Supporting Educators

A practical approach to managing issues and concerns raised about individual educators

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NACT UK Trading as Medical Education Leaders UK
Championing improvements in postgraduate medical and dental education across the UK

1. Foreword and Acknowledgements

The Medical Education Leaders UK document 'Supporting Trainees: A Guide for Supervisors'[1], which was first published in 2008 and updated again in 2019, has been widely adopted across the UK and overseas. It provides advice for Supervisors, Tutors, Hospitals, Training Programmes, and Deaneries/LETBs on how to manage and support a trainee with a problem. We hope this guidance will be an important resource for all involved in supporting educators in difficulty.

Many specialties and programmes have encountered issues with or confronted by educators. Most issues are minor and dealt with easily. Occasionally an issue arises concerning an educator, which is more serious, and there is often little clarity or consistency as to how these situations should be managed. Investigations can be lengthy, involve many different people and be damaging to the mental and emotional health of the individual(s) concerned. A previously reported approach to a complaint about an educator was 'suspend first and ask questions later'. Colleagues in General Practice will be aware that there are already well-defined supportive processes for GP trainers.

The GMC[2] have defined an Educator as 'an individual with a role in teaching, training, assessing and supervising learners'. It includes Supervisors but also 'other doctors and healthcare professionals involved in training and assessing in the course of their daily clinical or medical practice'. This document applies some of the well-established principles for 'Managing trainees in difficulty' to develop a more logical, efficient and systematic approach to supporting an educator who finds themselves in trouble.

The revised GMC Standards[2] R4.4 states 'Organisations must support educators by dealing effectively with concerns or difficulties they face as part of their educational responsibilities'. Developing our educators is essential to ensure all learning opportunities are maximised and constructive feedback happens routinely in a supportive learning environment. We hope that this guidance will be incorporated into faculty development programmes to assist all parties to understand their role in this important area.

It is the diligent and the courageous who, by giving the difficult feedback, may find themselves challenged. The correct handling of these educators is key.

Jo Szram, Chair NACT UK trading as Medical Education Leaders UK

Throughout this document we have used the term Deanery/LETB for simplicity whilst recognising that these organisations may have different formal names depending on geography.

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2. Background

The responsibilities of the educator have changed beyond recognition over the last 20 years. The role of the Supervisor has been formalised and defined by the GMC. Curricula have evolved through competency-based, outcomes-based and now 'Capability in Practice' based structures including the introduction of General Professional Capabilities. Formative workplace-based assessments as well as a reliance on evidence from a variety of team members (through TAB or 360 degree assessment) to collate a rounded view of the trainee and produce a summative placement reports have been introduced. There is an increasing expectation of trainees to demonstrate evidence of their learning in ePortfolios. All of this has added to the complexity of being involved in postgraduate medical and dental education.

Issues come to light from various sources, often following a complaint raised by a trainee. Being an effective educator can be challenging enough with good trainees; the difficulty increases exponentially with trainees who are in difficulty. Feeding back to a trainee who is in denial or who lacks insight for example can be received badly and issues are often denied vigorously.

It is often the most diligent educators who find themselves 'in trouble'

Without a clear structure, complaints about educators may provoke a destructive process, which can damage the individual, a training rotation and even a specialty within an institution in the long term.

Some of the reasons that an Educator finds themselves 'in trouble'

- A trainee complains about their feedback, assessment outcome, supervisor report.
- A trainee doesn't "get on" with their educator, doesn't think educator is fair.
- An educator and/or trainee is not performing their role well.
- A trainee reports that they are concerned about educator's clinical performance/communication / teamwork.
- A trainee accuses the educator of undermining, bullying or harassment.
- Complaints about educators arising from GMC, NETS or other Surveys.
- Longstanding issues are uncovered with a trainee in difficulty which previous supervisors have not recognised or chosen to ignore. Commonly this issue affects a diligent trainer which the trainee then considers criticisms from to be unjust.
- Educator is conflicted with 'trainer role' – blurring boundaries as a clinician when trainees have health issues or when educator knows the trainee or trainee's family outside work

3. Support for the Educator [2,3]

3.1 Education about Education

All those involved in educating and supervising trainees require the knowledge and skills to undertake and maintain their roles and responsibilities. This may take various forms for example more generic 'Training the Trainer' packages through to bespoke specific-specialty knowledge which may need to be updated on a regular basis. These may be delivered locally by Specialty/College Tutors or DMEs, or by Deaneries, Royal Colleges and even private organisations. Delivery methods may involve e-learning and/or face-to-face sessions and should ideally cover issues around how to giving constructive feedback and how to formulate a Personal Development Plan for trainees. Training should highlight situations where cultural or other differences can be an issue and cover and the impact of Differential Attainment.

Education should also be given to trainees to explain their role, the nature of their interactions with their supervisors/educators and the principles of receiving feedback and being 'reflective practitioners'. This ability is at the heart of their development as a professional and they should develop their skills to effectively listen, discuss and reflect on any feedback they receive.

3.2 Role of Specialty / College Tutor / Departmental 'Educational Lead'

Every department with trainees should have an educational lead whose role it is to develop a learning environment, which is challenging but supportive, and ensure the delivery of the training programme. The Specialty Tutor is involved in appointing supervisors, developing educators and advising when issues arise. They also have a key role in acting as a mentor for a new supervisor. They should be supported locally by the DME to undertake these roles.

3.3 Local Faculty Group

It is recommended that each department should have a 'Local Faculty Group', which meets every 3-4 months, to discuss issues around training, ensuring and demonstrating quality of training and discussing performance of all trainees. This provides an opportunity for education and training topics to be discussed and for the professional development and support of all educators. These groups should be chaired by the Specialty/College Tutor.

3.4 Other Resources

- Postgraduate Schools (chaired by a Head of School), Specialist Training Committees (SACs, STCs, chaired by a Training Programme Director (TPD(), Colleges and LETBs/Deaneries should host meetings to develop their educators.
- Directors of Medical Education (DMEs) and TPDs are available to discuss generic issues on an individual or faculty basis.
- Numerous personal development opportunities (courses and eLearning) are available to enhance educator self-awareness, giving difficult feedback and working with different types of personalities.
- LETBs/Deaneries resources and advice through Professional Support and Wellbeing structures.

