Health concerns, personal problems and underperformance in General Practice Registrars

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Abstract

Background: Early identification and management of underperformance is repeatedly highlighted in the remediation literature as being important and inadequately addressed health issues have often been found to underlie the overt clinical skills concern. Because of the prevalence of burnout, many studies emphasise the need for doctors generally to better attend to self-care and for the wider availability of supportive programs that promote resilience and prevent burnout. The literature however, is limited on how doctors, let alone general practice registrars, with health concerns may be identified and once identified, how they should be managed.

Method: This paper reflects on the experiences of a team of medical educators responsible for the management of underperforming registrars in a General Practice training program over a 10-year period, from 2006 to 2015. Data is presented showing the incidence of health concerns and personal problems affecting registrars who came to the attention of the medical educators managing remediation for that period. The paper also reflects on the processes that were developed for identifying and managing those registrars.

Results: Over the 10-year period, the incidence of health concerns and personal problems, and particularly anxiety related issues, increased while clinical skills concerns declined. A significant finding was that health concerns and personal problems impacted on clinical skills and the converse was also observed. Furthermore, unless identified health concerns and personal problems were addressed, any existing clinical skills concerns were not easily resolved. As processes improved, health concerns and personal problems were more readily identified and addressed, sometimes even before clinical skills concerns arose.

Conclusions: This study has provided insight into the nature of the health concerns and personal problems that general practice registrars contend with and highlights the importance of addressing those issues alongside any clinical skills issues in the interests of registrar wellbeing and patient safety.
Keywords: Remediation; Underperformance; Performance concerns; Clinical capability; General Practice; Registrars; Post-graduate trainees; Health; Anxiety

Introduction

Early identification and management of underperformance is repeatedly highlighted in the remediation literature as being important. Chronic illness and disability affects doctors like anyone else and illness is not a contra-indication to clinical practice, however, inadequately addressed health issues have often been found to underlie the overt clinical skills concern. The literature once again highlights the importance of addressing those health concerns at the same time as the clinical skills concerns. (Paice and Orton, 2005; Cox et al., 2006; Cohen, Rhydderch and Cooper, 2007; Lucey and Boote, 2008; NACT, 2018; Steinert, 2013)

It is well recognised that stress increases the risk of developing anxiety, depression and other health issues. (Dreher, 2003; Freeman, 2016) Stress itself can compound any pre-existing health issues (Dobkin and Hutchinson, 2010; Shattner et al., 2010; Shrestha and Joyce, 2011; Anagnostopoulos et al., 2012; Gómez-Gascón et al., 2013; IsHak et al., 2013; Lebensohn et al., 2013; Kehoe et al., 2016) and any significant illness, whether physical or mental, acute or ongoing, has the potential to affect judgment and performance, with subsequent impact on patient care. (Cox et al., 2006)

Some studies have identified that work stresses, work-life balance and mental health issues such as anxiety and depression, contribute not only to the development of burnout but also impact negatively on clinical performance and the well-being of the medical student and doctor. (Dobkin and Hutchinson, 2010; Shattner et al., 2010; Shrestha and Joyce, 2011; Anagnostopoulos et al., 2012; Gómez-Gascón et al., 2013; IsHak et al., 2013; Lebensohn et al., 2013; Kehoe et al., 2016) Many studies highlight the need for doctors to better attend to self-care and for the wider availability of supportive programs that promote resilience and prevent burnout. (Shattner et al., 2010; Shrestha and Joyce, 2011; Cooke, Doust and Steele, 2013; Galam et al., 2013; Gómez-Gascón et al., 2013; IsHak et al., 2013; Lebensohn et al., 2013; Linzer et al., 2013; Nedrow, Steckler and Hardman, 2013; Dyrbuye et al., 2014; Brennan and McGrady, 2015; Walters et al., 2015; Byrne et al., 2016) Indeed, the predominant focus of the medical literature, regarding the health of medical students and doctors, is burnout and its prevention. (Dobkin and Hutchinson, 2010; Shattner et al., 2010; Tartas et al., 2011; IsHak et al., 2013; Dyrbuye et al., 2014; Rutherford and Oda, 2014)

