ISSN 1753 - 044X

IJOCS

DOCENDO AC DISCENDO

Volume 3 Issue 3
September 2009

INTERNATIONAL JOURNAL OF CLINICAL SKILLS

A Peer Reviewed International Journal for the Advancement of Clinical Skills

- 'docendo ac discendo' - 'by teaching and learning'

In this issue:

Executive Board

International Journal Of Clinical Skills
P O Box 56395
London
SE1 2UZ
United Kingdom

E-mail: info@ijocs.org
Web: www.ijocs.org
Tel: +44 (0) 845 0920 114
Fax: +44 (0) 845 0920 115

Published by SkillsClinic Ltd.

Acknowledgements

I would like to take this opportunity to show appreciation to all those involved with the production of the International Journal of Clinical Skills (IJOCS). Many thanks to all members of the Editorial and Executive Boards. A special thank you Dr Ronald Woro and Dr Dora Affam for their inspirations.

Our sincere gratitude for the kind support from Sir Liam Donaldson, the Chief Medical Officer for England, United Kingdom.

The International Journal of Clinical Skills looks forward to contributing positively towards the training of all members of the healthcare profession.

Contents

Editorial Board for the International Journal of Clinical Skills

Disclaimer & Information

Foreword

A Message from the Chief Medical Officer for England, United Kingdom

The systematic and safe acquisition of high quality clinical skills is an essential part of modern medical training as highlighted in my Annual Report published in March 2009. I wish the International Journal of Clinical Skills every success in highlighting research and knowledge in this important area.

Sir Liam Donaldson
The Chief Medical Officer for England

Managing trainee doctors experiencing difficulty in acquisition of clinical skills

Atef R Markos FRCOG FRCP
Consultant in Genito Urinary Medicine
Mid Staffordshire Foundation Trust

Correspondence:
Mr Atef Markos
Consultant in Genitourinary Medicine
Mid Staffordshire Foundation Trust
Stafford
ST16 3SA
UK

E-mail: atef.markos@midstaffs.nhs.uk
Tel: +44 (0) 1785 230264
Fax: +44 (0) 1785 230261

Keywords:
Ethics
Good medical practice
Safety
General Medical Council
Training

Abstract

Clinical skills educators may encounter the unpleasant situation of having to deal with doctors or trainees in difficulty. Professional and educational responsibilities, employment regulations, UK General Medical Council (GMC) regulations and educational deaneries' expectations widen the landscape of competing interests. The case we present explores practical areas and competing interests that could be encountered during clinical skills training. The aim is to test procedures already in place for dealing with doctors in difficulty. Our goal is to set recommendations and improve the outcome of training for the candidate, the organisation and overall health care.

This paper describes a hypothetical scenario relating to a trainee in hospital medicine who is planning to go into general medical practice (UK based primary care). The name used *(Dr Smith)* is a fictitious name and character, used only for illustration purposes throughout this paper.

The training scenario

The Genitourinary Medicine (GUM) Department takes Foundation Year 2 trainees (F2) as part of a rotational training programme. The F2 candidates attend a closely supervised programme of training, which includes clinics at the three levels of services (primary, secondary and tertiary care). F2 training includes some degree of training on manual procedures of venepuncture, taking specialised female and male genital swabs, assisting and performing skin biopsies (in preparation for the independent practice in primary care). The F2 candidate attends the procedures first for observation. During the observation phase, the consultant explains step-by-step the procedures, principles and practice. During skin biopsies, the candidate attends several sessions first as an assistant, to understand the principles of application of local anaesthetics, lines of skin incisions, extent and variable methods of biopsies, suture materials, healing and follow-up care procedures.

Dr Smith was an F2 trainee who presented himself as pleasant, friendly and easy to work with. He was liked by both patients and staff. He had good references from his previous psychiatric post. During the clinical sessions, Dr Smith was able to communicate well with patients. His clinical skills of examination were progressive. Patients appeared comfortable to interact with him. His explanation of clinical findings, diagnosis and treatment were clear and reported by patients to be well understood.

The appraisal process

Dr Smith seemed anxious during the training and observation sessions. Nursing, medical staff and patients expressed concern at the apparent apprehension that Dr Smith expressed during minor surgical procedures. Dr Smith's apparent anxiety reached a level of hand tremors, during assisting in genital skin biopsies. In a discussion with members of staff, he indicated that he was unable to use shoes with laces, as he could not tie these properly.