4. What is the nature of the problem or complaint?

Difficulties with/experienced by an educator or an 'Educator in Difficulty' may be highlighted through a number of routes. There are similarities in the types of problem that may be found with trainees in difficulty. Concerns about an educator may be informal, formal, direct and indirect. They may originate from trainees, consultant colleagues, other staff groups, from the employer or the regulator.

The way in which concerns emerge can present a challenge:

- Complaints from trainees may be verbal during ARCPs, written through various surveys/questionnaires or in a letter from an individual or group.
- Concerns from colleagues may be from an individual, from a group or from the TPD. The problems could range from a simple lack of engagement with an element of the training process, to serious patient safety concerns.
- Trainers may seek support either after an event (which a trainee might not report) or perhaps after their appraisal when development needs are identified.

4.1 Problems originating from outside the educational process

Concerns about an educator's clinical performance, allegations of undermining/ bullying/harassment or inappropriate sexual (or other) behaviour require an immediate investigation by the HR department of the Trust. The DME and if appropriate the TPD should be informed to ensure that the necessary educational and/or pastoral needs are provided for both trainee and educator. There may be relevant information in the training portfolio / documentation about both parties which could make a valuable contribution to the process.

4.2 Problems originating from the educational process

- Collect all the instantly available information and decide the significance of the issue -
  - Does 'it' matter?
  - If 'it' does matter is the problem 'significant'?
  - If significant, how much does it matter and to whom?
- Determine the best person to investigate the issue raised or complaint made. Ask 'to whom does it matter?'

Decide if the issue falls purely within the administration of education, totally outside the administration of education or awkwardly (and commonly) across both.

- Determine the appropriate level of the problem and who should investigate. This may need to be reconsidered as more information is collected.
- Involve an appropriate source of support for yourself, the educator and any involved trainee(s).
- Decide how the various interested parties e.g. Dean, Medical Director, HR, DME, TPD, (college/specialty) Tutor will work together and determine precisely who is leading on the investigation. An early agreement will avoid duplication of effort and the risk that two or more investigations could interfere with each other.
- Follow a pathway for Managing Issues raised within Education.

4.3 Levels of concern

The following table illustrates the increasing level of concern around an incident and how to respond to this in terms of how to escalate and who to involve:

Level 1: Investigate and resolve locally (within the LEP) by Tutor or DME
Level 2: Investigate and resolve locally (within the LEP) by Tutor or DME but inform TPD/School/Medical Director (MD)
Level 3: Escalate to and investigation led by TPD/Deanery, inform DME/MD
Level 4: Escalate to and investigation led by TPD/Deanery. Inform DME and MD
Level 5: Escalate to MD and TPD simultaneously in expectation of joint investigation.
Level 6: Contact the regulator and/or the police

4.4 A problem appears to be entirely within the educational domain.

Some issues may be best sorted out by talking to both parties, individually or together; suggesting both reflect on the episode of difficult feedback using the 'Reflection on Difficult Communications Episode' document in Appendix 2 or similar. This could be formative for both parties.

It might be better for two people to talk to the educator and the trainee independently and for this group of four to plan a next step. Where the problems extend across a group of trainees and a group of educators, then the process will need more support and personnel.

4.5 A problem appears to have a minor or incidental link to their role as educator

If the problem sits outside training and its impact on training is minor or incidental, then the person raising the issue should be advised to raise the concern with the educator's employer. When the complaint has been made to one of the educational team and the complainer does not wish to engage with the appropriate process (for example the Trust's Bullying Policy or inappropriate sexual behaviour) this will inevitably become a joint issue (Level 4 or 5, see table below). As the issue has been flagged from a training angle, an appropriate and prompt meeting with the educator should be organised. Complex issues may start off appearing to be 'purely educational' but as evidence is collected, issues may cross into professional practice and move to Level 4 or above.

4.6 A problem that, from the start involves both professional inappropriate behaviour and educational role

This type of problem is rare but important. It could be unfair to ignore the contribution of their role as an educator. Any investigation should involve both the employer and the Deanery because without contributions from both these areas, the whole picture may elude the investigating team.

There would be value in the Trust/LEP and LETB/Deanery discussing how they would manage a joint problem such as inappropriate behaviour before a problem arises. It may simply involve recommending the trainee makes a bullying complaint through LEP's standard process, but it may be more complex if it is a group complaint against an educator or a group of educators. Trust policies are usually geared to manage a specific incident or problem, but additional Deanery information may demonstrate a pattern to the incident, or not.

5. Principles of an investigation into a concern about an educator

The principles are the same for every level of problem:

- Collect existing data without delay, review and triangulate this data.
- Decide if this information changes the level of the complaint.
- Discuss with educator(s) and trainees(s).
- **Decide after these interviews if further information is needed to plan an intervention;** If so collect and collate this additional information.
- Make a plan for the future and include educator support and review.