The literature, however, is limited on how health concerns may be identified and once identified, how they should be managed. It is also limited regarding the health of general practice registrars (GPRs). (Shattner et al., 2010; Cooke, Doust and Steele, 2013; Galam et al., 2013; Rutherford and Oda, 2014; Brennan and McGrady, 2015) The aim of this paper is to shed some light on those areas by looking specifically at the health concerns and personal problems affecting underperforming GPRs. This paper reports on the experiences of a team of medical educators (MEs) responsible for managing underperforming GPRs over a ten-year period in the Victorian Metropolitan Alliance (VMA), an urban based general practice (GP) training program. Data is firstly presented with respect to the incidence and prevalence of clinical skills concerns, health concerns and personal problems over that period. Observations are made on that data, focusing particularly on the health concerns and personal problems, followed by a discussion on how those concerns were addressed, the lessons learnt along the way and how processes were progressively improved. This paper supports what is stated by the literature, namely, that health concerns and personal problems are not uncommon in underperforming GPRs, that those issues do impact on clinical performance and are therefore important to address.

Background
VMA commenced as a training provider under the Australian General Practice Training (AGPT) program in 2001. Training was delivered by an apprenticeship model with GPRs working under supervision in general practice, participating in regular educational workshops and receiving regular formative, workplace based performance assessments. While processes for managing underperformance existed from the time of VMA’s inception, a formal remediation framework, modeled on the National Association of Clinical Tutors (NACT, 2018) framework in the United Kingdom, was introduced in 2006. The term ‘education enhancement’ was preferred at VMA to the potentially stigmatizing and restrictive term ‘remediation’. A senior ME (GZ), with more than twenty years of general practice experience, was appointed as the Educational Enhancement Officer (EEO) to investigate and manage GPR underperformance. In all instances, management was individually tailored and if the GPR was also affected by either a health or a personal problem, this was also addressed. With experience and continual feedback from MEs and GP supervisors (GPSs), processes were refined, clearer guidelines developed and the framework strengthened. When GPR numbers increased substantially, a number of MEs (also experienced general practitioners), was appointed to assist the EEO (the EE Team). Over time, the EE Team succeeded in managing underperformance more effectively.

Methods

Data was collected at VMA on all GPRs identified as having or potentially having performance concerns over a 10-year period, from 2006 to 2015. Data was analyzed retrospectively, manually and independently by two of the authors (GZ and KJ) and then de-identified. Table 1 presents this data. No demographic data was collected for the purposes of this paper. Essentially however, the GPRs were predominantly Australian medical graduates, with an average age of 25-30 and a male to female ratio approximately 30:70 for each year.

In managing underperformance and for practical reasons, identified GPRs were categorized according to the nature of the assistance required:

1. **Formal remediation**: GPRs requiring formal remedial intervention because of high level clinical skills concerns.
2. **Focused learning interventions (FLIs) OR being monitored**: GPRs for whom there were low to medium level concerns, requiring relatively simpler, informal interventions. GPRs having completed an FLI or formal remediation were included in this category and their progress monitored until completion of training. This category was introduced in 2007.
3. **Exam failure**: those GPRS having failed all or part of the Royal Australian College of General Practitioners (RACGP) Fellowship examination were given support with respect to their next sitting of the exam. The level of concern varied for each GPR.

As the concerns changed, GPRs were moved from one category to another. The level of concern also changed as concerns arose and were addressed. The data represents a snapshot of identified GPRs at the end of each calendar year. For the purposes of this paper and for each category, the data has been sub-categorized according to when the concerns were identified and the nature of the concerns (Table 1):

- **When identified:**
  - **New**: Concerns first identified in that year.
  - **Continuing**: Concerns identified in a previous year.
The nature of the concerns:

I. Clinical skills.

II. Health, physical: any physical condition requiring attention by the GPR’s treating doctor and encompassing: short and long-term illness; surgery; pregnancy; physical disability.

