TEACHING ROUNDS

The “problem” junior: whose problem is it?

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When working with “problem” learners, clinical teachers often feel at a loss as to how to tackle the difficulties. This article offers guidance on how to do this

Clinical teachers often work with junior doctors whom they find challenging or “difficult.” However, we all view learners’ problems differently, and whether we label a junior doctor as a “problem” doctor depends on many factors. Some of us may have encountered junior doctors like Dr James and Dr Roberts (see box 1) and perceived them as challenging or difficult; others may not. This article describes an approach to identifying, diagnosing, and working with problem learners^{1,2} that has been used successfully in our setting.

What do we know about problem learners?

Various terms have been used to describe the problem junior: the difficult resident, the troublesome learner, the disruptive student, the impaired physician.³⁻⁶ Definitions of a problem learner include those by the American Board of Internal Medicine (a “trainee who demonstrates a significant enough problem that requires intervention by someone of authority, usually the program director or chief resident”) and by Vaughn and colleagues (“a learner whose academic performance is significantly below performance potential because of a specific affective, cognitive, structural or interpersonal difficulty”).⁷ Others have used the term to refer to impairment, secondary to emotional stress or substance abuse.^{3,8} In this article, we define a problem junior as a learner who does not meet the expectations of a training programme because of a problem with knowledge, attitudes, or skills.

Clinical teachers often wonder whether other teachers come across problem learners, as many feel that they are alone in dealing with the challenges that these learners present. Prevalence studies are limited,⁹⁻¹¹ but reported rates of problem learners vary from 5.8% over a four year period in a psychiatry programme¹¹ to 9.1% over a 25 year period in family medicine.⁹ In one study, the most common problems identified by teachers were insufficient medical knowledge (48%), poor clinical judgment (44%), and inefficient use of time (44%).¹¹ Another study identified

insufficient knowledge and attitudinal problems as the most common challenges, followed by interpersonal conflict, psychiatric illness, family stress, and substance misuse.⁹ Not surprisingly, problem residents rarely identify themselves.¹¹

How can we best work with problem learners?

The following recommendations for working with problem juniors are based on published studies,⁹⁻¹¹ expert advice,³⁻⁶ and our own experience in working with residents.¹²

Define the “problem”

When working with problem learners, teachers often report an intuitive sense that something is wrong, although they may not be able to describe it easily. Answering the following questions will help to determine what, if anything, might be wrong:

- What is the problem?
- Whose problem is it?
- Is it a problem that must be resolved?

In our experience, learners’ problems usually lie in one of three areas: knowledge, attitudes, or skills.

Box 1 Case scenario

Dr James

Ward staff have complained to you about Dr James, a junior house officer who has been working with you for three months. Apparently he is slow to answer his pager, ignores requests to complete discharge summaries, and can be abrupt with staff and patients. He often makes dismissive comments about patients and other team members. However, no one doubts his medical competence

Dr Roberts

Dr Roberts is completing her rotation in internal medicine. She is well liked by everyone but seems indecisive and disorganised. She has difficulty prioritising and as a result does not get to see the sickest patients until the end of the day, when it is difficult to organise tests and seek help. She often pages her seniors to ask about little things (though she does not always remember to tell them about more important problems), and lately she seems worried and withdrawn

This series provides an update on practical teaching methods for busy clinicians who teach. The series advisers are Peter Cantillon, senior lecturer in the department of general practice at the National University of Ireland, Galway, Ireland; and Yvonne Steinert, professor of family medicine, associate dean for faculty development, and director of the Centre for Medical Education at McGill University, Montreal.

Knowledge	Attitudes	Skill
Example: Gaps in knowledge of basic or clinical sciences	Example: Difficulties with motivation, insight, self assessment, doctor-patient relationships	Example: Difficulties with interpreting information, interpersonal skills, technical skills, clinical judgment, or organisation of work
<i>Be sure to identify not only challenges but also strengths</i>	<i>Attitudinal problems, which usually manifest themselves in behaviours, are often easy to identify but challenging to resolve</i>	<i>Skill deficits often overlap with gaps in knowledge. Strengths must also be identified</i>
Teacher	Learner	System
Example: Teachers' perceptions, expectations, or feelings; personal experiences or stresses; colleagues' perceptions, expectations, or stresses	Example: Relevant life history or personal problems, including acute life stresses, learning disabilities, psychiatric illness, or substance misuse; learner expectations and assumptions; learner reactions to identified problems	Example: Unclear standards or responsibilities; overwhelming workload; inconsistent teaching or supervision; lack of ongoing feedback or performance appraisal

Framework for analysing learners' problems

Knowledge problems often include deficiencies in basic or clinical sciences. Attitude problems (usually manifested as behaviours) typically include difficulties related to motivation, insight, doctor-patient relationships, and self assessment; although such problems may be easy to identify, they are often the most challenging. Skill deficiencies include problems with interpretation of information, interpersonal or technical skills, or clinical judgment and organisation of work.¹ The figure provides a framework for analysing these problems, many of which often overlap. Teachers in our setting have found that this framework helps them to identify the learner's problems and strengths and analyse whether the problem lies with the teacher, the learner, and/or the system.

