Irish Medical Journal
Established 1867

Issue: Ir Med J; Vol 114; No. 6; P374

The Problem Trainer

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A consistent strand in the literature of medical training worldwide is recognition of a proportion of trainers who engage unchecked in unsupportive and undermining behaviour towards their trainees[1]. Associated with hierarchical structures and traditions, transient work placements, asymmetric power relationships, and fear of retribution for those who complain[2], what is less apparent is emergence of positive solutions and structures.

While the unsupportive and undermining almost certainly represent a minority among trainers, their existence is an open, if unacknowledged and unaddressed, secret in most hospitals in Ireland. This situation been quantified in more formalised study in recent years: while not all bullying of trainees arose from within the medical profession, the results are sobering[3]. Just under half of trainees reported undermining behaviour from a consultant or general practitioner, for one in five occurring on a monthly or more regular basis, and over half reported witnessing a colleague being the victim of bullying or harassment.

Even more troubling is that almost 70% of those who reported being bullied and harassed did not divulge this to an authority figure: of the minority who did, less than one-third report that action was taken. These figures are reflected in a report from one training body which indicated that only two-third of basic specialist trainees felt supported in their posts[4]. The silence of the Intern Networks on the topic to date is notable.

The situation is further complicated by separate entities managing training and employment: postgraduate training bodies and intern networks on one side, and the HSE and its agencies on the other. *Dignity at Work*, the process to deal with bullying for all employees of the HSE and its agencies is problematic for engagement by temporary employees on short placements, and no formal mechanisms exist for coordinated engagement of employer and training body to respond to reports of unsupportive or undermining behaviour. Such conduct may be a cause of concern to hospital management if associated with inadequate out-patient attendance or supervision of post-take ward rounds.

There are also potentially perverse incentives for the institution and clinicians to avoid focussing on the problem – appointing trainees through recognised training schemes streamlines recruitment and removes significant extra work associated with appointing free-standing non-consultant hospital doctors for both clinicians and human resources departments. A final complexity is the difficulty of removing trainer privileges and substituting replacement trainers in rotations of posts of short duration.

Responses in other jurisdictions seem to work from the premise of the virtuous trainer, and are marked by a focus on supportive structures for trainers[5]. This is mirrored by the development of more systematic trainee feedback and trainer support resources by a number of Irish postgraduate training bodies. These are welcome but fail to address the fact that some doctors, for a variety of reasons from learned behaviour, distraction by private practice, personality or unsuitability for the role, are simply not appropriate to undertake the trainer role, even with support and remediation. This aspect is neglected in the medical literature: amid many papers on the 'problem trainee', there is an extraordinary lack of attention to the problem trainer[6].

A perceptive overview of the root causes points to a culture based on a physician ethos favouring individual privilege and autonomy—values that if unchecked can lead to disrespectful behaviour. This behaviour underlies the dysfunctional culture that permeates health care and stymies progress in its resolution[7]. This culture is compounded by the tendency of doctors to avoid confronting dysfunctional practice of which they are aware in their own hospitals, as evidenced in the Lourdes Hospital Inquiry[8], almost certainly a global phenomenon.

Proposed actions by the Medical Council do not yet address the realities of the problem sufficiently. One was the Civility Project, in which two training bodies were funded by the HSE National Doctors Training Programme to undertake a project to gain a better understanding of incivility in a hospital setting with a view to developing a suitable programme of improvement to promote civility. Unfortunately, this project was halted in early stages without any outcome, or indication of a further similar project to continue this work.

The current processes of training bodies and employers are not yet developed for managing unsupportive and undermining trainers, and require radical review and coordination – a trainer who is unsupportive to interns is also likely to display similar patterns of behaviour to basic and higher specialist trainees, and other staff. Removal of training status alone may expose even more vulnerable staff, such as those originating from outside Ireland in free-standing posts, to the inappropriate behaviour.

At a national level intensive work is needed immediately between training bodies, employers, the IMO and IHCA, and the Medical Council on addressing realistic and comprehensive frameworks for preventing, detecting and managing unsupportive and undermining trainers. A key underlying issue is that of culture change, using approaches that address both positive and negative values and behaviours, with an emphasis on fairness: seniority should not confer any protection from scrutiny. A look-back survey of previous trainees would be helpful in identifying problem services and contexts, given that these colleagues no long fear retribution and benefit from experience of a range of services. A palette of resources and responses may be of use, such as mandatory attendance at remediation courses and an ombudsman role.

However, given that disruptive behaviour is also a significant patient safety issue[9], individual institutions should not await such national consensus to start actively promoting a clearer profile of intolerance for unsupportive and undermining conduct. A hospital that offers no official and transparent response to such behaviour quickly loses its moral authority, degrading opportunities for emphasizing strengths and positive features to bring about culture change[10]. Medical Boards, hospital boards, clinical directors and executive management teams should place elimination of this conduct overtly on their agendas, clearly signalling seriousness of intent to all staff, including trainers and trainees. They should prepare appropriate processes and demand regular focussed feedback from training bodies and networks. Our trainee colleagues are the vital lifeblood of our present and future health service and deserve no less.

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