

“Call me if you need me. But remember – it’s a sign of weakness.”

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Author: Abhijit Pal



Abhi is a medical oncology advanced trainee in the final year of his core training and has an interest in healthcare economics, decision making, ethics and JMO wellbeing. He plans to go overseas in 2019 to the Royal Marsden Hospital to work in the Drug Development Unit as a clinical trials fellow.

Terrence Holt’s remarkable part fiction/part non-fiction memoir of his residency, *Internal Medicine*¹, starts with a vignette titled “A Sign of Weakness”. Note the Americanisms – attending = consultant, resident = senior registrar, intern = junior registrar.

“My first call night as an intern, I ran into Dr M, one of the senior attendings, whom I had known for several years. “How’s it going?” he asked me. I told him I was on call. “First call?” He smiled. “I remember my first call. About ten o’clock that night, my resident said to me, “I’m going to be just behind that door. Call me if you need me. But remember – it’s a sign of weakness.”

This sentiment, whether meant in serious jest or mock irony, will resonate with many junior doctors in training. The intern on an after hours shift hesitating to pick up the phone to call the medical registrar; the medical registrar hesitating to call their consultant when feeling uncomfortable with a patient; the surgical registrar hesitating to call their consultant when feeling uncomfortable with a procedure.

The pivot for much of this tension comes from the fact that a **purpose of training is to foster independence** and so it is a sign of progression when junior staff don’t call for help and manage situations on their own (this assumes that they are competent to deal with the situation). The key caveat to this statement, is that the community, senior staff (and most importantly, the junior staff delivering care) want this to happen without compromising patient care.

The concept enabling this near-miracle (doctors in training delivering high quality healthcare) is supervision. **But when supervision goes wrong, there can be fatal consequences for patients.** A tragic example of this is the case from Victoria in 2001³ where a paediatric resident charted 50% dextrose as maintenance fluid instead of 5% dextrose for a four week old infant with pyloric stenosis, resulting in the child suffering severe and permanent brain damage after a whole night of 50% dextrose. The medical board’s report makes for frightening reading as system errors accumulate in tandem with a significant human error into a horrific outcome. In reflection, the resident describes finding the consultant “*intimidating*” and in a sad moment of honesty states “*she went on to say that another factor why she did not admit her uncertainty to her.*

[registrar and consultant]... was that they assess residents, so it was important to appear knowledgeable and competent if she wanted to have a good report”.

So why don't junior doctors ask for help? There are both trainee factors, supervisor factors and medical culture.

Trainee Factor #1 - Imposterism - *when asking for help we in fact reveal that we don't know something.* Ironically, many interns don't really believe that they are doctors⁵.

This is a phenomenon that occurs in many industries, and medicine is no exception. The principle of faking it till you make it is something that will ring true for many doctors. But what if by asking for help they are found out? The crux of this issue is - what is OK to know and what is OK to not know? The answer to this question varies with the stage of the intern (registrars will have different expectations from term 1 vs term 5 interns), the type of term (ICU registrars will have different expectations from medical registrars). It's important to keep in mind that in the first few weeks of a term or an internship, it is *expected* that interns ask questions. Registrars and consultants will worry about the quiet intern. It is interesting that junior staff who don't ask for help are often perceived as more competent or confident -everyone has heard about the “slick” or overconfident intern who, when pressed, actually has extensive gaps in their knowledge. Some people are better at being imposters than others.

Trainee Factor #2 - Unconscious incompetence - Asking for help is a skill in itself and it takes knowledge and skill to recognise where one's limits lie (one of the goals of training is to move from junior doctors from unconscious incompetence to conscious incompetence). An intern is called to see a patient with low oxygen saturations (80%), applies a 15 L non rebreather, which brings the saturations up to 95%, and then walks away since “the numbers are OK now”. This intern is unconsciously incompetent. . See the Dunning Kruger effect⁴ for more on this - “If you're incompetent, you can't know you're incompetent. [...] the skills you need to produce a right answer are exactly the skills you need to recognise what a right answer is.”

Supervisor Factor #1 - Poor Supervision - the ideal supervisor is supportive, available and approachable. Unfortunately not all supervisors are like this. Medicine is a broad church with a diverse range of personalities, and part of the challenge of medicine is learning to work with different personalities. But is poor supervision reflective of innate personal attributes or can these skills be taught? Maybe poor supervision reflects the failure of the system to teach doctors how to supervise. Just as there are incompetent trainees, there are incompetent supervisors and when faced with this situation, trainees should seek support from other senior colleagues.

Supervisor Factor #2 - - Stressed Supervisor - In times of stress (a daily occurrence in many hospitals!), even the ideal supervisor can become less than ideal - a busy medical registrar caught between ED and deteriorating patients on the ward may become less than friendly. Depending on the junior doctors' personality structure, their social confidence, their medical “confidence”, this can become a significant barrier to calling.

Finally, medicine superficially appears to have a culture of independence and self reliance -perhaps in a high stress occupation where the daily workload can involve life and death decisions and activities, the expectation is for practitioners to be immune to the grief and complexity and “just deal with things”. There is little room for uncertainty,

hesitation, indecision or inaccuracy – asking for help can be perceived as weakness. The reality is that medicine is a team sport, and there is always someone to talk to, and most importantly, the aim of the game is to deliver the best outcome for the patient. One of the revelatory moments for junior doctors is when their consultant who they previously thought was god, asks a colleague for help because they are confused and not sure where to go next with a patient.

Asking for help can in fact be a sign of strength and competence – knowing where your limits are is crucial to being an effective doctor.

After his foreboding introduction to being on call at night, Terrence Holt's describes how he struggles with a patient with scleroderma at the end of her life over the course of the night. She had already been classified as DNI "Do not intubate", but her respiratory rate and saturations are outside the normal ranges for much of the night and the narrator valiantly uses nasal prong oxygen, face mask oxygen, anxiolytics, analgesics to support her; all to no avail and the situation is exacerbated by her inability to tolerate face mask oxygen. As a last resort, he uses larger doses of analgesics and anxiolytics to enable tolerance of the BiPAP. Unfortunately, a few hours later, the patient dies.

At the end of the night, he meets the resident who he did not call throughout the night

"How was your night?"

I told him. He listened to the story, pulled his lower lip, shook his head.

"You should have called me"

I flinched. "What would you have done?"

"Nothing" he said. "Just like you. There was nothing to do. But at least we could have done it together"

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