
   - Review of patient management issues.
   - Possible videotape and analysis of Trainee performance.
Q. Why is there no “satisfactory/unsatisfactory” check box on the current ITA forms?
A. The ITA process currently deals solely with formative assessment. Formative assessment is used for the purposes of improving learning or teaching and not for assigning any form of grading (including satisfactory/unsatisfactory, pass/fail, etc.).

Q. In order for an evaluation process to be successful, is it necessary for the evaluation to be able to be used to prevent a Candidate from being able to sit their examinations?
A. Effective formative evaluation is essential to maximise effective learning and teaching. Yet this form of evaluation cannot be used to prevent a Candidate from being able to sit their examinations.

Q. A satisfactory/unsatisfactory check box is very useful to orientate Trainees to how we feel. If this facility is not available on the ITA forms, how can this be achieved?
A. Open discussions between the Supervisor and Trainee as part of the supervisory process should be used to inform Trainees about the feelings and opinions of the SOT, Instructors and other Consultants.

Q. How should we advise Candidates about the likely success of sitting both sections of the Primary Examination at once vs. sitting both separately?
A. Candidates should choose whichever option is best for them. The College has no preference for either option. Candidates are offered the choice of sitting either or both sections of the Primary Examination as an aid to those Candidates who may encounter difficulty passing both sections concurrently.

Q. Is there any data on the success rates of Candidates who attempt either or both sections of the Primary Examination in a single sitting?
A. Data is inconclusive at present (June 2003).

Q. Has there been any feedback from Candidates about the option of choosing whether to sit either or both sections of the Primary Examination?
A. Candidates appear to appreciate the opportunity for choice. Candidates tend to adopt one of several strategies including studying intensively for:
   • Both sections and sitting both sections.
   • A single section and sitting this section only.
   • One section, sitting this section, and then sitting the second section simply to gain the experience of the second section.

   The College has no preference for any of these strategies. There is no penalty for Candidates who choose to sit for either or both sections in a single sitting.

Q. How important is mentoring? I have suggested mentoring on a number of occasions and tried to “set up” a scheme but neither Trainees nor Consultants seemed very keen to take it up. Some Trainees said that they had different advisors for different problems and others felt a little embarrassed at the idea.
A. Mentoring can be an extremely effective strategy. The success of a mentoring program is not guaranteed and depends on many factors including the specific blend of Trainees and Instructors within a Department, interest levels amongst
prospective participants, and the willingness of the hospital to support a mentoring program. If you wish to learn more about mentoring then section 2.10 of the Supervisor of Training Support Kit provides the following information:

- What is a mentor?
- What is required by a mentor?
- How to get an effective mentoring program started.
- The needs of a successful mentoring program.

Q. Are there any practical suggestions to help Candidates who have not been successful in examinations?
A. The College has developed a module entitled “Effective Studying for Trainees” which is included within section 8 of the Supervisor of Training Support Kit and section 7 of the Trainee Support Kit. A study skills course was developed based on this module and was successfully piloted with Trainees who had been unsuccessful on multiple occasions.

Q. How do we assess Trainees after six months?
A. The ITA process specifies that Trainees can be assessed by three Consultants chosen by the SOT or by consensus meeting of the staff. If a consensus meeting is to be used then it is important to chair the meeting properly. Otherwise there is a risk that the meeting may be “hijacked” by one individual who has a particular view of the Trainee.

Q. For how long are the ITA forms to be kept after they have been collated?
A. ITA-1 forms should be kept for the training life of the Trainee. That is, they should be kept until the Trainee has completed their training.

Q. Can the SOT disclose the names of the Consultants who fill in the ITA-1 forms?
A. It is appropriate that Trainees know the names of those Consultants involved in the assessment process. If they are to be assessed via a consensus meeting of staff then they should know this.

Q. Can SOTs request copies of ITA-2s from the College if a Trainee refuses to show their previous ITA-2 to a subsequent SOT?
A. Yes.
Q. Who is responsible for keeping the ITA-2 forms?
A. Trainees are responsible for keeping the originals of all their ITA-2 forms within their Learning Portfolio. A copy should also be retained by the SOT and another copy forwarded to the College via the REO.

Q. What proportion of Trainees encounter significant difficulty and what percentage of Trainees appeal against assessments?
A. It is estimated that between one and five percent of all Trainees encounter significant difficulty at some time in their training. There may have been some appeals at the hospital level, there have been no appeals at the College level.

