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Poorly performing supervisors and trainers of trainee doctors

Paice & Ginsburg (2003) surveyed postgraduate medical trainees in London and found that most considered their training as satisfactory and the proportion that evaluated their training as poor had fallen compared with a previous survey. They also reported, however, that the training experience for some trainees remains unsatisfactory and that the single most important factor in determining trainee satisfaction is the quality of supervision provided by the consultant trainer. In the light of this it is alarming that in a recent survey of psychiatric trainees in the West Midlands, 47% had experienced bullying and in 27% of cases of alleged bullying the perpetrators were senior medical staff (Hoosen & Callaghan, 2004). Paice *et al* (2004) reported consultants as the source of bullying in 27% of cases in a survey of bullying among doctors in training in north London.

There is a dearth of studies dealing directly with the issue of poorly performing educational supervisors and trainers. We have attempted to fill this gap by first providing trainees with an understanding of postgraduate medical education systems and hierarchies, employers' obligations and procedures and educational supervisors' responsibilities and attributes. Second, by providing a 12-step practical problem-solving approach, empowering trainees to resolve difficulties in a constructive manner.

This article has been written in the current context of separate basic specialist and higher training provision, however, the same considerations will apply in relation to changes according to Modernising Medical Careers and the creation of a unified training grade.

Postgraduate medical education and training

Educational and training hierarchy

There are well over 100 000 doctors practising in England alone and, according to figures generated in September 2004, 44 259 were in training grades in hospitals (NHS Confederation, 2005).

Under the provisions of the Medical Act 1983, the European Dental Directive, the European Specialist

Medical Qualification Order and the European Medical Order 93/16EEC/, the statutory authority for medical education rested with four competent authorities, namely the General Medical Council (GMC), the General Dental Council (GDC), the Specialist Training Authority (STA) and the Joint Committee on Postgraduate Training for General Practitioners (JCPTGP). The new Postgraduate Medical Education and Training Board (PMETB) assumed its statutory powers on 30 September 2005 taking over the responsibilities of the STA of Medical Royal Colleges and JCPTGP. Brown (2005) states that Royal Colleges will no longer have independent control over training, curricula, examinations and approval visits, and that they will work with PMETB within the parameters of service-level agreements.

Regional postgraduate deans develop, commission and assure quality of delivery of postgraduate medical and dental education (Green Guide; Academy of Medical Royal Colleges & Conference of Postgraduate Medical Deans, 2000). Deanery-based specialty training committees oversee their specialty-specific training in a given region. The Royal College of Psychiatrists is represented in relevant specialty training committees through its regional advisors.

Employer's obligations and redress procedures

Employers provide education under contract with the relevant postgraduate medical dean. They are accountable to the deans for the quality of educational experience they provide. The medical director usually has board-level responsibility for delivery of the medical education contract. The medical director is often supported by an associate medical director for medical education. Further support is always available from deanery appointed training programme directors, who may or may not be employed by the trust, and college tutors. It is likely that these would be the people through whom the trust would mediate educational problems in the first instance.



Where educational problems, including problems with educational supervision, emerge, good employers will respond in a proactive and constructive manner to address these in an informal, consensual and conciliatory manner. Such an approach should always be favoured in the first instance and will usually be successful. In exceptional circumstances the trainee may need to seek redress through formal procedures.

A large number of National Health Service (NHS) trusts now have clearly defined grievance procedures for settling differences between the trust and individual employees and for clarifying the rights, responsibilities and obligations of management, staff organisations and employees (e.g. West London Mental Health NHS Trust, 2002).

We strongly advise trainees to make themselves familiar with their employer's grievance procedures, and also with their employer's bullying, harassment, discrimination and whistle-blowing policies and procedures.

Role of a supervisor

'The example of the teacher is the most powerful influence upon the standards of conduct and practice of every trainee, whether medical student or junior doctor' (General Medical Council, 1999).