III. Health, anxiety: anxiety beyond what might be considered appropriate in the circumstances. This determination was based on the presentation and the EEO’s judgment (as an experienced GP, including mental health), rather than on formal criteria. Included are contexts such as: commencement in general practice; returning to practice after a period of absence; lack of self-confidence and/or assertiveness; performance anxiety; fear of litigation.

IV. Health, other mental health (excluding anxiety): depression; past psychotic episode; ADHD; unspecified mental health problem.

V. Personal problems: family concerns; interpersonal difficulties; relationship problems; attitudinal issues. Included in this category: acute stress reactions manifesting as situational anxiety or depressed mood and of a level consistent with the context (this judgment was made by the EEO). Personality disorder was also included because this generally manifested with interpersonal difficulties.

The sub-category numbers overlap because some GPRs had more than one concern.

Results/Analysis

From the data (Table 1), the following general observations have been made:

- The total GPR numbers increased steadily from 170 (2006) to 378 (2015) as the VMA training program grew.
- The number of identified GPRs (all reasons) increased steadily, from 28 (2006) to 82 (2015). As a percentage of all GPRs, ranging from 11.3% (2008) to 21.7% (2015). (Table 1)
- ‘Physical health’ and ‘other health’ concerns remained low over the entire period; range: 0-2 GPRs (Table 1; Figure 1).