Q. What is the role of SOTs in advising Overseas Trained Doctors (OTDs)?
A. The primary task of a SOT is to supervise their Trainees. Unless an OTD is a Trainee under the care of the SOT, the SOT has no direct responsibility for an OTD. An OTD who has a question concerning any aspect of the College training program, assessment or examinations may be advised to contact the College Headquarters. Also OTDs have advisors appointed to oversee required experience.

Q. Can the Trainee nominate a Consultant for assessment?
A. Different circumstances within different departments may influence how best to identify Consultants who should be approached to assess Trainees. In some larger hospitals the Trainee may be in the best position to identify those Consultants best able to assess them. However, there is a potential for Trainees to be tempted to nominate Consultants most likely to give them a favourable report. Hence, if an SOT permits Trainees to nominate those Consultants responsible for assessing them, the SOT should also ensure that these Consultants are in a position to provide an objective overview. (For example, it is important to ensure that the Consultants a Trainee nominates are indeed those with whom the Trainee has substantially worked.)

Q. How to substantiate the judgement given by Trainers on Trainees especially for attributes with unsatisfactory performance? Trainees will ask for examples and evidence. The Trainer himself or herself may not like to confront with the Trainee on this.
A. The current formative ITA process does not include a judgement regarding satisfactory/unsatisfactory performance. ITA-1 forms are kept by the SOT so, if necessary in an appeal, these may be used to substantiate the information recorded on an ITA-2. The evidence used in the ITA generation should always be first hand, not hearsay. As part of the teaching and learning process it is appropriate that a Consultant be willing to explain or describe Trainee attributes, behaviours, skills and knowledge that can be improved. Trainees also sign off their ITA, thus indicating their acceptance of the judgement contained therein.

Q. There have been a number of potential Trainees applying for jobs distant from their homes and families who intend to commute over the long term. How can
we advise them? Should we consider in any way the impact this will have on their work and families when making appointments?

A. You cannot fail to hire a person on the basis of the length of their prospective commute. However, it is appropriate to emphasize to a Trainee that lengthy commutes are demanding in terms of time and energy, and thus can have a negative impact on work and family life. The Trainee should be aware of these considerations when considering whether to accept a position.

Q. How should specific problems be prioritised?
A. Useful concepts when considering Doctors with difficulties are “red flags” and “yellow flags”.

Q. What are red flags?
A. Red flags refer to a situation in which there is an urgent need for intervention. These include issues of:
   - Gross incompetence,
   - Professional misconduct,
   - Substance abuse.

Q. What are yellow flags?
A. Yellow flags are indicators of potential problems that, of themselves, are not indicative of impairment, high risk, or an imperative to intervene. However they do offer an opportunity for a preventative approach of intervening before major problems develop. These problems might well involve adverse outcomes with patients, illness of the medical practitioner, a substance abuse disorder, or a dysfunctional work environment.

Q. What are examples of Yellow Flags?
A. Yellow Flags generally fall into one of five categories. These are summarised in the following table:

<table>
<thead>
<tr>
<th>Professional Behaviour</th>
<th>Clinical Factors</th>
<th>Medical Illness</th>
<th>Lifestyle</th>
<th>Practice Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Late</td>
<td>Difficult patients</td>
<td>Tired</td>
<td>Activity – physical, intellectual, social, spiritual</td>
<td>No CME</td>
</tr>
<tr>
<td>Untidy</td>
<td>Critical incidents</td>
<td>Poor concentration, memory</td>
<td>No disability insurance</td>
<td>No private health insurance</td>
</tr>
<tr>
<td>Rude, aloof, anxious</td>
<td>Support failures</td>
<td>Sleep disorder</td>
<td>No collegial membership</td>
<td>No medical defence</td>
</tr>
<tr>
<td>Inattentive</td>
<td>Work load</td>
<td>Difficulty relaxing</td>
<td>Unsafe hours</td>
<td>Unsafe hours</td>
</tr>
<tr>
<td>Poor documentation &amp; communication</td>
<td>Experience and training</td>
<td>Disillusioned, demoralized, cynical</td>
<td>No holidays, time off</td>
<td>No holidays, time off</td>
</tr>
<tr>
<td>Mistakes &amp; complication</td>
<td>Mistakes &amp; complication</td>
<td>Sick leave</td>
<td>Staff concern, low morale</td>
<td>Staff concern, low morale</td>
</tr>
<tr>
<td>Incomplete work</td>
<td>Mistakes &amp; complication</td>
<td>Self prescribing</td>
<td>Delayed reports</td>
<td>Delayed reports</td>
</tr>
<tr>
<td>Avoids supervision</td>
<td>Mistakes &amp; complication</td>
<td>Physical illness</td>
<td>Too busy</td>
<td>Too busy</td>
</tr>
<tr>
<td>Inflexible</td>
<td>Mistakes &amp; complication</td>
<td>Psychiatric illness</td>
<td>Debts</td>
<td>Debts</td>
</tr>
<tr>
<td>Disorganized &amp; poor prioritizing</td>
<td>Mistakes &amp; complication</td>
<td>Illness disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inappropriate interpersonal</td>
<td>Mistakes &amp; complication</td>
<td>PH illness/abuse/disadvantage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Behaviour</td>
<td>Clinical Factors</td>
<td>Medical Illness</td>
<td>Lifestyle</td>
<td>Practice Management</td>
</tr>
<tr>
<td>------------------------</td>
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<td>----------------</td>
<td>----------</td>
<td>--------------------</td>
</tr>
<tr>
<td>behaviour &amp; relationships • Conflicts – peers, patients, staff, admin, authorities, social</td>
<td></td>
<td></td>
<td>No GP</td>
<td></td>
</tr>
</tbody>
</table>

