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Guest Editorial

Dr Kee Whye Chin

From the first days of internship and throughout our training as junior doctors, we quickly recognize that healthcare is a unique industry. We are part of the medical workforce serving in the 'business' of care, whether this be the hospital setting or in general practice, as a locum in regional Australia or across international borders. Entrusted by our patients who are in sometimes very vulnerable states – illness, suffering, distress, and pain – everyday, we have the privileged opportunity to provide medical treatment, practical support, and kindness during their experiences.

For the junior doctor, clinical practice is a steep learning curve – working in a busy and bustling environment, learning to adapt to each new medical rotation, juggling time pressures while keeping on top of our duties and 'paperwork', and all the while, interacting with many different people: our colleagues, seniors and consultants, nurses and allied health practitioners, patients and their families. Learning the "ins and outs" of the job, whilst managing the emotional stressors of its responsibilities makes a junior doctor's day challenging. I remember how difficult it was to formulate what to say or know what to do next when patients rapidly become unwell and complications snowball despite our best efforts, or when distressed families ask those hard questions of 'why?' or 'why not?'.

In this edition of the Future Leaders Communiqué, our case explores the relationship between our work experiences and our professional development, the two axes of this steep learning curve. It highlights the challenge that many junior doctors experience during their early career as clinicians in medicine – of striking the balance between independence, and the need for supervision and support. From knowing what we are expected to do, the tasks we can and should take on with confidence, to growing in clinical competence, expanding our knowledge and skills and developing autonomy in our daily work, it is important to also have the self-awareness of our limitations and recognise when we need to ask for help. This part of our job relies upon a different armamentarium of skills, and professional qualities such as accountability, initiative, humility and insight.

Our guest commentators for this edition are Dr Emma Ku, Supervisor of Intern Training at Eastern Health, and Associate Professor Bruce Waxman, Clinical Lead of the Accreditation Team, at the Postgraduate Medical Council of Victoria (PMCV). Dr Emma Ku writes about the scaffold that healthcare systems provide throughout our development as clinicians, and discusses how we can be supported and safe-guarded in our training by senior supervision. Exploring this concept further, Associate Professor Bruce Waxman discusses how we as junior doctors develop autonomy and mature personally and professionally. He defines a framework that helps us to understand the attributes and responsibilities of our role.

Junior doctors are often the first port of call when a deterioration in a patient is identified. We are regularly in an opportune position to recognize potential risks and respond proactively to prevent adverse events. We may be the first person to bring happy news of normal test result and provide reassurance to an anxious patient, or an ear to listen to their worries and future hopes. We are privileged to be alongside our patients, to share in their experiences and provide them support wherever they may be along their journey within the healthcare system.

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Editorial

Brendan Morrissey

Welcome to the latest issue of the Future Leaders Communiqué! In this edition, we review a coroner's investigation into the unexpected death in hospital of a complex major trauma patient. As the case unfolds, issues around protocolised care, junior doctor autonomy, and senior supervision within the treating team arise. The case has been adeptly presented to us by our guest editor, Dr Kee Whye Chin.

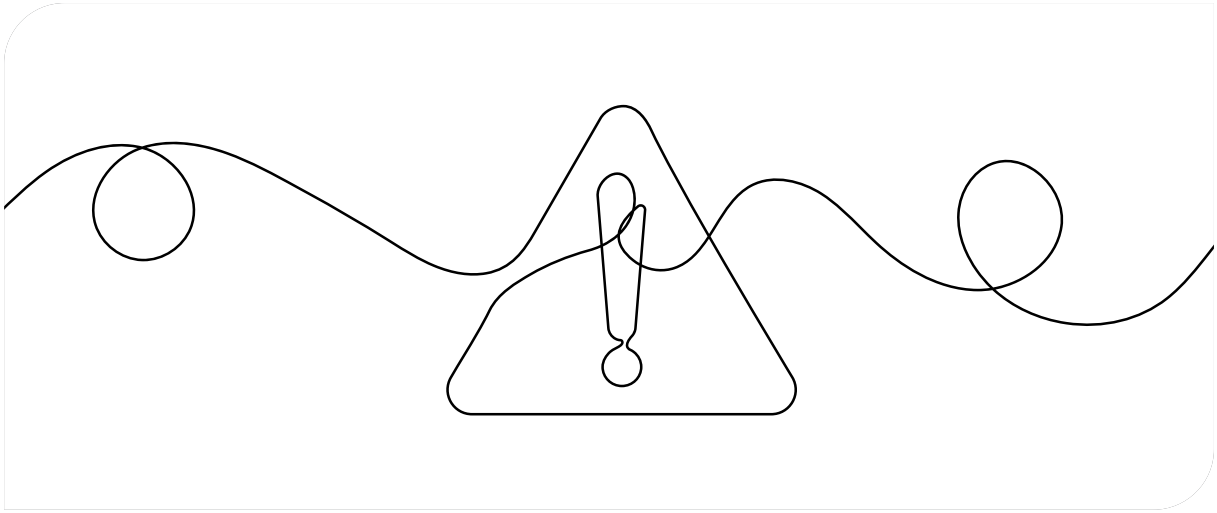
I can see reflections of my own practice and evolution as a junior doctor so often in this case. I recognise the burden of responsibility placed on the treating intern, and I reflect on the challenge of being the first point of contact for the day-to-day questions around patient care; on feeling like I was expected to know it all but also not knowing every answer.