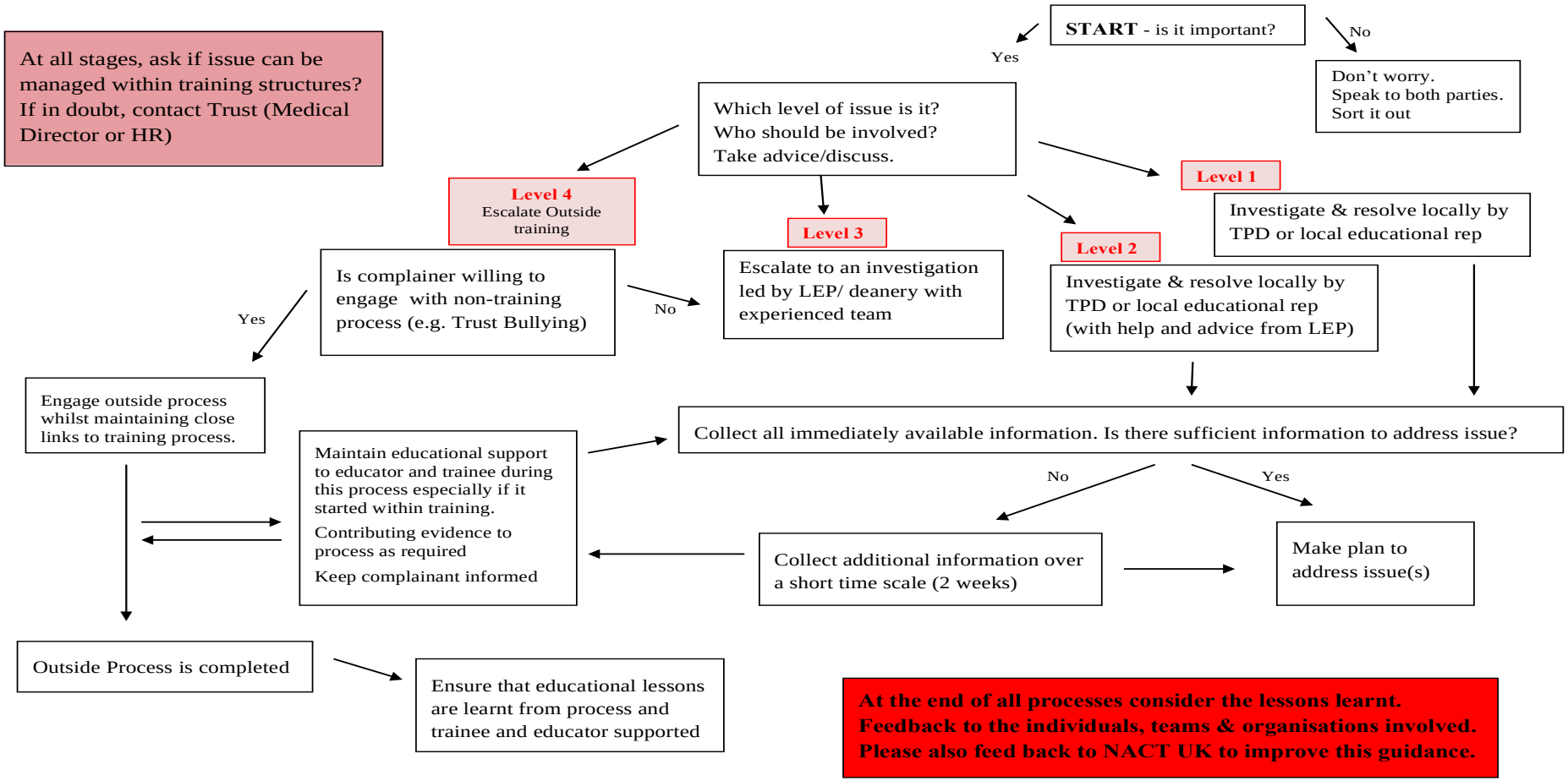
6. Take advice and seek support

Early and proportionate intervention may prevent problems becoming intractable. There will be considerable experience and expertise within Trusts/LEPs, Deaneries and STC/SACs. It is rare for a problem to arise that has never arisen before. Escalate and engage local and regional resources at your disposal in a proportionate manner and at an early stage. SAC liaison members can provide externality, and STC/SAC chairs can link into College/Faculty support structures.

Do not try to deal with complex scenarios on your own:
Ask for advice early and widely

Early recognition, constructive intervention, effective feedback and appropriate support for the trainee and educator concerned, as well as the investigator, are essential

7. Managing Issues raised within Education



8. Who should investigate?

Who should investigate depends on how serious the difficulties are, and the nature of the problem(s). This outline refers to Levels 1-3. The principles should be the same where the problem extends beyond education into professional practice (Level 4 and 5).

8.1 Educator not performing their role

The educator should be educated and supported by the DME and the Specialty/College Tutor/TPD as appropriate. All educators should have clear written roles and responsibilities and have up to date training. The establishment of Local Faculty Groups will enable regular discussion about the educator role and its challenges and expectations. All hospitals should have incorporated the educator role into annual NHS appraisal to encourage reflection and personal development of the role.

8.2 Trainee complains about their educator

The person investigating should be outside the immediate hierarchy of judgment for that particular trainee. The Educational Supervisor and the TPD are responsible for the judgments associated with trainee progression and to preserve this important relationship they should not be directly responsible for investigating the issues raised.
Investigators could include:

For the LEP – the Specialty/College Tutor supported by DME.
For the School – a nominated individual (SAC rep, regional adviser, STC Chair) supported by specialist from the Deanery Support Unit, an Associate/Deputy Dean or local DME.

8.3 Complaint about an educator is 'significant' – Level 3, 4 and 5

Level 3 - A review team of experienced educators from the Deanery with, possibly, some externality e.g. from the STC/SAC, should be able to manage most problems.

Level 4 and 5 - Involvement from the employing Trust will be needed. This will usually involve the MD or their deputy, and a representative from Human Resources (HR). This team should meet with both trainee and educator, and then collate, review and triangulate the evidence. Much of the evidence is usually available within the training records of the trainee(s) in question.

An investigating educational team should ideally consist of at least three people:

- Someone with experience of having complaints made against them, who has returned to training after investigation.
- Someone who has been on a previous investigation/Deanery visit.
- Senior educator who has been NCAS trained to participate in an investigation or visit.

The professional practice component is likely to include an HR representative from the educator's employing trust to provide administrative support and rapid action if further Trust processes were to be considered. For more serious problems it may also include the MD or their deputy.

The next step will depend on the nature of the evidence collected. This may range from additional support, mediation between the educator and the complainant, to referring one or both parties to the regulator or even the police.

Serious issues related to personal conduct, such as allegations of inappropriate behaviours such as bullying or sexual harassment must be referred to HR who should take the lead in the investigation. The Tutor/DME should remain involved in an educational capacity to support both trainer and trainee.

The diagnostic framework and suggested management options proposed here attempt to provide the investigating team with a systematic approach to dealing with these challenging and often complex issues.

Formal management guidelines and protocols from your local HEE / deanery, LEP or employing organisation supersede this guidance in all circumstances

9. Consider all the dimensions to the problem

There are often many dimensions to the problem. Effective and fair management of educators in difficulty requires an objective assessment of all the circumstances.

9.1 Trainee expectations and requirements from their educator

These vary and depend on previous experiences of education and supervision, their own professional security of progression in training together with a host of personal issues such as changing jobs, moving regions, countries/cultures, personal life events etc.

9.2 Supervisors may be new to the role and feel inexperienced

The relationship required nowadays is more about facilitative coaching conversations focusing on professional skills rather than the old-fashioned 'teacher' model of teaching clinical skills. New educators may lack confidence discussing professional skills and reflective practice.

9.3 Changes to training or service structures

A problem with an educator may arise after a new TPD is appointed or when a service or training reorganisation disrupts the normal lines of administration and support. This may be the result of previously hidden issues coming to light.