The supervising consultant addressed the issue of surgical aptitudes and hand skills with Dr Smith during the second episode of appraisal. Dr Smith denied any problem issues. He

expressed strongly that he was as competent as anyone else in doing minor surgical procedures. The consultant assured Dr Smith that the final aim of the appraisal and training period is to achieve competencies and ensure safe professional performance. Dr Smith continued to appear uncomfortable, anxious and distressed during minor surgical procedures. During assistance, there was an apparent time lag between him receiving a request and undertaking the task (for example, to dab a blood ooze or cut a suture). On his first attempt of performing a skin incision, his hand shakes produced an irregular skin incision. On appraising the procedure, Dr Smith continued to express denial of any problems and showed lack of insight into the issues. Dr Smith continued to attend minor surgical procedures, on his request, as an observant.

Managing the difficulty

The consultant trainer organised a meeting for Dr Smith with the GP trainer, hospital clinical tutor and director of post graduate medical education, to discuss the issue of training for basic minor surgical procedure skills. It was made clear to him that no other clinical, personal or professional issues were to be considered. Mr Smith continued to show lack of insight into any difficulty in performing minor surgical procedures. The panel had to write formally to Dr Smith advising him, on another training programme opportunity, for minor surgical procedures. The committee made it clear to Dr Smith that failing to attend the training programme or reaching an agreeable competency level that could ensure his safe performance, would entail advising current and prospective employers and trainers of his difficulty. We suggested to him that not being able to perform minor procedures competently may affect his future capability to apply for certain posts. We advised him that we are obliged to inform the GMC, who may consider restricting his future practice in relation to minor surgical procedures.

The panel kept systematic and progressive notes about every stage of the events and shared the findings with the regional post graduate deanery. The deanery supported the committee's line of action and noted the case history and outcome of actions. The findings were communicated with the hospital management team and filtered through other training supervisors. It was made clear that the committee had no other issues regarding Dr Smith's personal, professional, clinical, diagnostic, therapeutic, communication or clinical governance. The minor surgical procedures issue was the committee's area of concern.

Observations and analysis

Dr Smith's issue was one of competence and aptitude for minor surgical procedures which reflected on performance. He had no problem in the level of theoretical and practical knowledge: "knows" and "knows how". He continued to express difficulty in showing "how to perform" a minor surgical procedure and consequently the steps of "doing" it, independently. The committee reviewed the possible and potential cause and whether it was related to the post or the trainer. The GUM department deals mainly with medical conditions and a number of minor surgical procedures - other trainees undertake training in the department's minor surgical procedures, satisfactorily with no problems. Dr Smith was given the opportunity of having an extended training programme to address the issue of minor surgical procedures with other trainers, including the prospective trainer consultant.

Dr Smith appeared to have an aptitude problem in performing manual tasks (e.g. making a shoelace knot and extending to surgical knots). It appeared that the problem was deep rooted with a long-standing difficulty in dexterity. This consequently reflected on his ability to undertake surgical procedures. His continued self-denial and refusal to take an extended training programme could have underlined a covert belief that he may not be able to undertake surgical tasks. More seriously, the denial may have stemmed from lack of insight. He may have concluded that surgical performance and its reflection on future uptake of training and service posts, was outside the scope of positive achievement. It was unfortunate that he was unable to give himself an opportunity to discuss the issue with the trainers in an open and honest dialogue; and undertake extended training there after.

Strengths and weaknesses

We identified the strengths of the case procedure:

1. Documentation of the case history and process.
2. Explaining every step and sharing it openly with Dr Smith.
3. Involving the current and future trainers, the clinical tutor and the director of post graduate education.
4. Involving the regional post graduate deanery, at each and every step.
5. Rearranging further follow-up appointments to meet with Dr Smith.
6. Suggesting an extended minor surgery training programme, to undertake with other trainers.
7. Clarifying the positive aspects of Dr Smith's clinical practice to himself and other team members.
8. Communicating his eventual difficulty in achieving a level of competence and safe performance in surgical procedures with the post graduate deanery, hospital management team and clinical staff (to safeguard patients' interests).
9. Communicating the same for future references with Dr Smith's prospective employers.
10. Giving Dr Smith a timetable for completing the necessary skills with the prospect of informing the GMC for restrictive practice, if this further training was unsuccessful.

We identified the weaknesses as follows:

1. There could have been more time and further opportunities of dialogue to address the psychological barrier that Dr Smith had developed against minor surgical procedures.
2. There could have been a chance of involving an industrial psychologist to address Dr Smith's fears and anxieties.
3. The restricted time and training resources, coupled with increasing patient demand and clinical pressures, did not provide ample time to deal with a training situation out of the ordinary.