**Q. What else should be considered?**

A. Although the immediate focus may fall upon the individual Trainee, it is also important to consider the overall context with issues related to:

- The doctor’s patient and the clinical situation,
- The medical practitioner – short term and long term issues,
- The environment – home and work, resources and support.

**Q. What contributing factors are associated with perceived incompetence?**

A. At first glance incompetence might be directly attributable to the individual medical practitioner. However, other issues should also be considered. These include:

- Amount of training,
- Past experience,
- Level of supervision,
- Degree of complexity of the clinical problem,
- Degree of urgency,
- Familiarity of the environment,
- Level of support offered from the environment etc.

**Q. What are some red flags relating to misconduct?**

A. These are serious behaviours which must be attributed to the practitioner alone unless an alternative explanation can be provided. Examples include failure at very basic tasks, sexually interfering with patients, and intoxication at work that interferes with judgment and performance.

**Q. To what extent must substance abuse be demonstrated?**

A. The risk of future impairment through intoxication from a pattern of substance abuse (or even inappropriate substance use) is so high that even if actual impairment and misadventure has not been demonstrated to have occurred, the risk of this occurring is such that preventative intervention may be warranted. However, expert advice should be sought before any intervention is contemplated.

**Q. How can Trainees in difficulty be identified?**

A. An important identifying factor is often a change in behaviour. This is more likely to be a reliable indicator of difficulty if the Trainee is known well to their associates. Each individual change might not be of major importance. For example, a person might not be as punctual, might not laugh as much, may not be as diligent in writing up notes and may be irritable. Alternatively they may be less enthusiastic and less likely to ask for assistance. There are many
ways in which this change might present, with the concept of change, any change, being more important than any specific change. However, this may occur at a time when change is expected so judgment is required as to whether what is observed is likely to enhance long term progress and welfare or not.

It is possible that such changes could be misleading. Very occasionally the practitioner might be known as “a very good Doctor” because they are so diligent, preoccupied, willing to stay long hours, work through lunch in a selfless manner, etc. At times it is later found that such a Doctor might be finding sanctuary in their work in response to other stressors in their life, with the possibility that they are avoiding these stressors, with accumulating risk.

Often the Trainee’s colleagues will be the first to notice such changes.

Other Trainees, while not exhibiting a change, may have a number of idiosyncratic behaviours and approaches (as we all inevitably do) which have no sinister significance.

**Q. When should intervention occur?**
**A.** A desirable approach is to be able to intervene before the development of major problems. This might mean, for example with a depressive disorder, that intervention may be undertaken before the development of features serious enough that one could confidently diagnose a psychiatric illness, at the level of a sub-clinical presentation, early in its development.

Such intervention requires confidence. This confidence might be obtained by consistency of concern about features noted:
- On several occasions,
- By several observers,
- In several situations.

**Q. Should Supervisors treat Trainees in a medical sense?**
**A.** No. The Supervisor should NOT act as the treating Doctor of the Trainee, but rather have a focus on providing appropriate training experiences for the Trainee, supervising the implementation of these experiences, and overseeing the Trainee’s progress with a view to continually evolving the training. The emphasis for the Supervisor is the Trainee’s progress, although obviously placing a very high priority on the welfare of the patient, and being mindful that the welfare of the Trainee has to be considered if there is to be a successful outcome to training.