9.4 Serious performance issues amongst trainees are rare

This infrequency, together with an educator's perceived lack of expertise, the increasing requirement for robust evidence and fear of being accused of bias or prejudice, heightens the educator's anxiety when required to deal with a trainee with performance / conduct issues.

9.5 Diversity and difference

A significant number of colleagues come from other countries, cultures, religions or other differences where healthcare systems and social/cultural norms are sometimes quite different. This complexity may introduce conflicting tensions and make effective management all the more challenging.

9.6 Confounding Elements

Confounding elements include legal aspects, health and safety, employment, race, sexual and gender discrimination legislation amongst others. An educator may have a confounding conflict of interest blurring boundaries as a clinician when trainees have health issues, or when an educator knows the trainee or trainee's family outside work. There may also be moral, ethical or confidentiality considerations.

9.7 HR Factors

HR factors, such as bullying and harassment, litigation, industrial tribunals, conflict management, the need for mediation and reconciliation.

9.8 Challenge of having effective 'difficult' conversations

Communication can be challenging in both verbal and written forms, and formal and informal contexts.

9.9 Professional accountability and registration

Issues around professional accountability and professional registration, including your own.

10. Roles and Responsibilities

10.1 The Educator

As an employee, an educator has a contractual relationship with their employer and is subject to local and national terms and conditions for both their clinical role and their training responsibilities. Educators have a professional responsibility to ensure they are up to date and fit to practice in their educational role. This role should be discussed in their NHS Appraisal and any fitness to practice concerns reported to the doctor's RO. If the performance of an educator is a concern, either because of capability, conduct or health, this will usually be managed by reference to Maintaining High Professional Standards[4].

10.2 The Local Education Provider (LEP)

There is an Educational Contract between the Deanery/LETB and the LEP stating the requirements for PGME, its regulation and quality management. The DME, supported by Specialty/College Tutors in each department, is responsible for the quality of training, recognising educators and providing faculty development opportunities. The Tutor oversees the allocation of educators to specific trainees.

The Clinical Director / Clinical Lead is responsible for managing performance and disciplinary matters in a proportionate, timely and objective way. They should have robust processes for the identification, support and management of doctors whose conduct; health or performance is giving rise for concern. HR and Occupational Health may also be involved. Employing organisations have a contractual responsibility to provide counselling and pastoral care for all doctors.

10.3 The Postgraduate Dean

The Postgraduate Dean is responsible for all doctors in training programmes, including those OOP (out of programme) with a National Training Number (NTN) and for overseeing effective systems for managing problems that arise.

The LETB / Deanery is responsible for ensuring the quality management of PGME and should have systems in place to respond quickly to any concerns raised. They should have a process for educational governance and operational educational frameworks led by the Head of School and TPDs, under the supervision and guidance of the Associate and Postgraduate Deans. LEPs must keep the School / Deanery informed of all significant concerns about an educator and vice versa. LEPs and Deaneries/LETBs should have a process to manage issues relating to educator in difficulty to enable investigation, support and shared learning. In small specialties consider augmenting this with external expertise from the STC/SAC. Further information can be found within the current edition of the Gold Guide (see COPMeD website).

10.4 The National Clinical Assessment Service (NCAS)[5]

NCAS can offer specialist expertise in assessing complex issues of doctor performance. They provide a framework for local assessment so that problems can be identified, and a plan developed to address them.

10.5 The General Medical Council (GMC)

The GMC should be involved in all cases if there are concerns about fitness to practice, or if the educator's revalidation is called into question. Good Medical Practice[6] applies to all doctors and this includes the responsibility to raise concerns about the fitness to practice of another doctor.

It also states that

- 'You must work collaboratively with colleagues, respecting their skills and contributions'.
- 'You must treat colleagues fairly and with respect'.
- 'You must be aware of how your behaviour may influence others within and outside the team'.

11. General Principles – investigating an educator in difficulty

The first step is to decide if it is a 'serious' complaint (which may involve the educator's line manager or other agencies). The seriousness of the problem may evolve as evidence is collected. Efficiently collecting all the existing evidence that is instantly available will help gauge the level of the issue. The second step is to talk to the educator. After this initial interview, further triangulating information could be collected.

11.1 Are there patient safety issues?

Assess the nature of the complaint (including if it has been made by the correct route). Issues of patient and staff safety take precedence over all other considerations. If there is a patient safety, trainee safety or criminal component then the situation should be reported to the educator's line manager immediately. The relevant Specialty/College Tutor/DME/Education Manager should be informed so they can find alternative educator(s) for the trainee(s) and inform the Head of School/TPD/Dean as necessary. The Tutor should also ensure that the educator is offered appropriate support during any subsequent investigation.

11.2 Inappropriate behaviour (Including Bullying and harassment)

The educator's employing hospital will have clear policies that should be followed. The initial stages are informal data collection (rather than exclusion). If a bullying complaint is anonymous, verbal or a group complaint, it is still important and will need further investigation and evidence. The educator must be involved and should be offered advice and support. It is well recognised that trainees who are having difficulties often misinterpret difficult or challenging feedback as 'bullying' or 'harassment'. In appropriate sexual behaviour is another important area for investigation and must involve the Trust HR processes.

11.3 Is the problem serious? Genuine mistakes can happen

Educators can make mistakes in their educational roles with trainees. Approaches may be perceived differently; demarcation of clear boundaries may be received as inappropriate behaviours including undermining or bullying. This may occur early in an educator's career but can also occur when very experienced. This can be upsetting for the educator and for example can precipitate a defensive response or lead to a sense of disillusionment, even in senior educators. When a trainee becomes a consultant in the region they trained in, the change from being another trainee's peer to being that trainee's educator can be challenging.

11.4 Meet the educator and complainant

Involve the educator as soon as you have written information about them. The purpose of the meeting is to hear their viewpoint - they may have useful insight into the issues, which provoked the complaint. A lack of insight can also be revealing. Remember to remain non-judgmental, objective and not to collude. This can be challenging with colleagues. Considering involving a colleague to talk to the educator or complainant can be helpful to keep some separation between these two lines of enquiry and body of evidence as it is assembled.

The meeting will not define the issue or determine an action but to inform the educator about the complaint and to establish a supportive relationship. Inform them that you are going to collect further information and encourage the educator to help with this.

