Sessions for trainers with trainees in Difficulty.

Format;

Three sessions of four hours each three weeks apart. Group size totalled 11, as a broad range of experiences was needed hence the large group size. Each trainer was funded to attend (£225 per session).

Selection of trainers;

In this group all trainers with trainees who were on an extension were invited, whether extending in ST1,2 or 3.

Approach summary;

Session 1 – each trainer related their story, a series of nine ‘themes’ recurred relating to trainees in difficulty;

1. Poor responsibility for their own learning.
2. The trainees tend to be charming and manipulative (pushing the boundaries all the time).
3. The trainees tend to be lazy and have a different attitude to patients (they do not worry about the patients or their actions like the trainers do).
4. The trainees tend to get patient complaints starting early in their attachment.
5. Their performance improves near target times (before ARCP panel) but is not sustained and returns to lower performance within a few days or weeks.
6. The trainees have little insight into their poor performance often blaming others for their failure.
7. The panel was not seen to be robust enough with poor performers.
8. Their consulting skills are poor, this was categorised in four areas; delivery of words, chaotic consultations, lack of patient involvement and inability to extract or respond to patients health beliefs.
9. Poorly performing trainees have a significant impact on the trainer and on the practice.

Session 2 and 3 we look at potential solutions to these themes. I also asked for a single point the trainers have taken away after 1.5 sessions. These included;

1. I am not alone.
2. There is a process to move on.
3. More structure and discipline is needed with a poorly performing doctor.
4. There are always worse trainees than yours.
5. Evidence is the key – documentation.
6. The trainer is too soft.
7. How much effort it takes to work with these trainees and how draining it is.

Potential solutions;

1. Responsibility for their own learning.

The group conclusion here was to make sure they sign the learning contract and give them strict boundaries that they cannot wriggle out of. A practical solution, if they had not prepared something that was agreed for the tutorial/ assessments, was to stop the tutorial and not continue as they had not done their part of the bargain. Resume the tutorial in one hour (or the length of time it would have taken) and ? get them to see some duty patients in that time.

1. Charming and manipulative.

The trainee seems to charm the staff while things are going their way, and also charm the trainer. They will however push the boundaries to manipulate the situation to their best advantage – ‘I have to go by 5pm to pick up the child’, ‘I would like study leave for this, that and the other and everyone else has been given the time off’.

The agreement here was about boundaries and complete consistency from the start. Make it clear that they are expected to do certain things and have little room for manoeuvre or else they will take a mile.

1. Lazy.

The poorly performing trainee will appear lazy and their attitude will not meet your expectations. The group felt that the trainee did not worry about things like the trainer did (thinking about a management plan for a patient and worrying about the patient).

The solution was to lay down the rules at the beginning and to be directive with the trainee and not enter discussion on whether they are going to do it or not. Do not say ‘would you be happy to do…’ but say ‘please do…’ The group also felt you must be precise and objective, giving clear precise instructions about what is to be done. ‘Every day you are to look at the bloods and act on the results.’

The CPD half day must be used to improve the trainee. The use of this time seeing patients is entirely appropriate for poor performers, or to write up log entries/prepare for assessments.

1. Patient complaints.

It is unusual for a trainee to have many complaints. If they start be careful even if they are individually quite small.

The solution here was, if the complaint is justified, to get the trainee to deal with the complaint themselves, in writing (do not let them loose on the phone), and viewed by the trainer prior to sending. It was felt that by the trainee having to take responsibility for their actions it may sink in. Some practices discuss all complaints with the clinical staff, this may also be appropriate as it is not singling out the trainee as everyone is involved.

1. Sustainibility.

The trainee can come up with the goods for important deadlines but falls back into their old ways almost immediately. The trainers are fed up nagging their trainees, and being ‘mum’.

The solution suggested was regular feedback and asking the question ‘how do you think you make me feel having to say the same thing over and over?’. It was recognised that there are few solutions to this one, but this is the one that drains the trainer.

1. Insight.

The trainees often feel it is the trainers fault not theirs. This is about how to get the lightbulb switching on.