Recommendations

1. To develop a regular "forum of discussion" between trainers, clinical tutors and director of post graduate education (preferably with an input from the regional post graduate deanery) and trainees' representative(s).
2. Allowing for time, within the educational program, to deal with the unusual training challenges.
3. Communicating the experience with other trainers, to identify the extent of the problem. If it transpires that a substantial number of trainees are incapable of performing, eg. minor surgical procedures, at a competent and safe level

of performance, it may be necessary to readdress job plans for such a group of future practitioners.
4. Offering trainees information about independent organisations that provide doctors with counselling and support.

Conclusions

The Good Medical Practice guidance of the GMC pontificates that patients will be put at risk if a trainer describes as competent someone who has not reached or maintained a satisfactory standard of practice [1]. This lays a professional, ethical and moral responsibility on trainers and educators to objectively, fairly and accurately assess trainees. The National Association of Clinical Tutors have also addressed the issue, offering practical advice for educational and clinical supervisors [2]. The West Midlands Deanery has proactively considered the issue of effective feedback to trainees and doctors [3].

There are professional organisations that provide support for doctors in difficulty, in counselling and advisory capacities. In the UK, The Association of Anaesthetists, Sick Doctors Scheme, BMA Counselling Services, BMA Doctors for Doctors Service, Doctors Support Line, Doctors Support Network and Clinicians Health Intervention, Treatment and Support, are all organisations providing professional and counselling support for doctors in difficulty [4].

The National Patient Safety Agency and the National Clinical Assessment Service (NCAS), which is part of the UK National Health Service (NHS), provide assessment, advice and support for health organisations having concerns or difficulties with a practitioner. The NCAS provides a toolkit to address areas of developing, alerting, supporting, documenting, investigating, rebuilding, disciplining and providing feedback [5]. Overall the NHS acknowledges that supporting doctors is in the interest of safer practice and better patient care [6].

References

1. General Medical Council. (2006). Good Medical Practice: Teaching and Training, Appraising and Assessing. London.
2. National Association of Clinical Tutors. (2008). Managing Trainees in Difficulty: Practical advice for Educational and Clinical Supervisors. Available from: www.nact.org.uk [Accessed February 2009]
3. Wall D M. (2000). Giving Feedback effectively. In: Mohanna K, Chambers R, Wall D (Editors), Teaching Made Easy. A Manual for Health Professionals. Oxford, Radcliffe Medical Press.
4. UK Royal College of Obstetrics and Gynaecologists (RCOG). Doctors in Difficulty. Available from: www.rcog.org.uk [Accessed February 2009]
5. National Clinical Assessment Service (NCAS). Available from: http://www.ncas.npsa.nhs.uk/toolkit/introduction/ [Accessed February 2009]
6. Department of Health (1999). Supporting Doctors, Protecting Patients. London, Department of Health. Available from: www.nhs.uk [Accessed February 2009]

If you would like to subscribe to IJOCS, please contact subscription@ijocs.org

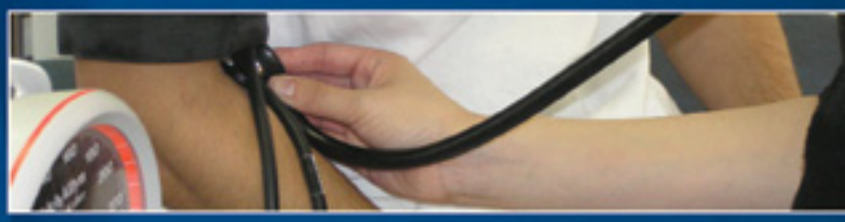
INTERNATIONAL JOURNAL OF CLINICAL SKILLS

IJOCS

DOCENDO AC DISCENDO

If you wish to submit material for publication, please email info@ijocs.org

Clinical Skills Lab (CSL)



The Clinical Skills Lab database will comprise information on over 200 clinical skills, broadly separated into:

- ➔ History taking skills
- ➔ Communication skills
- ➔ Clinical examination/interpretation skills
- ➔ Practical skills

Not only will this valuable resource provide material to students as a learning tool and revision aid, for example, OSCEs, it will also offer educational materials for teachers from all disciplines, allowing some standardisation of practice. The Clinical Skills community will also be encouraged to contribute, making this database interactive.

CSL is a free not for profit database. Visit **www.ijocs.org** for access