11.5 Collect information - establish and clarify the facts

All documentation regarding the issue should be gathered in one place for review. This should include but not be limited to:

- Educator Information, such as training and support in the role, feedback from previous trainees, engagement with educational activities such as ARCP etc.
- Trainee information, such as general progress, previous assessments, e-portfolio data etc.
- External information, such as GMC trainee/NETS survey data, local feedback, information regarding department resources, staffing and rota's etc.

Also collect information about the trainee complainant. It may be that they are in difficulty, that. their educator may be thorough, with high expectations, and has given some rigorous feedback.

11.6 Review information, meet educator and the complainant

Most concerns can be addressed by early, effective discussions between the investigator and the educator culminating in a realistic and pragmatic action plan, which is regularly reviewed to monitor satisfactory progress. An open and supportive culture should be encouraged. On occasions further information may be required and permission sought for this.

11.7 Keep the complainant involved and informed

11.8 Additional Data collection

11.8.1 Multi-source Feedback. When serious accusations have been made (particularly when the majority of trainees support the allegation), then an MSF can be a relatively rapid, structured way of confirming or refuting the problem. If MSF confirms the problem, then those trained in processing feedback can help the educator address their weaknesses. If the MSF refutes the problem, then further clarification may be needed with the source of the complaint. Consider including previous trainees in the MSF, as separate identifiable group.

11.8.2 Structured interview. A structured interview with all current trainees (and maybe past trainees too) specifically addressing the problems highlighted. All those who work with the educator could be contacted and asked for their observations. A meeting with the education team (other educators, TPD, STC members etc) may be required if the problem appears of a system rather than individual nature. These interviews could be led by the investigator or delegated to a neutral third party.

11.9 Explore underlying causes of poor performance

- Not understanding educational role (knowledge, skills).
- Personal, attitude and behavioural issues: (professionalism, motivation, cultural and religious issues).
- Sickness / ill health: (personal/work stress, career frustrations, financial).
- Environmental issues: (organisational, workload, bullying and harassment).

Both trainees and educators require a high degree of professionalism. They have to relate to each other regardless of personality and other personal factors. We cannot 'choose' our trainees / educators i.e. the ones we get on with / like. This is particularly important in small specialties with few trainees and few educators.

'Stress is not a characteristic of jobs but of doctors; different doctors in the same job being no more similar in their stress and burnout than different doctors in different jobs' (McManus et al., 2004, p. 9) [7]. Tutors should be on the lookout for educator burnout and move trainees accordingly so that all take their share of training. This is particularly true where an educator has been involved in a particularly challenging encounter. This needs to be handled sensitively so that the educator does not feel that he/she is being punished by being 'suspended' from the role, but rather given an opportunity to rest and reflect.

'What started out as important, meaningful and challenging work, becomes unpleasant, unfulfilling and meaningless. Energy turns into exhaustion, involvement turns into cynicism, and efficacy turns into ineffectiveness'.[8]

It is the collective responsibility of the whole department to ensure that trainees receive appropriate training and feedback – not just the duty of 'Mr Nice Guy'

11.10 Formulate SMART[9] plan with support and review; different problems require different solutions

A doctor with an evolving medical problem, e.g. new diabetes or mental health issue, requires a different approach than an individual with poor interpersonal skills or lack of insight. The former needs engagement with occupational health and a GP, the latter perhaps supportive mentoring and feedback to change the beliefs behind the undesired behaviour.

11.11 Clear documentation

All relevant discussions and interventions with both trainee and educator should be documented contemporaneously, communicated to both parties and key individuals in the accountability framework (Trust and/or School/Deanery, possibly GMC) and followed up by named accountable individuals such as the Educational Supervisor, HoS, TPD or DME to ensure the process is concluded satisfactorily and managed appropriately. It is important to follow up to date local Trust and LETB/Deanery guidelines for accountability frameworks. Remember that an individual has the right to put in a Subject Access Request for any information stored about them. Ensure any information stored or exchanged (written or electronic) is factual, accurate and compatible with local Information Governance procedures.

11.12 Handling anonymity requests

Allegations should be open so that they can be appropriately investigated, and all parties should see the pertinent evidence. It is strongly recommended that educators should be allowed to see the details of the allegations made against them as they have a right to reply. Complainants must be supported in raising issues without fear of personal recrimination. Accusations of inappropriate behaviours including sexual and bullying allegations cannot be anonymous. Protected disclosure is legally defined and could involve complaints against educators where it is alleged that their conduct gives rise to patient safety concerns.

When faced with a complaint or issue relating to an educator it is important to remain non-judgmental, obtain written information from all parties, check factual accuracy of all reports, triangulate data in a transparent manner and attempt to remedy the problem

12. A Diagnostic Framework

‘Events and Diagnostic Process’

Trigger event or complaint

Investigate. Define the problem.

Speak to both parties and listen.

Collate evidence from as many sources as possible.

Be objective and document in detail

Decide nature of problem(s)

Is this an individual performance issue?

An organisational issue?

Or both?

Consider the following three questions

‘Does ‘it’ matter?’

If **no,** relax!

If yes, do something! Next ask…

‘Can they normally do ‘it’?’

If **no** then it is a training or personal motivation issue – resolution may be possible with training or support.

They may also be ‘un-trainable’ and hence never be able to do ‘it’. This is a ‘diagnosis of exclusion’ and can only be reached when a period of intensive training has proven ineffective.

If **yes** the next question is…

‘Why are they not doing ‘it’ now?’

Have training requirements changed?

Is the trainee (complainant) in difficulty?

Has their workload changed?

Are they ill?

Who needs to be involved in the management of the diagnosis and how directly / how soon?

‘Thoughts’

Are there patient or trainee safety issues?

Is it in isolation? – Genuine mistakes happen

Does it really matter? Is it serious?

Is this educator new / experienced?

Who do I need to talk to?

Do not jump to conclusions initially. Formulate your opinion as the investigation proceeds.

Is it one trainee or all trainees?

Why now?

This analysis is crucial as systems failure is often overlooked and it is easy to blame the individual in isolation - try and resist this temptation!

Be fair and objective.

Key areas to explore when considering poor performance i.e.