Equally, it is so easy to see oneself as the supervising registrar delegating responsibilities to more junior staff. It is a perennial challenge: hoping to offer the opportunity to build confidence and autonomy in those you are supervising but at the same time aware that a safety net is required.

We are very lucky to have Dr Emma Ku and Associate Professor Bruce Waxman offer their insights and guidance on these vexing challenges for this edition in their expert commentaries. Dr Ku is an Emergency Physician and Supervisor of Intern Training at Eastern Health, Victoria. She unpacks the interplay between senior medical supervision and junior doctor responsibility, suggesting practical steps both junior doctors and senior supervisors can take to optimise that supervisory relationship and with it, the standards of care that we provide our patients.

A/Prof Waxman draws on the wealth of experience and expertise he has garnered through a storied career, particularly in his role as the clinical lead of accreditation with the Postgraduate Medical Council of Victoria, to provide insights into what an intern should expect from their health service with regards to support and supervision, and what professional values an intern should aim to develop and embody.

We are excited for you to read this edition and, hopefully, learn from the lessons presented by this case. Look out for the podcast to accompany this edition of the Future Leaders Communiqué in the near future. It will be available and free to download through Spotify, Apple, Stitcher or via our website (www.thecommuniqués.com), where you can also find our podcast library of previous editions of the Future Leaders Communiqué, the Clinical Communiqué, and the Residential Aged Care Communiqué.



Case - Prescribing a protocol unsupervised

Case Number 21/2005 (2916/2002)
Author **Dr Kee Whye Chin**

i. Clinical Summary

JM, a 35-year-old man with no significant medical comorbidities, was involved in a serious road crash late one evening when his motorcycle collided into the passenger-side of an approaching car on a major highway. He was taken immediately from the scene of the crash to the local tertiary trauma centre with life-threatening injuries.

In the emergency department, JM was found to have multiple injuries, including fractures of both wrists, his pelvis, left tibia, and multiple bones of his left foot. He sustained a major laceration over his left foot and numerous other bruises and abrasions. In the early hours of the next morning, JM underwent emergency surgery that lasted 3.5 hours, and consisted of three different procedures including surgical repair of his left tibia, closed reduction of his right wrist, and debridement of the laceration over his left foot. He returned to theatre on the same day, and once more two days later, for definitive management of the last of the major injuries, with reduction of the fractured pelvis and stabilisation of the tibial fracture with plates, screws and placement of a hybrid external fixator.

Following these surgeries, JM was transferred to the orthopaedic ward. Each of the two separate orthopaedic units at the hospital were overseen by one consultant, and JM was under the care of Mr P, an orthopaedic surgeon. JM's treating team also included Dr B, one of the three orthopaedic registrars, and Dr H, an internationally trained medical officer who was the primary intern. On the days when Dr H was not rostered, Dr R was the covering intern.

On the orthopaedic ward, every patient who underwent major surgery to manage pelvic fractures was commenced on a protocolised 'Pelvic Fracture Anti-Coagulation Regimen'. The regimen was usually commenced 48 hours after completion of surgery due to the risk of post-operative bleeding, and in case the patient was required to return for further operations.

The regimen outlined a titrated dose of heparin being administered three times a day at 8am, 4pm and 12am. A blood test was to be done every 24 hours to check the Activated Partial Thromboplastin Clotting Time (APTT) score, which was used to monitor the patient's anticoagulation status. It was one of the intern's daily tasks to check each patient's APTT and adjust the next dose of heparin as directed by the protocol.

JM was commenced on the anti-coagulation regimen two days after his last surgery, and Dr R, who was working that day, charted the first dose of 3500 units of heparin according to the protocol. The APTT blood test was performed each day at noon, and the result was used to adjust the 4pm dose according to the APTT range. Dr H charted an increase of 500 units of heparin for the doses on the days he was working. Dr R, who was covering for Dr H on the sixth day of the anticoagulation regimen, prescribed an increase of 1000 units of heparin for that day.