Table 1: VMA GPRs having performance concerns (all data) from 2006-15

| Table 1: VMA GPRs having performance concerns (all data) from 2006-15 |
|------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
|                        | 2006   | 2007   | 2008   | 2009   | 2010   | 2011   | 2012   | 2013   | 2014   | 2015   |
| a. New                 | 12     | 2      | 4      | 2      | 4      | 4      | 4      | 2      | 0      | 2      |
| b. Continuing          | 0      | 7      | 5      | 0      | 1      | 1      | 3      | 5      | 0      | 0      |
| Total 1.1 (New and Continuing; 1a+1b) | 12     | 9      | 9      | 2      | 5      | 5      | 7      | 7      | 0      | 2      |
| i. Clinical skills     | 9      | 2      | 1      | 3      | 3      | 6      | 3      | 6      | 3      | 5      |
| ii. Health, physical   | 1      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      |
| iii. Health, anxiety   | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      |
| iv. Health, other mental health | 1     | 0      | 1      | 0      | 1      | 0      | 0      | 0      | 0      | 0      |
| v. Personal            | 3      | 2      | 1      | 0      | 1      | 1      | 1      | 2      | 0      | 0      |
| Total 1.2 (Health & personal; 1i+1iii+1iv+1v) | 5     | 2      | 2      | 0      | 2      | 0      | 1      | 2      | 0      | 0      |
| 2. Focused Learning Interventions / Being monitored | 2006   | 2007   | 2008   | 2009   | 2010   | 2011   | 2012   | 2013   | 2014   | 2015   |
| a. New                 | 0      | 13     | 11     | 23     | 13     | 19     | 21     | 26     | 30     | 23     |
| b. Continuing          | 0      | 1      | 8      | 13     | 12     | 10     | 19     | 13     | 21     | 21     |
| Total 2.1 (New and Continuing; 2a+2b) | 0     | 14     | 19     | 36     | 25     | 29     | 40     | 39     | 51     | 44     |
| i. Clinical skills     | 0      | 7      | 6      | 12     | 10     | 12     | 11     | 12     | 17     | 7      |
| ii. Health, physical   | 0      | 1      | 1      | 0      | 0      | 1      | 1      | 2      | 1      | 2      |
| iii. Health, anxiety   | 0      | 1      | 0      | 7      | 3      | 2      | 8      | 10     | 9      | 8      |
iv. Health, other  
|   | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|------|------|------|------|------|------|------|------|------|------|
|   | 0    | 0    | 1    | 1    | 0    | 0    | 1    | 1    | 0    | 1    |
| v. Personal | 0    | 5    | 5    | 7    | 5    | 6    | 11   | 12   | 12   | 14   |
| Total 2.2  
(Health & Personal; 2ii+2iii+2iv+2v) | 0    | 7    | 7    | 15   | 6    | 8    | 16   | 24   | 22   | 25   |
| a. New | 16   | 4    | 4    | 9    | 8    | 10   | 5    | 12   | 12   | 21   |
| b. Continuing | 0    | 7    | 2    | 0    | 7    | 6    | 9    | 5    | 10   | 15   |
| Total 3.1  
(New and Continuing; 3a+3b) | 16   | 11   | 6    | 9    | 15   | 16   | 14   | 17   | 22   | 36   |
| i. Clinical skills | 5    | 2    | 1    | 3    | 3    | 6    | 3    | 6    | 1    | 5    |
| ii. Health, anxiety | 2    | 0    | 0    | 0    | 0    | 0    | 0    | 1    | 0    | 1    |
| v. Personal | 2    | 0    | 0    | 0    | 0    | 0    | 0    | 0    | 2    | 3    |
| Total 3.2  
(Health & personal; 3ii+3v) | 4    | 0    | 0    | 0    | 0    | 0    | 0    | 1    | 2    | 4    |
| 4. Totals |      |      |      |      |      |      |      |      |      |      |
| Total A: All identified GPRs | 28   | 34   | 34   | 47   | 45   | 50   | 61   | 63   | 73   | 82   |
| Health, physical (1ii+2ii) | 1    | 1    | 1    | 0    | 0    | 1    | 1    | 2    | 1    | 2    |
| Health, anxiety (1iii+2iii+3iii) | 2    | 1    | 0    | 7    | 3    | 2    | 8    | 11   | 9    | 9    |
| Health, other mental health (1iv+2ivv) | 1    | 0    | 2    | 1    | 1    | 0    | 1    | 1    | 0    | 1    |
| Personal (1v+2v+3v) | 5    | 7    | 6    | 7    | 4    | 5    | 7    | 13   | 14   | 17   |
| Total B: Health & personal (1.2+2.2+3.2) | 9    | 9    | 9    | 15   | 8    | 8    | 17   | 27   | 24   | 29   |
| Total C: Clinical skills (1i+2i+3i) | 14   | 11   | 8    | 18   | 16   | 24   | 17   | 24   | 21   | 17   |
| Total D*: Number of GPRs in the program | 170  | 239  | 300  | 303  | 335  | 360  | 375  | 388  | 402  | 378  |
| Total E: GPRs with more than one concern | 14   | 5    | 5    | 7    | 8    | 7    | 10   | 18   | 10   | 16   |
| Total F: GPRs with more than one concern, one being health/personal | 9    | 2    | 4    | 4    | 6    | 1    | 7    | 10   | 9    | 11   |

*Total D is an average for the two semesters of every year

Figure 1. Graph of the number of newly identified health concerns and personal problems from 2006-15
‘Clinical skills’ concerns (Table 1; Figure 2):

- Ranged
  - in number: from 8 (in 2008) to 24 (in 2011)
  - in percentage:
    - of identified GPRs, from 20.7% (in 2015) to 50% (in 2006);
    - of all GPRs, from 2.7% (in 2008) to 8.2% (in 2006).
- With respect to ‘health concerns and personal problems’
  - were greater than them, from 2006-2011 (as a percentage of all identified GPRs, but excepting 2008);
  - equaled them in 2012;
  - were fewer than them from 2013-2015.

Health concerns and personal problems (Table 1; Figure 2):

- In relation to identified GPRs: ranged from 8 (2010 and 2011) to 29 (2015); 16% (2011) to 35.4% (2015);
- In relation to all GPRs: ranged from 2.4% (2010) to 7.7% (2015);
- Showed great variability from year to year and were:
  - fewer than ‘clinical skills’ concerns from 2006-2011;
  - equaled ‘clinical skills’ in 2012;
  - exceeded ‘clinical skills’ from 2013-2115.

