The trainee in difficulty

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• SEE RELATED COMMENTARY, PAGE 228.

ABSTRACT

The trainee in difficulty is someone who is either marginal or at risk of failing in his or her clinical performance. Dealing effectively with these learners can pose problems even for seasoned medical educators. This article discusses some of the common mistakes made by educators in dealing with the trainee in difficulty and offers suggestions for a systematic approach. Further, the roles of faculty, including the program director and associate dean's office, and some of the legal issues are described.

RÉSUMÉ

Le stagiaire en difficulté est un individu qui est soit un cas limite, soit à risque d'échouer sa performance clinique. Il peut être difficile de s'occuper efficacement de ces étudiants même pour des enseignants en médecine expérimentés. Le présent article traite de certaines erreurs courantes commises par les enseignants face au stagiaire en difficulté et propose des suggestions pour une approche systématique. Le rôle du personnel enseignant, notamment du directeur de programme et du bureau du doyen, ainsi que certains points juridiques sont également décrits.

Key words: Clinical competence; education, medical, undergraduate, graduate, jurisprudence

Introduction

The emergency department (ED) is an ideal setting for teaching and learning clinical medicine. Trainees see a vast range of clinical problems in a 24-hour, on-site setting that provides access to the emergency physician (EP). This degree of contact between the EP and students is in contrast to the limited direct contact students have with attending physicians on other clinical rotations. As a result, the EP is in a unique position to evaluate students and, specifically, to identify and assist the trainee who is experiencing academic difficulty.

The trainee in difficulty is someone who is either marginal or at risk of failing in his or her clinical performance, usually because of deficiencies in knowledge, attitudes or skills. It is essential that these students be identified early in their training and be provided with effective remedial learning opportunities. However, if remediation is unsuccessful and a student is unable to meet the required standards of performance, faculty must be empowered to assign a failing grade and, in the case of terminal evaluations, be able to dismiss the student.[1] Thus, the role of the EP is to find a meaningful balance between ensuring that the student has every opportunity to meet learning objectives and identifying those students who fail to meet the standards for competent care.

Unfortunately, few medical educators receive formal training in how to deal with the trainee in difficulty, and most find it a very stressful experience.[2,3] The purpose of this article is to review some of the challenges presented by these situations and to consider strategies for dealing with these students.

Identifying the problem

The first step is to identify the problem as specifically as possible.[4] It is useful to consider problems under the general headings of "knowledge," "skills" and "attitudes." Knowledge problems relate to deficiencies in understanding in areas of the basic and clinical sciences. These students have difficulties recognizing or understanding the ba-

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sic elements of a clinical problem. For example, a 4th-year medical student who fails to recognize the central role of coronary artery thrombosis in the pathogenesis of cardiac ischemia has a knowledge deficit.

The "skills" of emergency medicine include technical skills, such as suturing, as well as the basic clinical skills of interviewing, physical examination and clinical reasoning. A senior emergency medicine resident who is having difficulty with the technique of endotracheal intubation has a technical skill deficit. A student who persistently orders a multitude of clinically irrelevant laboratory tests may have a problem with clinical reasoning.

Attitude problems can be easy to recognize but difficult to resolve.[4] The student with an attitude problem will usually be recognized by behaviours that faculty find troublesome.[5] For example, the student may be resistant to feedback, appear insensitive to patients or be repeatedly in conflict with other staff. In the ED, where team relations are so important, these students will usually be identified early in their rotation.

It is important to recognize that there can be overlap and interplay between the categories of knowledge, skill and attitude. A student who sees a limited number of cases or avoids difficult cases may be shirking responsibility, covering up weaknesses, or may be simply be intimidated because of deficiencies in knowledge and skill. Faculty should also be wary of the "socially adept" students who have an excellent attitude and are well liked by everyone but who, in fact, have significant deficiencies in clinical knowledge. A charming demeanor will only carry them a limited distance in a busy ED.

Finally, faculty should consider other important contributing factors.[4] Could problem behaviour be a reflection of a program deficiency, a specific teacher–student conflict or could there be other extenuating circumstances? A student who is overwhelmed by the clinical workload and academic responsibilities might start to experience difficulties in relations with patients and staff. Also, stress, fatigue, substance abuse or a student's response to intimidation or harassment may manifest as problem behaviours. Not addressing the contributing factors, and dealing with problem behaviours in isolation is unlikely to be successful.