In the UK, the educational supervisor is always a consultant or a principal in general practice. The educational supervisor has the direct responsibility for ensuring that the trainee receives training to an agreed syllabus and standard during part or the whole of a period of specialist training. Others may undertake clinical supervision of the trainee or teach specific parts of the syllabus. However, the educational supervisor retains the responsibility for ensuring the quality of that training. It is important to note that the postgraduate medical training structure and mechanisms in the UK are in a process of transition at present and that along with these new changes the use of the term 'educational supervisor' may also change over a period of time. However, the term and the role of the educational supervisor have been retained in the new foundation programme (Modernising Medical Careers Team & British Medical Association, 2005).

The Royal College of Psychiatrists' Collegiate Trainees' Charter (Royal College of Psychiatrists, 1994) includes clauses such as 'trainer providing constructive positive and negative feedback on progress with a minimum of 3 months to act on such advice (within the current placement'. Another clause states the need for trainees 'to be treated with the consideration and respect expected of a professional colleague irrespective of status, sex or race'. Training days for the educational supervisors are regularly convened at the College, so as to ensure that supervisors have the knowledge and skills to meet the above requirements.

Attributes of doctors with responsibilities for clinical training and educational supervision

'All experienced doctors have a responsibility for the personal and professional development of the senior house officers with whom they work: as role models, teachers and supervisors.' (General Medical Council, 1998).

The General Medical Council's professional guidance *Good Medical Practice* (General Medical Council, 2001) and *The Doctor as Teacher* (General Medical Council, 1999) set high standards for the personal and professional attributes of the doctor with responsibilities for clinical training and educational supervision:

- strong commitment to the principles of *Good Medical Practice*
- enthusiasm for the specialty
- personal commitment to teaching and learning
- sensitivity and responsiveness to the educational needs of doctors in training
- capacity to promote development of the required professional attitudes and values
- understanding of the principles of education, with specific reference to adult learning
- understanding of research methods
- practical teaching skills
- willingness to develop as a doctor and as a teacher
- commitment to audit and peer review of teaching
- ability to appraise trainees and undertake assessment of progress
- up to date with continuing professional development as recommended by the appropriate College.

Identifying a poorly performing supervisor

The poorly performing supervisor is one that, during their work and supervision of their trainee, fails to meet the responsibilities and does not demonstrate the attributes outlined above. It is unlikely that all will achieve excellence in each and every area. On the other hand it is expected that all should be 'good enough' (i.e. meet minimum acceptable standards in all of the above).

Following review of available literature (e.g. Paice *et al*, 2002; Houghton, 2003; Garelick & Fagin, 2004) and discussion with colleagues, we have provided a number of profiles for the purpose of illustrating the problem clearly. These are not intended to create stereotypes of difficult or poorly performing trainers but to aid thinking and understanding:

- invisible and inaccessible supervisor
- stressed and irritable supervisor
- professionally incompetent supervisor
- arrogant or rude supervisor engaging in behaviours such as shouting and ridiculing of trainees
- supervisor engaging in systematic bullying of trainees
- supervisor engaging in unethical practices.

In a significant number of cases, poor performance by an educational supervisor may be related to one or several of the factors outlined in Box 1.



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Box 1. Causes of poor performance

Systemic and cultural factors

- excessive workload
- inappropriate workload
- poor management
- rapidly changing work culture

Professional factors

- incompetence as a clinician
- incompetence as a teacher and trainer

Personal factors

- stress and burnout
- relationship difficulties
- alcohol and drug misuse
- mental or physical illness
- personality difficulties

Power relations in postgraduate medical education

Trainees require support, positive appraisal and assessment and references from their educational supervisors in order to progress in their careers, to secure new employment opportunities and, most importantly, to learn and survive and provide high standards of care in the complex workplace of modern day medicine. This position of dependence creates a potential power imbalance and in some cases may even lead to intentional or unintentional harm to trainees. However, it is important not to exaggerate the importance or significance of such imbalance.