Personal problems (Table 1; Figure 1):

- Were greater in number compared to any of the individual health concerns in every year except in 2009 (equaling ‘anxiety’) and 2012 (second to ‘anxiety’).
- Increased steadily from 2010-2015, significantly surpassing ‘anxiety’ in 2015.
- ‘Anxiety’ was second to ‘personal problems’ for most years except in 2008 (no new ‘anxiety’ identified), 2009 (equaled ‘personal problems’) and 2012 (greater than ‘personal problems’).

Figure 2: Graph of the clinical skills concerns, health concerns and personal problems as percentage of all identified GPRs from 2006-15
GPRs having several issues (Table 1; Figure 3):

- The number of GPRs with more than one concern ranged:
  - Numbers: 5 (2007 and 2008) to 16 (2015);
  - Percentages: 13.7% (2014) to 50% (2006), of all identified GPRs. If 2006 is excluded (where there was a significant increase in identifications overall), the range is narrower, from 13.7% (2014) to 19.5% (2015).
- The number of GPRs with more than one performance concern and with one being health or personal, ranged:
  - Numbers: from 1 (2011) to 11 (2015);
  - Percentages: in relation to all GPRs having more than one concern, from 14.3% (2011) to 90% (2014); in relation to GPRs having ‘health concerns and personal problems’, from 12.5% (2011) to 100% (2008).

Figure 3: Graph of the number of GPRs identified as having more than one concern from 2006-15
Discussion

As the program grew the number of identified GPRs increased, however, proportionately more were identified in the later years. Of the identified GPRs, the low incidence of ‘physical’ and ‘other’ health concerns probably reflects a largely young and relatively well demographic. Health concerns and personal problems were identified increasingly in the later years and were comparatively greater than the clinical skills concerns. Several factors may account for this:

- In the early years, the focus was predominantly on identifying clinical skills issues, which were generally moderate-high level of concern. As the EEO program developed, GPSs and MEs were encouraged to report concerns more readily, clinical skills as well as health and personal problems. The significant increase in ‘health concerns and personal problems’ in 2009 occurred at the time when the initiatives for early reporting of whatsoever concern. While this initiative may have resulted in over reporting, it was considered better to have concerns reported, so that they could be evaluated and addressed rather than be missed or left to escalate.
- As the EE team gained experience, it became easier to speak to GPRs about their health concerns and personal problems.
- As GPRs recognized that help was available, they were more willing to admit to having health concerns and personal problems and also to ask for help. Similarly, GPSs and MEs were more willing to report their concerns because they knew that the EE team would act on them.

The data provides a clear picture of the extent and nature of the identified performance concerns. Importantly also, a rich understanding of underperforming GPRs was obtained over the 10-year period. The EE Team’s experiences...
with respect to health problems and personal concerns in underperforming GPRs are now presented.

1. Identification

Given that GPRs spend most of their time in the training practice, most performance concerns were identified by their GPS. (Gladman, 2011; Magin et al., 2016) At times, issues first became apparent in peer learning workshops or GPRs self-reported to practice staff, or to MEs conducting workplace based assessments, or in some instances, to administration staff of the training program.

Anxiety was readily identifiable because its symptoms tend to be overt. Depression generally presented differently and could go undetected because depression can be subclinical or because the GPR tried to hide it. Certainly in the earlier years, health concerns became apparent or were suspected only when clinical skills issues arose. GPRs were often reluctant to disclose that they had a health concern or personal problem and, even when they did disclose, reluctant to provide details. This reflected the reported tendency for clinicians generally to self-treat, avoid disclosure and to deny having difficulties. (Clode, 2004; Fox et al., 2011) Similarly, in the early years of the program, MEs and GPSs might have had suspicions, however, they were reluctant to enquire about health concerns and personal problems because of the belief that they were private matters. Even after ascertaining from the GPR that there was an issue, there was still reluctance by GPSs and MEs to act on that information. Regardless of the issues at hand, patient safety became the driving concern and in turn, the need for more openness.

2. Stress and illness

GPRs are confronted with various stresses from the time that they enter GP training. They have to adjust to being the prime decision maker as well as a mode of practice different to hospital practice. We found that for some GPRs, settling in and adjusting was more problematic than for others, with anxiety being a common presentation. The GPSs’ experience was that part time GPRs took longer to adjust.