Providing effective feedback

As clinical teachers one of our key roles is to provide timely and effective feedback to students at a variety of levels of training. For the trainee in difficulty, effective feedback will play a significant role in early identification and remediation. Feedback "refers to information describing students' or house officers' performance in a given activity that is intended to guide their future performance in that same or in a related activity."[6] Put simply, feedback is "information about current performance to improve on future performance."

We usually think of two types of feedback. Positive feedback is used when the clinical teacher is satisfied with the student's performance and wishes to reinforce the behaviour. Negative feedback is used to discourage the observed behaviour. Positive feedback is much easier to give, but providing effective negative feedback is an essential part of the evaluation process and is especially important when dealing with a trainee in difficulty.

Effective feedback is tough to give

Giving effective feedback is a difficult task.[7] Some preceptors feel uncomfortable judging others, while some err on the side of wanting to be the "good guy." It is particularly hard to give effective feedback if the evaluators are using an appraisal system that they don't like or with which they are uncomfortable. Having a systematic and logical approach to giving feedback can alleviate some of this natural discomfort.

Feedback, especially negative feedback, should be given in private. If a student is embarrassed or angry because negative feedback was given in front of a patient or peers, it is unlikely that student will be very receptive.

Feedback should also be timely. It is more effective if offered as soon as possible after the observed behaviour; for example, take a student aside immediately after an event or at the end of the shift for a brief discussion. EPs typically spend a great deal of time on a daily basis providing immediate feedback to students on their clinical reasoning and problem-solving when discussing cases. Therefore, even with time constraints, a busy EP should be able to take a few minutes to discuss a problem behaviour or skill deficit with a student. Telling a student for the first time at the end of a rotation that she or he has an attitude problem is not helpful, as it doesn't provide an opportunity for change or reassessment.

Feedback should be specific and informative, and should focus on the behaviour, not on the person. Rather than telling a student he or she has a bad attitude, the educator should be specific (e.g., showing up late for a shift).

The recipient should be encouraged to self-evaluate and problem solve. Begin these sessions by stating the problem clearly for the student and then asking the student for an interpretation of events. If a student is allowed to identify problems and generate personal solutions that student is more likely to change his or her behaviour. Finally, there should be an opportunity for follow-up and reassessment. It is only fair that a student who has received negative

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feedback be given the opportunity to demonstrate an improvement in performance.

Effective feedback is tough to receive

The educator should be prepared for a negative reaction on the part of the student; these sessions can be emotionally charged.[7] If the student becomes angry or defensive, the educator should not get caught up in the emotion of the moment but, rather, focus on helping the student understand the specifics.

Students may also feel vulnerable during these sessions. They may not agree with what is being said but may not feel empowered to dispute the matter. The educator must be clear that he or she is willing to listen to and respect the student's opinion. The quiet, passive student is not necessarily agreeing with what is being said; that person may be just trying to hasten the end of the session.

Common mistakes

Late identification

Concerns regarding a student's performance are often not officially acknowledged until late in the training.[8] Then, educators are faced with the crisis of dealing with a student who is at the end of a rotation or residency, and who has not met the standards of training. In these circumstances, where there is little or no opportunity for intervention or remediation, faculty may be forced to assign a failing grade, which seems unfair to the student, or a passing grade, which is a disservice to the profession and the public.

Poor documentation

Documentation of a student's deficiencies, along with a specific plan for intervention is essential.[4] The record should reflect a fair and systematic approach to the problem and indicate that specific interventions were designed to help the student. Unfortunately, it is common that preceptors are well aware of a "problem student"; they share this information with each other but make no mention of these concerns in the student's file.

Failure to identify and document a problem, to intervene with an opportunity for remediation and to evaluate the outcome of the intervention are "fatal flaws" frequently encountered in dealing with the trainee in difficulty.

Who is involved and what are their roles?

The emergency physician

The role of the supervising EP, who has direct contact with the students in the clinical setting, is to identify problems, to provide immediate feedback to students, and report to either the undergraduate coordinator or program director. The chaotic scheduling of the ED can lead to the situation where individual physicians have limited contact with specific students. In this situation it is easy for students with problems to "slip through the cracks" and not be identified until late in the rotation or not at all. For this reason, physicians should have a low threshold for reporting concerns to the undergraduate coordinator or program director, who can investigate and decide if further action is necessary.