There are checks and balances to ensure that the power of the educational supervisor is not misused. College/specialty tutors and clinical tutors and/or programme directors have an obligation to act as the trainee's advocate where this is necessary. Where tutors and programme directors fail to act appropriately, a direct approach by the trainee to the local postgraduate dean or relevant College may be indicated. The local trainees' committee and its officers/representatives may also be helpful in acting as the trainee's advocate in appropriate circumstances. Deanery contract monitoring and training programmes' approval visits involving the College and conducted on behalf of the PMETB also afford opportunities to raise concern regarding the poor performance of educational supervisors.

Furthermore, trainees who consider that their health is being affected by the stress of working with a poorly performing educational supervisor should remember that all NHS trusts and most, if not all, other employers providing postgraduate medical training will have an occupational health department. This would be expected to maintain the strictest levels of confidentiality and might offer helpful advice.

In addition to the occupational health departments, many postgraduate deans also offer confidential services for the assessment of mental health problems affecting local doctors (for example, <http://www.londondeanery.ac.uk/MedNet/>).

Addressing the poor performance

Twelve-step approach

In the light of the facts identified in the first part of the guide and our experience as college/clinical tutor (G.I.) and trainee/trainees' representative (R.F.) we recommend the following 12-step approach for trainees.

Step 1

Agree explicit educational objectives, training programme and regular supervision time with education supervisor.

Step 2

Attend educational supervision regularly.

Step 3

Engage in constant monitoring of own performance. Be prepared to be self-critical and avoid complacency.

Step 4

Write down difficulties or uncertainties that your self-appraisal has highlighted. If your self-appraisal leads you to think that your educational supervisor is performing poorly write it down. (Writing problems and grievances down in a factual way may make the issues clearer in trainee's own mind and also help them decide about the next step; Cormac & Marston, 1999.)

Step 5

If discussion with the educational supervisor is likely to be difficult or seems impossible, and particularly if strong feelings arise, seek advice and support earlier rather than later. Discuss with a tutor, a former teacher or supervisor, a trusted senior trainee, a trainees' representative or the British Medical Association (BMA) or other trade union organisation. Keep some notes from such consultations.

Step 6

Discuss the difficulties with the educational supervisor if possible. Always start by acknowledging the supervisor's sensitivities. For example, you may say to your supervisor that they may not feel comfortable with the issues that you are about to raise but you do not intend to offend them and, indeed, you wish to hear their views. Be polite, conciliatory and prepared to be wrong, but do not allow yourself to be fobbed off or bullied. Always make some notes following such a meeting.

Step 7

If discussion with your educational supervisor is not possible or it has reached an impasse you must inform



your College tutor. You should expect your College tutor to respond reasonably promptly and to be prepared to give you the time that you need. Keep a record of your conversations with your tutor.

Step 8

It may be helpful that you suggest to the tutor a three-way meeting between the educational supervisor, the tutor and yourself to attempt to resolve issues in a fair and transparent manner. Normally your tutor should be expected to respond positively to such a suggestion and to set up a meeting within a reasonable time. Where the tutor disagrees with such a step they should provide you with a clear reason.

Step 9

Discuss with the tutor whether there is a need to involve the relevant clinical director or service manager. You should listen to your tutor carefully but you must make your own mind up about what to do. As long as you act within appropriate local clinical governance arrangements and in good faith it is unlikely that you will be criticised.

Step 10

You may wish to consult the BMA or other trade union organisation in parallel with your tutor. Again keep a record of relevant conversations. If you feel that you may be suffering from a health problem then consulting your general practitioner or relevant occupational health department may be an important option.

Step 11

If action by you, your local tutor or both fails to address relevant issues, you or your tutor or both should consider involving the medical director and the training programme director. You can expect them to make your concerns a priority and to respond within a reasonable time. Sometimes it might be necessary to involve the postgraduate dean or the relevant College or faculty training committee chair.