**Q. What are some contributing factors to the welfare of Trainees?**
**A.** It is important to consider that significant contributions to the welfare of any medical practitioner include provision of a good work environment, providing an appropriate match between task allocated and skills available, appropriate work and hours schedules, having ready access to extra support to allow for leave for study, illness and recreation. Establishing a good personal relationship would increase the chances of success, allowing a better opportunity for feedback (both pleasant and unpleasant) to be delivered and
accepted. This requires a considerable degree of trust and cannot occur between strangers.

This predisposes to a blurring of boundaries. A Supervisor must take some humanitarian consideration of their Trainee’s predicament, yet discipline themselves to define and to limit themselves against crossing the boundary of personal privacy unless invited or at least agreed. Even in situations where such an agreement is reached, it is inappropriate for the Supervisor to be acting like a treating Doctor by obtaining a clinical history (of the Trainee), conducting an examination, arriving at a diagnosis or recommending treatment. The enquiry should only be sufficient as to ascertain whether referral is appropriate, with a recommendation and assistance if required.

**Q. Should a Trainee have their own GP?**
**A.** Yes, there exists a long standing recommendation of the AMA regarding all Doctors having their own GP.

**Q. How should a Supervisor deal with Trainees with Problems?**
**A.** It is important for the Supervisor to take a broad perspective of the learning process, rather than restricting activities to academic learning. It is obviously of importance that practical, personal, and manual skills be acquired with this being achieved by supervised practice, as in an apprenticeship model.

However it is also important that the Supervisor encourages awareness and compliance with other aspects of the life of a professional which markedly decrease the risk of professional difficulties. This includes development of a balanced lifestyle, recognizing the importance of rest and recreation, with a balanced involvement in non-medical activities, physical, intellectual and social. This is in addition to involvement in continuing medical activities, formal study and the social activities of a work department.

**Q. How can a Supervisor be confident that an intervention is appropriate?**
**A.** The confidence regarding the appropriateness or otherwise of intervention can be developed by discussion about the situation with trusted, well meaning colleagues. Once intervention is under consideration, the HOD should be involved in any further discussions. This should be possible while preserving anonymity and confidentiality (at least initially). If support is provided by several trusted and respected peers, intervention can be undertaken with a much greater degree of confidence, which is important in obtaining a successful outcome. During these discussions, many alternative approaches and concepts may be clarified, as well as providing an opportunity for an informal rehearsal.

**Q. Are “corridor discussions” appropriate?**
**A.** The “corridor discussion” is NOT acceptable. Especially with respect to a Trainee, the importance of documentation and the processes of natural justice must be strictly adhered to. These particularly include providing the person concerned with very clear information regarding the nature of the concern, providing an adequate opportunity for them to respond, and carefully considering this response before deciding on further action.
Q. Who is able to enter into a discussion with a Trainee?
A. All those supervising Trainees should be willing and able to discuss the Trainee’s performance and progress with them, with a willingness to be able to consider favourable as well as unpleasant aspects. It is very important that Trainees are fully acquainted with areas in which they need to improve their performance to be able to have a fair chance to do so. In this way Supervisors also obtain experience in what can be a difficult area of their role. This is not very different from Doctors being able to advise patients of bad news.

Q. How should a Supervisor approach a situation involving a Trainee in difficulty?
A. It is very important NOT to approach the situation with a prejudiced point of view. It is NOT the case that all Trainees with difficulties are “bad people” or “sick”. It is quite possible that the difficulty does NOT arise from the Trainee. Indeed, an important part of the assessment of the difficulty is to assess the overall appropriateness of the working environment, particularly the hours worked, the level of supervision and appropriateness of the tasks with respect to their level of experience and training. A very potent source of stress is for a Trainee to be presented with a complex clinical situation for which they have not been equipped via training and experience, particularly if supervision and support is inadequate.

Q. To what extent is an employer or SOT able to obtain information on a current or potential employee?
A. In New Zealand employers cannot demand information from previous employers about an employee. However, the SOT can obtain information about a Trainee from the SOT of a previous hospital, as the SOTs are all part of the College training program. This information can only be used for training purposes (ie, this information cannot be used for employment related purposes).

Q. How should Supervisors deal with requests from their hospital seeking assessments of Trainees or comment on their performance in their speciality?
A. The information in the ITA process is gathered solely for that use, and cannot be used for any other purposes. However, the SOT in their role as an employed consultant can comment on the Trainee’s performance; s/he just cannot use the information gained as part of the College assessment processes.