Teachers' problems—As clinicians, we bring our own assumptions, experiences, and biases to the teaching encounter. We must therefore assess to what extent we are contributing to the identified problem. For example, we may label a learner a problem, not because he or she is difficult but because we are personally stressed or unsatisfied with our teaching role. Common responses reported by teachers working with problem learners include:

- Denial ("Maybe he's just having a bad day")
- Avoidance ("I think I'll schedule another clinic during my teaching session")
- Desire to rescue or protect ("If I work hard enough, I'll be able to help her")
- Anger or frustration ("Oh no! Why do I always get the challenging residents?")
- Helplessness or impotence ("It's so hard! We'll never be able to do it")

- Acceptance ("Let's get on with it and design a good programme").—Not surprisingly, teachers' feelings may often mirror those of the learner. Thus, identifying our personal responses can serve as a useful assessment tool.

Learners' problems—In addition to gaps in knowledge, attitudes, or skills, learners' problems can include life stresses (such as immigration, move to another city, marriage or divorce), psychiatric illness or substance misuse, interpersonal conflict, or learning problems. Learners' expectations, assumptions, and reactions to the perceived problem (such as a sense of inadequacy, insecurity, or being overwhelmed; anger; fear of losing control; or withdrawal) may also contribute to the nature of the problem. In addition, we must remember that labelling a junior doctor as a problem can seriously affect the learner, and whenever possible we should avoid labelling. It may cause more harm than good.

Systems problems—Systems problems, which are ubiquitous, include unclear standards and responsibilities; overwhelming workloads, compounded by difficult or complex patients; inconsistency in teaching or supervision; and a lack of feedback or appraisal. Identifying systems constraints is critical to defining the problem and designing an appropriate intervention. We must also ensure that the system supports the teacher.

Is change necessary?—In summary, we must ask ourselves whether a particular problem must be tackled

Box 2 Case scenario: defining the problem

Dr James

Dr James clearly demonstrates strengths in clinical knowledge and skills. However, he appears unmotivated to ward staff, who label his behaviours (such as being abrupt with patients and staff) as unacceptable attitudes. Dr James's teacher, a new recruit overwhelmed by his own responsibilities, has not had an opportunity to observe Dr James's interactions with patients and colleagues and is reliant on second hand information (teacher problem). Dr James has recently separated from his wife, moved to this city, and has few social supports (learner problem); in addition, his educational training programme does not offer a mentorship programme or residency support group (system problem).

Dr Roberts

Dr Roberts demonstrates a positive attitude and is well liked by colleagues and peers. However, further inquiry reveals serious gaps in core knowledge (which results in difficulty prioritising) and clinical skills. Her positive behaviour appears to have camouflaged these gaps (teacher problem), which are secondary to a recently diagnosed learning disability (learner problem). Her difficulties in medical school and on previous rotations have also not been communicated to any of her teaching staff, who are unaware of why she is struggling (system problem).

Box 3 Working with problem juniors: options for intervention

- Conduct further assessments
- Spend additional time with the learner (and monitor what they do)
- Communicate clear expectations
- Provide enhanced teaching and learning opportunities
- Arrange for peer or mentor support
- Reduce the clinical workload, with more protected time
- Change the primary supervisor or the location of training
- Design a remedial programme, with defined goals, objectives, strategies, and evaluation methods
- Offer a skill based training course tailored to individual needs
- Recommend counselling and/or therapy
- Enable a leave of absence
- Place the learner on probation
- Dismiss the learner from your programme

and what would happen if it was not resolved. Although many teachers would like their learners to be happy, pleasant, and cooperative,¹ this is not a realistic expectation.

Confirm the “diagnosis”

Having defined the problem and considered our own contributions to it (box 2), careful data gathering is essential, especially as we often make intuitive decisions about learners without verifying our assumptions or intuitions. To confirm the “diagnosis,” teachers should ascertain full details of the problem (such as when it started, what makes it worse); the learner’s perception of the problem; the learner’s strengths and weaknesses in knowledge base, attitudes, and skills (if not already identified); the learner’s relevant life history (such as current life stresses, coping strategies); the learner’s performance on different rotations; and other colleagues’ perceptions, feelings, expectations, and assumptions.

We also need to consider how much and what kind of information we should collect. In fairness to the learner and to help us make an accurate diagnosis and treatment plan,¹ we need to inquire about current life stresses, recurrent problems, and support systems, especially as referral to a mental health professional may be indicated at some point during the intervention.

To gather data effectively, clinical teachers also need to observe junior doctors in a variety of situations, systematically review patients’ problems with the learner, and ensure that their assessment of the learner is congruent with that of their colleagues. When appropriate, it is also helpful to get feedback from other rotations. Problems are most often identified through direct observation (82%) and critical incidents (52%).¹¹

Design and implement an intervention

Having diagnosed the problem, we need to determine how we will intervene, who should be involved, and when to evaluate outcome. Some problems (such as psychiatric illness, substance misuse) will require urgent attention; most will not occur in isolation. As a result, we need to prioritise carefully and ensure consensus on problem definition and intervention. Involving the junior doctor in designing the intervention programme is also essential, as is documentation of every step.