Step 12

A positive and supportive training and working culture without a semblance of abuse is only possible through positive contribution by all parties. We would advise trainees to support each other, trainers and higher education administrators to achieve the target of good provision of training leading to improved patient care.

This practical problem-solving approach is supported by two case studies (Boxes 2 and 3). Both of these case studies illustrate the consequences of adopting and not adopting the several basic principles identified in our 12-step approach.

Box 2. The harsh/irritable supervisor

Dr X was known to be very critical towards his trainees during ward rounds and other team meetings. His senior house officer, Dr H frequently found himself humiliated in front of other team members. His other colleagues advised him to speak to his consultant or coordinating tutor about this over-critical behaviour. He decided against this advice and opted to suffer in silence fearing that he might annoy his consultant even more by doing this. His successor Dr S encountered the similar fate; however, after a couple of weeks of suffering she decided to speak to the consultant about his behaviour. As a safeguard she also spoke to the coordinating tutor prior to approaching her consultant. She was polite but firm when she raised this sensitive issue and to her surprise discovered that her consultant was rather shocked and embarrassed. He stated that this was the first time any trainee had pointed out this problem to him. He admitted that he might be rather harsh at times but acknowledged that he never thought of the consequences of his harshness on his trainees. The trainee subsequently observed a significant change in the consultant's behaviour and was able to work in this placement without further fear.

Box 3. The stressed-out supervisor and a bereaved trainee

Dr X had lost his father in a car accident about 6 months before he started his placement with Dr G. He was not coping well emotionally and was tired most of the time. His consultant was not happy with him, as he was also occasionally late for important meetings and ward rounds. Dr G himself was very stressed-out because of a suicide inquiry and another complaint against him. After a heated discussion and argument one morning, Dr G asked his clinical director to reprimand Dr X and asked him to initiate formal disciplinary proceedings. Dr X panicked and lost sleep and his appetite under this added stress. He had not maintained any membership of a trade union or a medical defence organisation and found his own colleagues working in the same hospital rather indifferent and unhelpful. He approached a former supervisor who advised him to consult the occupational health department without any delay, and also advised him to immediately speak to a senior tutor and seek membership of relevant trade union and medical defence organisation. Dr X decided to join the relevant organisations but decided against contacting his occupational health department or approaching the senior tutor. The last time we spoke to Dr X he was jobless and awaiting the final results of his enquiry.

Comments from trainees

A selected group of trainees with interest in trade union activities or trainees' affairs were requested to provide their comments on our 12-step approach for addressing poor performance. All trainees considered the guide very helpful in providing a background context and a problem-solving approach. However, some trainees at senior house officer level thought that in comparison to specialist registrar trainees, they might be in a slightly disadvantageous position to help resolve their problems. Two trainees expressed their apprehension over the suggestion of contacting the occupational health department.



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We consulted an occupational health specialist, who considered these apprehensions unjustified and pointed out that occupational health departments serve both the employer and the employed, and that their remit also includes finding ways of rehabilitating the employees back into their jobs after periods of illness. We also wish to point out here that the distinction between the specialist registrar and senior house officer grades is likely to disappear after the introduction of the unified training grade proposed by Modernising Medical Careers (Department of Health, 2004).

Conclusion

Ikkos (2000) has previously outlined the emotional difficulties that arise when dealing with poorly performing trainees. Similar difficulties are likely to occur when dealing with supervisors suspected of poor performance.

It is important that trainees accept and understand that they may be distressed when appropriately tackling potentially thorny issues. They should not be embarrassed by such emotional difficulties nor try to hide them.

Similarly, throughout such discussions trainees must be aware that the educational supervisor may experience similar emotional turmoil. This is no reason to hold back from raising relevant issues but they should be raised in a thoughtful and clear manner, and in a way that values dialogue (Ikkos, 2002), forgiveness (Ikkos, 2004) and justice.

Declaration of interest

None.

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