'Histology sections prepared by the forensic pathologist found recently formed, as well as well-organised thrombi of at least one week old within the intramuscular veins of the left calf. '

JM remained a patient under the orthopaedic unit. However, sixteen days after his admission to the ward, he died suddenly and unexpectedly in hospital. This was on the twelfth day after he had been started on the anticoagulation regimen.

ii. Pathology

Due to its unexpected nature, JM's death was reported to the coroner and an autopsy was performed. The cause of death was determined to be a pulmonary embolism (PE) from a left calf deep vein thrombosis (DVT). Histology sections prepared by the forensic pathologist found recently formed, as well as well-organised thrombi of at least one week old within the intramuscular veins of the left calf.

iii. Investigation

A coroner's investigation was carried out to clarify the circumstances surrounding JM's death. The coroner also sought to establish the significance of preceding events, and examine the critical actions and people involved. In particular, the inquest focused on three aspects of JM's management:

1. The protocolised heparin anticoagulation regimen itself
2. The structure and organisation of the orthopaedic unit
3. The individual actions of doctors responsible for his care

The Anticoagulation Regimen

Due to the protocol's uniqueness in the management of pelvic ring fractures on this particular orthopaedic ward, the coroner inquired into its genesis and efficacy. Evidence was given by the consultant Mr P, who was recognised as an expert in his field from years of practice in orthopaedic surgery. He had developed 'The Anticoagulation Regimen' in 1987 after observing a high incidence of venous thromboembolic (VTE) events in this group of patients at the beginning of his career. The thrice-daily administration of heparin was designed to achieve stable levels and avoid wide variations in the level of anti-thrombotic protection seen with other regimens. Using the daily results of the APTT score, the next dose of heparin was increased if the level was too low, decreased if too high, or maintained if within the appropriate scoring range.

Mr P emphasized the challenges of balancing the risk of VTE and bleeding in patients with major traumatic pelvic ring fractures and stated that his regimen could not be "100% successful". This was in part due to the "window of risk" period, which referred to the first 48 hours after surgery when heparin was not given.

The Structure of the Orthopaedic Unit

The coroner investigated the structure of the Orthopaedic unit that JM was admitted under, and the nature of supervision provided to the interns. According to the unit's *"hierarchy of review"*, the coroner found that while it was the most senior clinician, the orthopaedic consultant, who held ultimate responsibility for the patients admitted under them, the registrar was expected to provide *"hands-on"* supervision for their intern. The structure of the unit meant that the registrars collectively held responsibility for all patients on their ward, whilst the interns were allocated patients for whom they were caring for. The coroner identified that no single registrar had been specifically assigned to the daily supervision of Dr H.

The interns' role included performing daily tasks of prescribing and charting medications, reviewing issues that arose on the ward, and escalating their concerns to any of the registrars.

Dr H acknowledged that he could have approached the registrar, Dr B, for advice if he required clarification of the anticoagulation protocol. Further expert advice was obtained from Professor D, a member of the hospital's Intern Education Program. Professor D described the level of supervision an intern could expect – as beginning *'well supervised initially'*, to then being assigned *'more and more responsibility'*, once they were *'assessed as being appropriate and competent'*. Professor D commented that due to its *'special nature'*, 'special supervision' would have been required to oversee the prescription of the anticoagulation protocol.

The actions of individuals involved

The coroner investigated the *'breach of [the anticoagulation] protocol'* and looked into the actions of Dr H and Dr R, the interns involved in JM's care. It was noted that the first dose of heparin was correct, however, excluding days ten and eleven (when the APTT score was in the range that did not require a change in dose), all subsequent doses prescribed by Dr H did not adhere to the protocol, which instructed an increase of 1000 units in response to low APTT results. Evidence provided by Mr P and Dr B established that the protocol was explained during the intern orientation to the term, and copies were made available for reference on the ward – which was also confirmed by both interns. Dr B stated that he had personally discussed it with Dr H to check his understanding, and Dr R provided evidence of his conversation with Dr H about their responsibility to check the APTT and follow the instructions of the anticoagulation protocol.

However, Dr H stated that *'as an intern like a robot'*, the registrar was responsible for following up and telling him what to do.

The coroner concluded that Dr H had seemed to understand the indications for the anticoagulation regimen and the importance of following and actioning the protocol. He found that, whilst English was not Dr H's first language, it had not impeded communication between him and other members of the surgical team. In response to the statement made by Dr H, the coroner commented that this was a "comprehensive misunderstanding" of his "important obligations" as a junior doctor.

iv. Coroner's Findings

Based on the findings of the inquest, the coroner made the following conclusions about the circumstances prior to JM's death and the management he received.