The solutions given by the group were to get the trainee to change practice or even have a practice swap. Another was to ask a fellow trainer (co-trainer or in a neighbouring practice) to do an assessment so that it shows it is not just one trainer that feels the same. Boundaries are very important here and also to put the trainee under pressure may spark a ‘lightbulb’ moment, as anyone can cruise if not under pressure, but when pressed they need their skills to manage situations and if they have no skills they do not manage.

It was felt that you must give regular feedback which is directive ‘you have had four complaints you need to change’. The feedback needs to be consistent and in small doses. The MSF can be helpful but not always.

1. Robust panel.

The trainee seems to get extensions even when all sorts of educator notes were entered. The panel has become more robust in the past year, with extensions being in ST1 and 2 rather than at the end of training. A solution proposed was for the trainer to attend panel to give verbal evidence. This is not allowed, having checked, as only written/electronic evidence can be considered as there is no way of collecting verbal data for the appeal.

The solution here was for the trainer to submit alternative written evidence to panel. It was recognised that short three month placements were difficult to manage as the ESR needed to be completed 6 weeks into the placement which is not enough time for decent evidence to be collected.

The group felt that the directions for the trainee in the educator notes should be more specific. Not 6 CbDs and 6 COTs but 1CbD per month to be completed by the last day of the month etc.

1. Consultation skills.

The four areas were looked at as a whole. The consultations are often chaotic, words are not fluent and leads to patients perceiving the trainee does not know what they are doing. The trainees do not involve the patient in management decisions (possibly cultural with IMGs) and do not investigate the patients health beliefs or even impose their own health beliefs on the patient.

The groups solutions were the use of regular observed consultations both with video and directly. They must be selected at random (video a whole morning and the trainer selects at random) or observe without the trainee knowing that was going to happen. The group felt that it may be helpful for the random consultations to be reflected on by the trainee prior to watching them. This involved more organisation.

The group discussed the use of trained patient simulators, available through the Associate Deans and Programme Directors.

It was felt that the trainee observing the trainer was useful, either directly or using video and marking them as a cot or CSA case.

With the delivery of words and phrases, this needed to be practised and Case Cards had useful phrases.

1. Impact on trainer and practice.

Having a poorly performing trainee can be both draining but also destructive. The trainers felt their spouses knew more of the problems than their partners. In some cases the double trainers grants were accepted by the practice with no recognition of extra time being necessary for the trainer. Some trainers were having to provide a business plan for the continuation of training to their partners as the trainees had been so destructive. Although there was a sense of partners ‘pointing fingers at the trainer and saying – your trainee has….’ The majority thought their practice had bought into training and taken responsibility as a whole.

The trainers were accepting of taking poorly performing trainees (take the rough with the smooth), but insisted that following a poor performer the practice need a good trainee. One trainer had three poor trainees in a row which was exhausting.

The group saw this as an essential solution. The problem lay in that the patch has little information on the trainee if they were allocated as ES at ST1. Those patches where the PDs were ESs for all ST1s made the allocation for ST2 and 3 much easier.

It was felt that having identified a poor performer regular contact by the AD/PD was important to make sure they do not feel alone. Richard Weaver had visited some practices which was highly appreciated.

Ongoing peer support groups with backfill helped enormously, both to share the experiences but also to help find solutions.

A practice swap was felt helpful, both to calibrate the trainers feelings about the trainee (as the trainer was made to feel it was them by the trainee) but also for the trainee not to get too comfortable in the practice.

When the second trainer grant is awarded, a covering letter to state that this is to support extra time for the trainer.

COTs and CbDs chosen by the trainer to demonstrate specific deficient competencies. Using these assessments and being very specific the trainee can see if they are developing or not.

If a poorly performing trainee is due to come to you as a trainer, then access to the eportfolio prior to their arrival is necessary. This can be done by someone with administration rights adding you as a trainer in their current post.

In conclusion the group felt that as a trainer you must be;

* Firm and not manipulated
* Directive
* Ask for a second trainers grant and use it for extra time
* Regular contact with the Associate Dean/Programme Director
* Not continue with the tutorial if they have not completed what was agreed
* Make it clear this is their training and their responsibility
* Involve colleagues and use their skills for assessment and calibration

There was one positive note from this;

It has taught every trainer to be harder and possibly a better trainer.

It was noted by the delegates that they were appreciative of the deanery to anxieties expressed by trainers, provision of a safe environment to share and support each other, and the planning of future similar courses.

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