In the training practice, a conducive working environment, a positive relationship with the GPS and staff in the clinic, and a manageable workload, are important requirements for optimum performance. Issues arose because of grievances that the GPR may have had with, for example, the requirements of training or employment contracts. While these types of issues occur in any workplace and do cause a level of distress, some GPRs became anxious, withdrawn or even depressed. In some instances, a GPR’s clinical performance was affected by a poor GPS-GPR relationship. Other sources of stress included: an unmanageable patient load; undertaking additional work or study outside of training; and, financial stresses. Indeed, the impact of the different stressors were sometimes significant, however, GPRs did not always acknowledge that they were affected.

Of all the health concerns affecting GPRs, anxiety featured strongly, as did personal problems. Personal and family problems were often in the background and while these may not necessarily have caused overt anxiety, having to cope with those issues, while at the same time managing patients, was difficult for some GPRs.

Anxiety was also observed as a manifestation of personality, a specific mental health disorder, physical health concerns, personal problems or inadequately developed coping skills. GPRs with such problems struggled more when they encountered difficulties with their consulting.

The stresses of training and of daily medical practice on GPRs should not be underestimated. While anxiety is a normal reaction to stress, when it was ‘out of proportion’ and certainly when clinical performance was affected, it could not be ignored. Because clinical performance was affected, health concerns, anxiety and personal problems had to be addressed alongside the clinical skills issues. The need then arose to know more about the GPR’s personal circumstances in order to support them better. There was difficulty in striking the right balance between the ‘need to
know’ and the GPR’s right to privacy and autonomy. In time, the EE team became more comfortable with raising and discussing health concerns and personal problems with GPRs. GPSs were more willing, upon realising that the concerns were being addressed, to not only report concerns and to provide background information but also to assist with management. Our experience has also been that GPRs frequently did not know how to proceed when they found themselves in difficult personal situations. They appreciated the guidance and support and they were then more willing to divulge relevant personal information.

Having gained this confidence in addressing health concerns and personal problems, it became easier for the EE team to look beyond the clinical skills concerns and explore whether there were any underlying problems. In practice, the underlying problem was more likely to be a health or personal problem, as reflected in the data and as reported in the literature. (Paice and Orton, 2005; Cox et al., 2006; Cohen, Rhydderch and Cooper, 2007; Lucey and Boote, 2008; NACT, 2018; Steinert, 2013)

3. Management

Regardless of the nature of the concern, the most important element was the conversation with the GPR, listening to their story, understanding them and their predicament and providing general support. Health concerns and/or personal problems were addressed with sensitivity as well as consideration for privacy and confidentiality. GPRs were encouraged to view their situation objectively and to actively address their problems. Usually this was best achieved with a discussion on personal wellbeing as well as how impaired performance actually impacts on patient safety. They were encouraged, as appropriate, to consult their treating doctor and/or psychologist.

From an organisational viewpoint, there were several interventions that were instigated to enhance the management of GPR health concerns. The most important element was the development of a culture that was supportive and mindful of GPR welfare while at the same time assisting GPRs to improve their clinical performance and to be well functioning. Awareness was raised so that everyone (MEs, GPSs and GPRs) knew that all issues, no matter how small, would be taken seriously and addressed. Professional development workshops were conducted for GPSs and MEs to improve their skills in identifying problems and addressing them at a basic level. The more experienced MEs, who were also experienced GPs, were brought together to form the EE team, to manage all performance concerns. The EEO was instrumental, not only in managing the team but also in creating the framework, ensuring that guidelines were promoted, processes followed, that underperforming GPRs were identified and issues appropriately addressed.

Limitations

The presented data relates to former VMA GPR and the extrapolation of the data and the observations to other training programs where the nature of the cohort may be very different should be done with caution.

Categorization and sub-categorization was not done according to strict criteria.