Firstly, the coroner was unable to determine why Dr H had not followed the anticoagulation regimen to prescribe the correct dose of heparin.

Whilst it was stated that the dosing errors could have been identified by someone *'exercising a reasonable level of initiative, and a sufficient level of interest in the matter to carry out their duties properly'*, no fault was attributed to Dr R, other members of the orthopaedic team or healthcare staff for not recognising the incorrect prescriptions.

Secondly, the coroner acknowledged the difficulty of senior clinicians holding ultimate responsibility – such as Mr P – to oversee every action performed by junior doctors in their unit. The coroner concluded that JM's death could not be attributed to *"failure at the operational level"*. However, it was noted that no practice reforms or structural reforms were introduced within the orthopaedic unit to address the factors contributing to JM's death, and that the hospital appeared to lack timely and appropriate incident analysis processes to review such adverse events.

Based upon the intrinsic properties of the heparin regimen, and Mr P's description of its unavoidable *"failure rate"*, the coroner conceded that the anticoagulation protocol did not guarantee absolute prevention of thromboembolic events. Even if a therapeutic antithrombotic range had been achieved, the post-mortem examination findings of co-existing fresh clot and older thrombi presented evidence

of the unavoidable risk of VTE related to the post-operative 48 hour *"window period"*. The coroner recognised the contributory impacts of both individual errors and systemic faults, but was unable to satisfactorily conclude that JM's death was the direct result of the incorrect implementation of the anticoagulation regimen.

Finally, reflecting on key findings of this investigation – notably the unstructured supervision of junior doctors, and absence of any reformatory action in response to the identified errors leading up to JM's death, and Dr H's apparent misconception of his role – the coroner made several recommendations including:

1. The hospital conducts a review of the existing structural layout of the orthopaedic unit, to improve the supervision of, and enable responsibility and accountability for, any individual intern by a designated registrar
2. The overseeing Medical Board consider the findings of this case and its implications, so far as they are relevant to the registration of internationally-trained doctors.

v. Author's Comments

As onlookers into the case of Mr JM's death, it can be simple to hear the coroner's harsh comments and scrutinise the specific actions of Dr H, to focus on the inadequacy of structural safeguards, or the unpredictable effects of a drug not completely controllable.

Part of a junior doctor's professional development does rely on active efforts to grow and develop as a clinician – like preparing as best as we can for a new rotation or position, taking 'ownership' of allocated duties, and reflecting on our actions and experiences. However, healthcare is delivered by a team from within an organisation, and understanding how we fit into this system also helps to inform us about our responsibilities and what is expected from us. It is important to remember that we are still learning, and there are systems that exist to support us during this training period in our career.

In the case of JM, we are reminded of the "hierarchy of review", a ladder of ascending seniority within the medical team. In times of uncertainty, when we feel "stuck" and need advice, this hierarchy directs us to who we can ask, guides the stepwise escalation of clinical concern, and suggests those who can provide us with mentorship. Whilst it never excuses us of our responsibilities, these structures also play a critical role throughout our career.

vi. Further Reading

1. https://insightplus.mja.com.au/2021/37/simple-ways-to-afford-junior-doctors-more-autonomy/
2. Wald, SH. Professional Identity (Trans)Formation in Medical Education: Reflection, Relationship, Resilience. Acad Med. 2015;90(6):701–6.
3. https://www.anaesthesiacollective.com/the-power-of-mentors/

vii. Keywords

Anticoagulation, protocol, intern, supervision, accountability

Empowering our interns

The learning of professionalism, and the attributes and responsibilities that define the role of the junior doctor

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With the introduction of the AMC's National Framework for Prevocational Trainees (NFPMT) across Australia in 2024, Prevocational Medical Trainees (PMTs) will be the term to describe Interns (PGY1s) and PGY2s (often called HMOs)[1]. The NFPMT is the so-called two-year internship. Indeed, this is what it is called in New Zealand, where is has been successfully implemented for over 5 years[2]. In the UK, it is called the two Foundation Years, F1 and F2[3].

I will restrict my discussions to the first year, or 'intern' year, as this is the most informative of the two years. Over 47 weeks and five rotations across the clinical year, this is the time when a PMT makes the transition from a medical student to a provisionally registered medical practitioner, with the objective of gaining general registration with the Australian Health Practitioners Regulatory Agency (AHPRA)[4] .