‘Potential Diagnoses’

i) Clinical performance

ii) Personal, personality and behavioural issues including impact of cultural and religious background

iii) Physical and mental health issues

iv) Environmental issues including process factors, organisational issues and lack of resources / time

Protect patients from harm

Protect people raising the concerns

Keep complainants involved / informed

Support the educator

Protect the organisation(s)

If the problem is institutional or extends beyond the educator themselves, who should be involved?

Interventions should be tailored to underlying ‘diagnosis’.
Systems failure usually play some part – not just educator failure
A successful outcome is often achievable but only with appropriate intervention.

13. A Management Framework for 'Educators in Difficulty'

The interventions depend upon the underlying 'diagnosis' or 'diagnoses'

13.1 Not understanding role

Some educators may be under-performing in specific aspects of their role and this should be addressed directly with focussed training or mentoring. All educators should understand their responsibilities towards trainees and undergo updates to keep them current.

13.2 Attitude and behavioural issues

Trainees expect to be respected, valued and included in clinical discussions. They are more likely to complain if they do not get what they want / need. A good workplace learning environment[3] with educational leadership from the Specialty Tutor and functioning Local Faculty Group goes a long way to ensuring that educators understand their role and feel supported. Accepted personal and professional behaviours should be agreed with the senior team and a clear way of tackling deviancy is key. This area is sensitive and difficult, but with appropriate communication skills, progress can often be made.

13.3 Health Issues – physical and mental

- Consider physical and mental health and substance misuse such as drugs or alcohol.
- *Good Medical Practice* requires doctors to seek and follow advice from a Consultant Occupational Physician if their judgement or performance might be affected by illness.
- Ensure adequate support is available e.g. mentor, Staff Counselling services etc.
- Consider national services such as 'Doctor Support Network' or 'Doctors for Doctors' run by the British Medical Association.

13.4 Environmental issues

Is the educator in difficulty or the trainee or the training programme? Problems with educators are often intimately entwined in issues with colleagues, environment and problem trainees. The problem may even be at TPD level. It is recognised that medical mistakes often happen "because systems are not working as they should" rather than because doctors are careless. An educator or educators may be blamed when complaints or whistle blowing fit with other personal / management / political objectives within a training rotation/region.

13.5 Consider training programme factors.

- Does the educator know what is expected?
- Have they received any training?
- How do we give feedback to the educators?
- Could this have been spotted sooner?

The National Clinical Assessment Service (NCAS) has identified that organisational issues, including systems or process failures are often under acknowledged in the investigation of poorly performing individuals.

"Failures include lack of resources, such as poorly maintained equipment, inadequate secretarial support, computer equipment etc., unrealistic work demands, poor clinical management, poor support and substandard working environments."

All can prove to be confounding variables when other problems arise and can often precipitate a dramatic deterioration in performance.

14. Common Reasons why Educators get into Difficulty

Area of difficulty	Evidence that should be collected.	Possible interventions
Clinical concerns	Document concerns. Is the educator role contributing?	Refer to Clinical Director. Follow Trust process.
Educator failing to engage with portfolio	Is the trainee driving the process? Does the educator require training?	Educator requires training. Trainees advised how to support an educator with portfolio.
Poor trainee /educator relationship	GMC requirement to work with colleagues.	Facilitated resolution with mediator and agreement from all sides.
Personal and professional behaviours including bullying and undermining	Written. Follow Trust policy. MSF from other trainees, and recent past trainees.	The trainee and educator should be made aware of Trust policies.
Lack of training opportunities	Trainees logbook / portfolio by date and time.	Why have training opportunities been missed? Agree plan to prevent this in future.
Complaint of serious misconduct or of a criminal nature, may include inappropriate sexual behaviour	Clinical Director involved. Hospital should investigate. Deanery/LETB should not become directly involved.	Complaint substantiated – GMC. Complaint unsubstantiated - Complaint not on educator's record. If persons making the complaint refuse to take it through the appropriate channels, then it should be treated as an unsubstantiated complaint.
Trainee who is failing / in trouble and blaming educator	Clarify the nature of the problem from as many sources as possible.	Local Faculty group report. Trainee 360. Tutor to support the educator.
Educator not allowing trainee to take responsibility	Details of situations. Educators view of the complexity.	Trainee not fully aware of the reasons for educator's decisions. New consultants may not be ready to take on responsibility of training in areas where they still feel they need to develop themselves.
Lack of supervision	Details of specific episodes where the trainee felt that they lacked supervision.	Education and support of educator Specialty/College Tutor.
Not enough surgical or practical experience being offered to the trainee by educator	Shortage of clinical material? Is the trainee prepared? Problems with workflow or timetabling. Are there competing trainees? Is trainee avoiding experience?	Set the rules of engagement clearly in the learning agreement – trainee should come to theatre prepared. Review the timetable for the trainee. Are they missing opportunities because of zero hours or rest periods, can these be changed? If educator unwilling to offer experience to a prepared trainee, then withdrawal of the trainee might be the only option.
Criminal activity	None – leave to proper authorities.	Report to Medical/Clinical Director, NHS Fraud, Police or appropriate authority.

15. References

1. Supporting Trainees: A Guide for Supervisors NACT UK 2018
http://www.nact.org.uk/getfile/8153/

Promoting excellence: standards for medical education and training. GMC July 2015
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3. Faculty Guide: The workplace learning environment NACT UK 2013
http://www.nact.org.uk/documents/national-documents/

4. Maintaining High Professional Standards in the modern NHS. DH 2005.
http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103586

5. Practitioner Performance Advice
https://resolution.nhs.uk/services/practitioner-performance-advice/

1. Useful Report: How to conduct a local performance investigation 2010

6. https://resolution.nhs.uk/wp-content/uploads/2019/03/How-to-conduct-a-local-investigation.pdf

7. Good Medical Practice. GMC 2013
http://www.gmc-uk.org/guidance/good_medical_practice.asp

8. Stress, burnout and doctors' attitudes to work are determined by personality and learning style: A twelve-year longitudinal study of UK medical graduates. McManus IC, Keeling A Paice E. BMC Medicine 2004, 2:29.
http://www.biomedcentral.com/1741-7015/2/29

9. Job burnout. Maslach C, Schaufeli WB, Leiter MP. Annu Rev Psychol. 2001;52:397–422.
https://www.annualreviews.org/doi/pdf/10.1146/annurev.psych.52.1.397

10. SMART in education usually means Specific, Measurable, Achievable, Realistic and Time-based but other similar words have been attributed
https://en.wikipedia.org/wiki/SMART_criteria