Reporting may not have been consistent over the 10-year period. In the early years, the focus was on clinical skills concerns, thus health concerns and personal problems were possibly under-reported. In the later years, because GPSs and MEs were encouraged to refer all concerns to the EE team, there may have been some over-reporting. Some GPRs, for example, were reported for relatively minor concerns that potentially could have escalated but didn’t.

Conclusion

This paper supports what is stated in the literature about underperformance, namely, the importance of early
identification and that health concerns should be addressed. (Paice and Orton, 2005; Cox et al., 2006; Cohen, Rhydderch and Cooper, 2007; Lucey and Boote, 2008; NACT, 2018; Steinert, 2013) It has also identified that health concerns and personal problems:

- Are not uncommon in underperforming GPRs, with ‘personal problems’ and ‘anxiety’ being the most prevalent
- Do impact on clinical performance, (Cox et al., 2006; Dobkin and Hutchinson, 2010; Shattner et al., 2010; Shrestha and Joyce, 2011; Anagnostopoulos et al., 2012; Gómez-Gascón et al., 2013; IsHak et al., 2013; Lebensohn et al., 2013; Kehoe et al., 2016) and the reverse is also true
- Are as important to address as clinical capability concerns because of their impact, directly or indirectly on clinical performance. (Paice and Orton, 2005; Cox et al., 2006; Cohen, Rhydderch and Cooper, 2007; Lucey and Boote, 2008; NACT, 2018; Steinert, 2013)

As a result of the rich understanding that has been obtained in managing underperforming GPRs over a 10-year period, the authors’ recommendations are that:

- Enquiry about health concerns and personal problems is appropriate, however, it should be motivated out of concern for patient safety and the GPR’s welfare and tempered by considerations for the GPR’s privacy and autonomy.
- Ongoing education of MEs and GPSs in identifying signs of impairment in GPRs is important.
- Encouraging the prompt reporting of GPR underperformance and distress, even if the issues appear to be minor.
- Assisting GPRs experiencing health concerns or personal problems to evaluate their situation objectively and to consider whether patient safety might be compromised.
- Empowering GPRs to seek assistance from a health professional (GP, treating specialist, psychologist), to better manage their problem.
- Promoting the importance of practitioner well-being for MEs and GPSs (role-modelling) and GPRs alike.
- Reducing stress risks for GPRs by examining critically organisational and workplace factors.

While measures and programs for the development of resilience and the prevention of burnout are vital, it is equally important for training organisations to have processes in place for addressing health concerns and/or personal problems. Research into this area is to be encouraged not only that we may understand and manage these issues better but also, to highlight to registrars and trainees the importance of physician health and to empower them as regards self-care.

**Take Home Messages**

- Not uncommonly, health and personal problems underlie a performance concern
- Enquiry about health and personal should be tempered by considerations for privacy and autonomy
- Early indentification of impairment is important
- Underperformers should be encouraged to evaluate their situation objectively and seek appropriate assistance
- Preventive measures include:
  - Promoting the importance of practitioner well-being
  - Reducing stress risks in the workplace
  - Putting measures in place that develop resilience and prevent burnout
Notes On Contributors

George Zaharias is a General Practitioner and Medical Educator, in Melbourne, Australia. His field of expertise is remediation, having managed the remediation of GP Registrars at the Victorian Metropolitan Alliance for over 10 years. In his current role with the Royal Australian College of General Practitioners, his responsibilities relate to the remediation across the General Practice spectrum.

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Caroline Johnson is a General Practitioner in metropolitan Melbourne and was one of the team of educators managing remediation at the Victorian Metropolitan Alliance. She is also Senior Lecturer at the University of Melbourne and Senior Medical Educator at Eastern Victoria General Practice Training. She has a strong interest in primary mental health care and has been involved in advocacy, policy development, research and teaching around this theme.

Christine Longman is a General Practitioner in Melbourne and a medical educator with MCCC General Practice Training. She was also one of the team of educators managing remediation at the Victorian Metropolitan Alliance.

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Appendices

None.

Declarations

The author has declared that there are no conflicts of interest.

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Ethics Statement

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