Box 3 lists a series of interventions that are often used when working with problem learners. Sometimes the clinical teacher will be involved in all components; at other times, programme directors or other senior administrators will be responsible. However, in all situations we must know what options are available and one person must be accountable. Often, spending additional time with the learner (and monitoring what they do) or conducting further assessments is sufficient. In other cases, we need to enhance juniors’ learning opportunities, either by increasing time for observation or feedback or by arranging one to one coaching with staff or peers. In some situations, workloads might need to be reduced to allow for independent study and reading (for knowledge problems) or increased practice and feedback (for skill related deficits). Alternatively, a formal remedial programme may be needed, with clearly defined goals and objectives, learning strategies, and evaluation methods. The latter may not occur in the usual place of learning. Although suspension, probation, and dismissal are not desirable options, they must be considered.¹²

Experience has shown that common interventions include increased observation and feedback (for gaps in knowledge or skills); increased time with a faculty adviser (for knowledge deficits, attitudinal problems,

Box 4 Case scenario: designing interventions**Dr James**

One to one discussions with Dr James were extremely helpful in determining the source of his problems and identifying possible solutions. His teacher decided to observe him more systematically and provide immediate feedback on inappropriate attitudes and behaviours. Dr James was surprised that his stress had affected his behaviour with patients and staff. However, he was motivated to succeed and responded positively to his teacher’s suggestions. He also started to work with a faculty adviser to talk about some of the stresses he was experiencing.

Dr Roberts

Dr Roberts required further assessment; a remedial programme to review her clinical knowledge; a reduced workload and protected time to enable skill acquisition; and enhanced teaching opportunities, with one to one coaching and feedback. Given her personal charm, and the results of a learning assessment that enabled individually tailored learning experiences, Dr Roberts was able to re-enter her regular programme within six months.

SUMMARY POINTS

A “problem” junior may be a learner who does not meet expectations because of problems in one of three areas: knowledge, attitudes, or skills

Teachers must identify whether the problem lies with the teacher, the learner, and/or the system

Careful data gathering with the learner is essential before any intervention

Teachers must identify learners' strengths as well as areas for improvement

Interventions may include increased observation and feedback, additional time with a faculty adviser, weekly study sessions, core content review, videotaping of clinical encounters, or counselling

Teachers must work collaboratively with the junior doctor to ensure “due process” and guarantee fairness, confidentiality, and informed consent

interpersonal conflict, or family stress); weekly study sessions, core content review, and videotaping of clinical encounters (for knowledge, attitudinal, or skill problems); and psychiatric counselling (for attitudinal problems, interpersonal conflict, family stress, or substance misuse).⁹ Box 4 illustrates how these interventions might be used.

Anticipated outcomes, and consequences of failed interventions, must also be determined early in the process, though it is heartening to note that close to 90% of problem learners succeed after a structured intervention or remediation programme.^{8,9}

Assure “due process”

Teachers must work collaboratively to ensure “due process” to guarantee fairness, confidentiality, and informed consent.^{13,14} Fairness implies that the learner is aware of the programme's educational objectives and rules of promotion. It also implies that feedback is given on a regular basis and that the teachers' evaluations are based on first hand exposure and objective data. Documentation is critical to the assurance of natural justice, and teachers must be encouraged to document their assessments, interventions, evaluations, and discussions with the learner. At the same time, we must also remember that due process is a bilateral process, so we must ensure natural justice for our teachers as well. Many a teacher has commented on the loneliness and vulnerability that they experience when working with problem learners.

What other challenges do we face with problem learners?

It can be difficult to identify learners' problems, and once we do, it may be even harder to confront learners with our perceptions. Many teachers in our setting report an overwhelming desire to protect or rescue their learners. Others report a lack of time to diagnose or manage learners' problems effectively. However, all teachers note that the rewards of helping a junior doctor to achieve his or her potential are great.

How can we prevent learners' problems?

Although the prevention of learners' problems is beyond the scope of this article, several strategies are worth considering.^{15,16} As teachers, we must acknowledge the stress of postgraduate training and offer support to deal with systemic issues. We must also provide an educational environment that allows for differences among learners, timely feedback, and ongoing assessment so that problems are identified early and evaluations are not a surprise. In addition, we should consider the role of faculty advisers or mentors so that learners can receive support and guidance in an atmosphere of trust and respect. Peer support, which can help to guard against delay in problem identification, can also be a useful intervention.

Conclusion

Clinical teachers often do not know what to do when faced with a problem learner who requires considerable time and effort. The goal of this article is to provide a structured approach to problem definition, effective data gathering, and timely interventions. Although junior doctors' difficulties are often seen as residing within the learner alone, teacher and system factors must be considered.

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