COMMENTARY

Understanding and remedying the performance of doctors in training

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Identifying and responding appropriately to doctors who are underperforming, whether they are in training or in clinical practice, is vital in a profession where high standards are a pre-requisite for ensuring high-quality care that is safe and effective and provides patients with a good experience.[1]

> *Identifying and responding appropriately to doctors who are underperforming, whether they are in training or in clinical practice, is vital.*

That said, underperformance in doctors is often difficult to understand and deal with, both for learners and for educators. The study presented in this issue, by Gingerich and colleagues entitled 'Seeing but not believing: Insights into the intractability of failure to fail',[2] provides important insights into why this is, by exploring the socio-cognitive rules that guide how educators conceptualise, recognise, document and communicate underperformance, as a precursor to evaluation and remediation. Here, I reflect on their findings by juxtaposing them with other seminal works in an effort to further explore the stubborn challenge they address.

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We know that recognition and documentation of performance successes and deficits are key parts of the process of assessment. Assessment is fundamental to the role of the educator and one of the three components of the educational triangle of objectives-methods-assessment. This consists of setting learning objectives, deciding upon the educational methods to achieve them and selecting assessment strategies to evaluate whether targets have been met.[3] Despite considerable efforts over the years, however, to create frameworks to guide the assessment of competence, we still struggle to identify the many things that might define underperformance. That is, even when using frameworks such as CanMEDS,[4] which broaden consideration to a variety of roles including medical expert, communicator, collaborator, manager, health advocate, scholar and professional, educators tend to focus on assessing the role of medical expert.[5]

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A previous systematic review by Boileau and colleagues, asking 'Is there a way for clinical teachers to assist struggling learners?', found various frameworks for understanding underperformance, but few were comprehensive and none were in widespread use.[6] The review synthesised published classification systems of underperformance in medical education, summarising these as 'cognitive' (due to insufficient knowledge or problems with clinical reasoning) and 'non-cognitive' (due to attitudinal or affective problems).[6] In doing so, the review revealed the limitations of these groupings given that such systems make no provision for key skills other than clinical reasoning (eg relationship-centred care and management skills).

Pushing us beyond such efforts to specify and frame what struggling learners struggle with, Gingerich et al used a grounded theory approach, interviewing educational supervisors in a limited range of specialties who had particular experience with underperforming doctors.[2] Noteworthy was that supervisors by default expected trainees to be capable of learning and applying what they learned. In other words, underperformance, labelled as such because of supervisors' aversion to the word 'incompetence', was a surprise that prompted disbelief and the urge to seek other explanations for a trainee's failure to progress. When individuals appeared to be trying, supervisors felt they must be unable to engage sufficiently with learning due to either temporary situational factors, a relevant medical condition or learning disability. Underperformance by individuals deemed *not* to be trying was felt by supervisors to be due to either a lack of interest in a specific rotation or a failure to recognise they had improvements to make.[2] These observations suggest that the challenge facing preceptors is less about identifying with what learners are struggling and more about grappling with their own cognitive dissonance in search for explanations as to why capable students might be struggling.

This search is consistent with previous seminal work by others[7,8] that suggest educators seek to avoid being seen (by themselves, their trainees and others) as failing their trainees. Together, these studies suggest a conscious or unconscious need on the part of supervisors to rationalise the disbelief created by trainees not progressing, when they appear to be trying and have been given additional targeted support. If everyone 'should' progress, a lack of adequate progression means there 'must' be an undiscovered path to competence. Although there may be cases in which students simply lack capacity to learn the material, that preceptors engage in such a search is encouraging because there are a great many alternative explanations that require a more holistic conceptualisation of underperformance (and one can always come back to the conclusion that the learner is not able, after alternative options have been exhausted). The question, therefore, becomes, how can we more effectively enable educators to give due consideration to the many reasons they can conceive for explaining underperformance in their trainees.

More holistic conceptualisation of underperformance would enable educators to deal more meaningfully and objectively with underperformance in their trainees.

Answering this question requires consideration of the many similarities this reasoning process has to the diagnostic process that doctors use with their patients. It is well known in that domain that identifying patterns and responding to them based on expectations with limited information can lead to errors in judgement by locking clinicians in on particular explanations. Giving due consideration to alternatives often requires deliberate prompting (ie explicit and careful consideration of what features are present that might refute or increase the likelihood of a diagnosis on a list of differentials). A fuller consideration of the many interacting factors that potentially influence underperformance, therefore, may need to be considered if we are to truly help our trainees advance.

Here, Norfolk's framework might prove to have practical value for enabling clinicians to consider possibilities more comprehensively. Labelled SKIPE[9] (Skills, Knowledge, Internal, Past and External factors), the aim of its development was to enable understanding of the underperforming doctor in all his or her complexity, to resolve the tension between individual and system factors and to develop a shared understanding of the problem by looking at the doctor's problems in dialogue with them and in context. The process involves checking each of the factors potentially undermining performance by first examining the directly identifiable domains (skills and knowledge) and then assessing other internal factors (especially attitudes, personal traits and health), past influences (eg professional background) and finally external factors (in the work and non-work environments).[9]

SKIPE (Skills, Knowledge, Internal, Past and External factors) is a comprehensive and holistic model for diagnosing the causes of individual medical performance problems.

Whether SKIPE or a different model is used, it is clear from the developing literature that accurate, holistic problem formulation in relation to underperformance is vital to successful remediation in trainees, exactly as it is to successful planning with patients. There nonetheless remains the thorny matter of finding effective interventions which will improve the doctor's performance for their future role rather than simply to pass an assessment,[10] but starting on a firmer foundation with respect to the root cause of the problem is likely to be invaluable in that regard. Rigorous methods are required to develop and evaluate effective interventions based on what we know and what we don't yet know about remediation,[11] but fortunately, there is now helpful guidance on which to base potential approaches.[11,12]

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