The undergraduate coordinator or residency program director

The role of the undergraduate coordinator and program director is, foremost, to facilitate communication with the physicians who are in contact with the students. With early identification being so important, it is essential that a system is in place that makes it easy for physicians to report their concerns. Daily evaluation cards, mid-term evaluations, email, voice mail and hallway consultation can all serve this purpose.

When the undergraduate coordinator or program director is made aware of a problem it is their responsibility to coordinate any interventions. Initially it will be important to collect information from other sources, such as physicians and nurses who have worked with the student, to see if others are aware of the problem. These individuals should be encouraged, if they have concerns, to record their observations immediately after the event to ensure accuracy. It is also important for the undergraduate coordinator or program director to meet with the student, express their concerns and let the student tell his or her side of the story.

Once the problem has been fully elucidated, the undergraduate coordinator or program director and the student should establish an educational contract that includes remedial work and an opportunity for reassessment. For example, a resident who is having problems communicating with patients and families might be asked to attend a communication skills workshop. This could be followed by reassessment, during which the resident is directly observed interacting with a patient in the ED.

It is the undergraduate coordinator or program director's responsibility to document the EPs' concerns, the content of any meeting with the student and the specific plan for remediation and reassessment.

The undergraduate or postgraduate dean's office

The associate dean should provide support and guidance for all those involved in the academic system. Although the associate dean's office may be an avenue for appeal by the student, the office can be a valuable resource for both faculty and

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students. The associate dean may act as an advocate for both sides by reviewing the evidence, providing venues for remediation and ensuring that due process has been followed according to university policy. The associate dean should be brought "into the loop" as soon as it is feasible and be informed about any learner who is in significant academic difficulty.

Legal issues

Faculty may be reluctant to assign a failing grade or dismiss a student because of concerns over the legal ramifications.[1] It is beyond the scope of this article to explore all the legal issues surrounding the failure or dismissal of a student. However, two general principles are important and deserve comment. The first principle is that the courts will avoid setting or judging performance standards. Medical educators are rightfully considered the experts in deciding the level of competence expected of students. The courts will defer decisions regarding competence to the medical educators.

The second general principle is that the courts will look for evidence of a fair, unbiased process.[9–12] The three main components of fair process are that students need to know the standards by which they are being judged, students must be tested in a fair manner and the evaluator must be unbiased. Decisions regarding probation, remediation and failure must be in accordance with standard university policies.[9,10] The principles of due process and natural justice must be observed. Processes that do not observe procedural fairness or the rules of natural justice will be subject to judicial review. This means that, in the legal context, the learner must have fair warning of the problem, an opportunity to present his or her side and to rebut any allegations in a non-threatening environment.

Resources

The trainee in difficulty will present many challenges, even to a seasoned medical educator. There are a number of resources that can and should be called upon to assist in assuring that the process is fair and in the best interests of the student. If the problem relates to health or personal issues, the student should be directed to the student health service or specific support programs available through the dean's office. If the problem is related to substance abuse, confidential assistance is available through programs operated by provincial medical associations. These programs can provide expert advice for investigating reports of impairment and for appropriate treatment and follow-up.[13,14] Finally, because the implications of a dismissal are so important, the student may seek legal action to gain re-entry. If failure or dismissal seem likely, the undergraduate coordinator, postgraduate program director or the appropriate associate dean's office should be involved in a timely fashion to ensure that university policies, the principles of natural justice and proper process are followed.

Conclusion

Dealing with marginal trainees or those experiencing significant academic difficulties is often a stressful experience for medical educators. In the ED, physicians have significant one-on-one contact with students and therefore are well placed to identify problems and provide effective remediation for the trainee in difficulty. Our role can be thought of as providing the best opportunity for students to succeed while maintaining a high standard of clinical care. In approaching the trainee in difficulty it is essential that educators employ a systematic and coordinated approach that demonstrates fair process. In the unfortunate event of a failure or dismissal the courts will support the decision if the process was fair and unbiased, it provided adequate opportunity for remediation and conformed to university policy.

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