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Anthony is a Psychiatrist, Medical HR Expert, Coach, Technologist and Educationalist. He is one of the three original founders of the onthewards website. As the site's first Chief Technology Officer, Anthony was integral in getting us up and running and helped to steer the onthewards website through its first three iterations. Whilst Anthony is no longer formally involved with onthewards, he remains a strong supporter, having spoken at our inaugural conference otw18. Anthony holds leadership and training positions at both the University of Newcastle and Hunter New England Local Health District. He is also the Managing Director of AdvanceMed, a medical education and training company dedicated to helping doctors manage their medical careers.

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C/- RUOK

A little while ago I wrote this post about my experiences in asking difficult but important questions in psychiatry. Today's article in the Sydney Morning Herald which relates the far too common experience of just one junior doctor seeing their colleagues suicide around them raises for me the issue of whether we more senior doctors are sufficiently addressing this problem as part of our duty of supervision of junior trainees?

I have strong personal views about what are the key components of medical supervision. Spoiler alert they include taking an interest in the welfare of the trainee. Not everyone shares these views and the best models of supervision are hotly debated in the health and medical education literature. But this is my post so here is my model.

I believe that medical supervision focuses around 3 core components which both vary in importance according to the circumstances at hand and also can come into conflict. They are: Performance Management, Coaching and Mentoring. So let's break this down a little bit.

Firstly, the medical supervisor has a responsibility to performance manage the trainee, by this I mean as the doctor in charge you are ultimately responsible, not just for your own direct contributions to patient care but those that work with or for you, including trainees. So you must give good, constructive, prompt feedback, you must correct errors when you see them and you should also provide praise and thanks when you see good work and growth in knowledge and capability. Sometimes you may also need to have some challenging conversations when trainees are consistently underperforming.

Secondly, coaching. A key feature of the medical supervision model going as far back and possibly further than the Hippocratic Oath is of course to impart our knowledge and wisdom and instil the Art of Medicine in others. At times this will mean guiding the trainee in their learning. More often these days (with the amount of medical knowledge constantly updating and changing) its about encouraging the trainee to keep at it and checking in on their progress. Sometimes it is also about advocating for the trainee to ensure that the balance between provision of service and time to learn what is required for a lifelong career in whatever discipline we are speaking of is fair.

Finally we have Mentoring. Medical careers are experiences. They constantly throw up new things on a daily basis both good and bad. Each day brings a bevy of both old and new patients. The teams we work in change on a daily, weekly, monthly basis. When junior doctors commence they are often even changing work sites every couple of months. This can be very disorientating at times. But the good news is that as one progresses up the hierarchies of medicine to consultant practice the amount of change does tend to settle somewhat at least relatively speaking. So it is up to us as supervisors to recognise this challenge for our trainees. To be aware that transitions can be times of psychological stress. To provide a safe psychological space so that trainees can reflect on their experience. To discuss the role of good proactive physical and mental health care. To know our trainees well enough so that we are able to tell when things are not going as well.

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Now as alluded to earlier these roles are sometime brought into conflict. Such as the situation where a trainee maybe having a crisis of confidence in their ability and

therefore underperforming. Experience, common sense and my values have taught me that very few people step into a medical career with bad intent. Trainees seldom deliberately underperform. There is generally a reason. So underperformance is one of the warning signs that a trainee may be struggling.

Whatever the sign or indication as a supervisor I will argue that we are in a fiduciary role when our trainee is in difficulty and we are ethically obliged to take action in such circumstances.

However, just as with patients, there are certain sorts of questions which can make ourselves or trainees feel uncomfortable and so we tend to avoid asking them.

And even if you have already established a good trusting relationship with your trainee an initial question, such as “How are things?” is not always going to lead to an opening up. If you have evidence or an inclination that all may not be well you are probably going to have to take it to a deeper level.

In my experience there are a few ways to approach this in a conversation with a trainee. I’m going to propose 3 here:

The first is to humanise. By this I mean establish a personal connection with your trainee by sharing your own experiences as a trainee and reflecting on some of the challenges that you had. Now of course there may be some challenging experiences in training that you may not wish to share with your trainee, I will leave that up to your discretion. The first is to share something personal in order to challenge any idealised notion that trainees have of their mind that you and your colleagues are Dr Perfect and “plain-sailed” their way through training. What you are doing here is saying “its ok to have problems because I had problems”.

So an example of how this might work is:

“Suresh I just wanted to share with you a bit of a story about my own experience as a trainee. I was at a point where I had had a difficult time for a few months where I wasn’t really sure if I had made the right career f

trainees end up talking to me about. I'd like to spend a few moments doing this because I want you to know that I have experience in helping trainees with challenges and see it very much a part of my role. So I'd just like to ask you is everything ok for you at the moment?"

third is to let the trainee know that you or others have noticed. I'd suggest that you use this one till after you have tried one of the above as it's a bit more confrontational. What we are trying to do here is highlight to the trainee that we think something might not be going well for them because we and or others have noticed a change at work and we are genuinely concerned.

an example of how this might occur is:

Hi Micah, I would like to spend a few minutes with you having a conversation which we might both find a little difficult. But I think its important to have this discussion. Myself and some of the nursing staff have noticed for the past few weeks that you have been struggling to keep up with your ward work and you've not been your normal self. This has surprised us all as we all have a genuine high level of respect for you and what you contribute to the team. So I'd just like to ask you is everything ok for you at the moment?"

fully the above 3 examples can be of assistance to any supervisor who might be struggling with an issue where they are concerned about a trainee.

to finish by suggesting that there is more harm in not asking than asking. Studies in patients have shown that subjects such as suicide are not easy to talk about and people are far more likely to open up and talk if they are given an invitation to talk and that they would prefer to be invited to talk rather than bring up the subject themselves.

important to ask our trainees if they are OK and its actually our responsibility to

(acknowledgement to the RUOK organisation for use of mnemonic).

For Further Information and Support:

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