16. Useful Resources

Local Employing Trust / Employer Guidelines and Policies

LETB / Deanery Guidelines for Dealing with Doctors in Difficulty

16.1 Bullying

Royal College of Obstetrics and Gynaecology / Royal Society of Midwives: Undermining Toolkit: One of the best resources on the internet for managing undermining behaviour in the workplace.
https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/improving-workplace-behaviours-dealing-with-undermining/undermining-toolkit/
NHS Bullying advice
http://www.nhs.uk/Livewell/workplacehealth/Pages/bullyingatwork.aspx

Bullying NHS Employers Guidance
https://www.nhsemployers.org/-/media/Employers/Publications/NHS-Bullying-Infographic.pdf?la=en&hash=C718BB43F770A967AFE117F69825EC6BA6CFD16A
https://www.nhsemployers.org/retention-and-staff-experience/tackling-bullying-in-the-nhs

16.2 Performance Issues with Surgeons (who are educators)

Improving Surgical Practice: includes a 'self-assessment' questionnaire, which would be useful for the educator involved to complete in the context of their own and their units surgical practice
https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/improving-surgical-practice-learning-from-the-experience-of-rcs-invited-reviews/

Good Surgical Practice – RCS England: Complimentary to GMC's Good Medical Practice
https://www.rcseng.ac.uk/surgeons/surgical-standards/professionalism-surgery/gsp/documents/good-surgical-practice-pdf

Invited Review Mechanism (IRM) RCS England
IRM is a partnership between the RCS, the specialty associations and lay reviewers representing the patient and public interest. An invited review supports - but does not replace - existing procedures for managing surgical performance.
https://www.rcseng.ac.uk/standards-and-research/support-for-surgeons-and-services/irm/

16.3 Medical Errors

Medical Errors – Joint MDU, MPS and NPSA Publication
http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=74247and

16.4 Clinical Supervision

AMEE Guide No. 27: Effective educational and clinical supervision. Med Teach. 2007 Feb;29(1):2-19. Kilminster S, Cottrell D, Grant J, Jolly B.
https://www.researchgate.net/profile/Janet_Grant2/publication/6297076_AMEE_Guide_N_27_Effective_educational_and_clinical_supervision/links/02e7e52e4fff8cec5f000000/AMEE-Guide-N-27-Effective-educational-and-clinical-supervision.pdf?origin=publication_detail

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Meeting record

APPENDIX 1

Always act fairly, equitably, supportively and confidentially within the training accountability framework

Educator Name: Date and Time:

List trainees that the educatoris involved with

Trainee	Role with this trainee	Programme	Training Prog Director

Persons Present:

Meeting led by: Notes taken by:

Concerns
State concerns and who / how they came to light

Discussion
Find out the facts, remain non-judgmental, and listen.

Consider

Are there any patient safety concerns?
YES / NO
If yes inform Clinical / Medical Director and HR

Have they got a GP?
YES / NO
What are the issues?

Clinical Performance
YES / NO

Attitudinal / Behavioural
YES / NO

Physical illness
YES / NO

Mental illness
YES / NO

Environmental issue
YES / NO
- support
- workload
- other

Action Plan

This may not be possible / relevant after the first fact-finding meeting. Return when triangulated information to create action plan.

What is the next step	Clear written Objectives	How will these be met (action and resources)	Date set to achieve goal	Date actually completed

Document agreed SMART goals and objectives:

i.e. Specific, Measurable, Achievable Relevant Time-framed

Use local educators and tutors for support

Agree clear timeframe

Identify date for review

Has the trainee got adequate support?

Date of next Review:

Refer to Occupational Health YES / NO Involve *(circle if appropriate)* Clinical Director/Director of Medical Education/School/other

Signed…… Signed…….. Signed…… Person leading the meeting
3rd person (if present) Colleague/Tutor Educator

Date……

APPENDIX 2

Joint Reflection on Difficult Communication Episode (JRDCE)

In medicine there is a tradition of learning from mistakes and adopting practices which reduce the likelihood of recurrence. When an episode of feedback doesn't go smoothly, there is a tendency to ignore it as the educator may fear being reported for bullying, and the trainee may feel they have shown weakness.

Best practice would be for both parties, when the dust has settled, to reflect on the episode and share these reflections. This could be done informally and verbally, but there is much to be gained by both sharing their reflections in writing, initially by both parties separately and then a joint reflection completed and added to the trainees record (in addition, the educator could add their reflections and the joint reflections to their appraisal documentation). Reflection should improve resilience, awareness and insight.

This document is based on a Significant Incident Form, which is well validated in training, but a few cues have been added to help both parties. Concerning signs include: A department or individual who seldom or never completes an incident form (suggests disengagement or an excessively high threshold for incident reporting). An educator or trainee who declares that they have never experienced a communication breakdown; Educators completing forms excessively.

(Joint) Reflection on Difficult Communication Episode (JRDCE)

Date and time of DCE:

Date of start of this reflection

Date joint reflection written (if at all):

What happened?

Describe what actually happened in detail AND what made the communication difficult. Consider:

a) The context, for instance, how it happened, where it happened, who was involved and what the impact or potential impact was on the patient, the team, organisation and/or others.

b) What made the communication difficult?

Why did it happen in the way it happened?

(Describe the main and underlying reasons (both positive and negative) contributing to why the communication was difficult. Consider, for instance, what was said, how it was said, if others witnessed the exchange, it may be worth asking them what they thought.

What have you learned? What would you do differently next time and what do you think the other person should do differently?

(This part of the document may be revised when both parties have seen the others version, to create a single agreed version)

What would you advise another person or other people in the same position to do?

APPENDIX 3

Bullying and Harassment

There is an excellent web-based 'Undermining Toolkit' launched in November 2014 by the RCOG, which is concise, comprehensive and structured and is a free resource for all to use. It stresses the benefits of improving workplace-based behaviours and promoting 'behaviour champions' in a prospective positive way. It has interventions for individuals (both victims and perpetrators), departments, local educators and over-arching organisations.

There may be times when negative feedback has to given acutely, without the opportunity to wrap it in two layers of good news and trainees should be prepared to process this critical feedback and learn from it. This is a core life skill and assists with developing resilience which is essential for careers in medicine. Everyone can have a bad day and sometimes the correct response of those involved in an 'episode of difficult communication' is for all parties to reflect on it and learn for the next time (the toolkit has a document to support this).

The aim is to improve everyone's behaviour, encourage discussion about acceptable and unacceptable behaviours and for everyone to be open to hearing how the impact of their behaviour affected others.

The principles of the NHS Bullying and Harassment Policy is summarised below.

The doctor's HR department should investigate serious concerns about a doctor's conduct.

NHS Bullying and Harassment Policy

Step 1: Initial response

Following receipt of the letter of complaint the investigating manager has five working days to inform the employee that an investigation will be undertaken and ensure that the employee is made aware of the process that will be adopted during the investigation, and what their role may be at any subsequent disciplinary proceedings that may take place. The person against whom the complaint is made should also be informed at the outset of the investigation of the complaint against them and given a copy of the letter of complaint.

Step 2: Possible suspension or redeployment during the investigation

The investigating manager should consider the appropriateness of suspension or redeployment for the duration of the investigation to relieve the stress and pressure on one or both parties and/or to prevent the risk of further incidents or victimisation occurring.

Suspension of the alleged harasser may be considered where a manager feels that it is in the interest of either the individual, the organisation or both. It may be appropriate in some cases for both parties to be suspended. It will be made clear at all times that suspension under this procedure is not a disciplinary act and does not imply that there has been any misconduct, or that there is any suggestion of guilt.

Temporary redeployment of one or both parties can also be considered. In normal circumstances it is appropriate that the alleged bully/harasser should be redeployed rather than the complainant. The complainant could, however, be offered the option of redeployment where appropriate. In some circumstances both parties may be redeployed.

Step 3: Meeting with the complainant

Following receipt of the letter of complaint the investigating manager has 10 working days to sensibly, sensitively arrange and conduct a meeting with the complainant. The purpose of the meeting is for the investigating manager to take a detailed written statement of the incident(s). A trade union official, equivalent professional representative or a colleague may assist the complainant. The complainant should be given the opportunity to nominate witnesses whom they wish to be interviewed by the investigating manager.

Step 4: Meeting with the person against whom the complaint has been made

The investigating manager will meet with the person against whom the complaint has been made and hear what they have to say about the alleged incident(s) having previously been informed of the allegation against them. Their trade union official, equivalent professional representative or a colleague may assist them. Notes of the meeting will be taken. The employee should be given the opportunity to nominate witnesses whom they wish to be interviewed by the investigating manager.

Step 5: Meeting with the witnesses

The investigating manager will meet with the witnesses nominated by the complainant and the alleged bully/harasser. Employees identified as witnesses to incidents may be assisted at the meeting by their trade union official, equivalent professional representative or a colleague. Notes of the meeting will be taken.

Important notes for steps 3–5

- The purpose of these meetings is to establish the facts. They are not disciplinary hearings of any sort. All those giving information to the manager or designated investigating officer will do so privately and not in the presence of any other person involved in or present during the alleged incident(s).
- Notes taken during these meetings will be made available to all those involved in their particular meeting and comments can be made if appropriate.

Step 6: Further clarification

The investigating manager may decide to meet any of the employees again to clarify or gain further information. He/she must also ensure that they obtain copies of any written material that may be used as evidence.

Step 7: Consideration of information

Having obtained all the information possible, the investigating manager and HR representative will review the information and decide whether the complaint is substantiated. In cases of sexual harassment, in no circumstances will evidence of the complainant's experience, sexual attitudes or behaviour be taken as relevant information.

In some cases, there will not be any witnesses and it will be one person's word against another's. In this instance, the investigating manager and HR representative will consider whether on the balance of probabilities the incidents/actions occurred.

Step 8: Further action

The investigating manager and HR representative will consider the facts and will recommend one of the following:

1. Take no action, as the allegation has not been substantiated or there is insufficient evidence.
2. Proceed to a disciplinary hearing, as the investigation has found that there may be a case to answer.
3. Take alternative management action, as the evidence and/or nature of the complaint do not justify formal disciplinary action. This could include:

- A recommendation for facilitated discussion/counselling for both parties, where both parties agree to this.
- A recommendation for redeployment of one or both parties, either on a temporary or permanent basis.
- Setting up arrangements to monitor the situation.
- Required attendance on training courses (such as equality and diversity awareness training).
- A period of special leave to enable working arrangements to be put in place. The preliminary investigation procedure will take no longer than four weeks.

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APPENDIX 4

Workplace Learning Environment

The clinical workplace is increasingly demanding for both trainees and educators. The expectations of managers and patients demand rapid service throughput with excellent individual patient care without incident or complaint. This requires good consistent team working with both senior and junior medical colleagues and across the whole multi-professional team. The learners in this workplace environment quickly gauge the culture of the team and this will determine their 'safety' and how much they will take away from this team, both clinical and non-clinical skills. Further discussion on the Workplace Learning Environment is found in the Faculty Guide[3].

Key ingredients for a Good Environment

Prioritise time for training

- Discussion around relevant cases - 2-3 minutes
- Time for feedback – both on the hoof and more formal settings

Learners Needs known and appreciated / respected by others

- CDs and managers aware
- Trainers valued, time in job plan, role reviewed and performance managed
- Time for Local Faculty Group and faculty development
- Learners own their curriculum and learning needs and state them
- Learners respect the role of others and the needs of the patients and service

Trainer Behaviours

- Organisation and planning for the learning
- Identify and prioritise opportunities
- Delegate suitable cases / opportunities
- Identify learners' needs and clarify learning goals
- Ensure clinical and non-clinical aspects covered
- Enthusiasm and willingness to support learners
- Consistent behaviours and expectations between trainers
- How to observe and give feedback – safe, non-judgmental
- Give constructive critical feedback in appropriate manner to learner taking into consideration personal characteristics, experience and trainee seniority
- Articulate their own learning needs around educational role
- Engage with Supervisors and Tutors to remain up to date
- Ask and receive feedback from learners on clinical and educational issues
- Communicate with Supervisors regarding individual trainees
- Be honest and constructive with trainee feedback and document it

Departmental Code

- Learners welcome, expectations articulated, made to feel comfortable
- Learners behaviours made known – ask, role of MDT etc.
- Trainees valued, given roles, included in team
- Roles of learners know to themselves and known to others
- MDT understand how to give (and receive) feedback
- Known acceptable behaviours and agreed mechanism to address unacceptable behaviours