My role as Clinical Lead with the Postgraduate Medical Council of Victoria (PMCV) is to ensure that the Health Service employing each intern is accredited to provide a supervised training and education program for the intern to gain general registration[5]. To this end, the PMCV has developed an acronym to demystify accreditation and empower the intern to insist their needs are fulfilled in each of their rotations: WE SAY SO (See Box)

WE SAY SO

Wellbeing - Includes overtime and workload
Education & Training - Protected teaching time

Supervision - Who is your Term Supervisor?
Assessment & Feedback - Mid and End of Term Assessment
Your Feedback - Your opinion and involvement

Satisfaction - What is good/bad about a rotation?
Orientation - Did you get properly orientated?

Indeed, during a survey visit initiated by PMCV to accredit a health service for a period of four years, the survey team gives the interns of that health service two opportunities to speak up and provide feedback on what is good and not so good about the health service's commitment to providing all aspects of their training. There is the pre-survey questionnaire and focus group interviews during the survey. The survey team relies very heavily on the information provided by the interns in formulating the report and may be the basis of conditions of accreditation.

Professional and Leader

The NFPMT includes a 'curriculum' in the form of 'Outcome Statements' which are incorporated by the health service into the Term Descriptor for each rotation, and act as a guide for the intern over four domains: Practitioner, Professional & Leader, Health Advocate, and Scientist & Scholar[6].

The domain of Professional & Leader highlights important attributes of the intern including:

i. Ethical behaviours

ii. Professional values: integrity, compassion, self-awareness, empathy, patient confidentiality, kindness and respect for all

iii. Optimising personal wellbeing: including responding to fatigue, and recognising and respecting one's own limitations

iv. Lifelong learning including teaching, supervision and feedback

v. Taking increasing responsibility for patient care, but knowing when to escalate

vi. Teamwork and respecting other healthcare professionals

vii. Contributing to safe and supportive work environments

viii. Being aware of cultural safety and the needs and gaps in care of Aboriginal and Torres Strait Islander people and

ix. Effectively managing time and workload demands, being punctual, and showing ability to prioritise work.

Whereas all nine attributes are important, maintaining **professional values** is the key to success as a professional, and many health services have values to which they base their work ethic. These are usually as an acronym – for example, in my own health service, *WE CARE: Wellbeing, Equity, Compassion, Accountability, Respect, and Excellence*. The value that is particularly relevant to interns is Accountability - responsibility for your actions and handing over/ transfer of patient care.

I think one of the 'Es' should be Escalate. The intern should not be embarrassed when unsure of what to do, to 'put up their hand' and ask for help – the patient will be eternally grateful for their humility and insight.

This leads to my other favoured message to interns around professionalism, and that is my **HIS principle** (yes, another acronym): **H**umility, **I**nsight, and good **S**kills of communication. Of these, the hardest to grasp is **insight**, the ability to be self-reflective and look into the mirror and ask oneself, 'is it me that is the problem' or 'am I out of my depth'?

Supervision vs. Autonomy

All interns must be supervised by a medical practitioner who is at least three years out from general registration and who stands accountable for the actions of the intern[4]. In the case presented in this edition, the supervising medical practitioner is either the orthopaedic registrar or the orthopaedic surgeon, who is the bed card holder for the patients and takes full responsibility for the patient's care.

Interns however should be encouraged to develop some autonomy and develop a sense of self mastery and satisfaction on their journey to becoming a professional. Interns enrich hospitals with their enthusiasm, commitment to continual improvement, and novel approach to problems.

This can be achieved by the Senior Medical Staff (SMS) taking an interest in their professional growth and taking them 'under their wing', not just leaving that task to the registrars. Interns thrive on the 'consultants' recognizing they exist, asking their opinion, giving them tasks, nurturing their career aspirations, and including some random acts of kindness, like even inviting them to an end of rotation dinner or BBQ[7]. It is notable that interns on rural rotations, where there is often a collapsed hierarchy, will experience greater autonomy and closer interaction with the SMS. Most find this experience enriching rather than daunting[8].

Interns are also given this opportunity for autonomy in the Accreditation Survey visits mentioned above, and by being involved in health service governance as JMO representatives for JMO Victoria or on the hospital Junior Medical Officer Advisory Committee (JMAC). There is good evidence that PMTs who take on these responsibilities become SMS leaders of the future.

Take home message!

From the Credo of my professional mentor, Sir John Monash (1865 -1931) Engineer, WWI military commander and administrator: *Adopt as your fundamental creed that you will equip yourself for life, not solely for your own benefit, but for the benefit of the whole community!*

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The building blocks of solid foundational years

Supervision, safeguards, and structural supports in junior doctor training

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It is easy to read the case described in this edition with a sense of both horror and inevitability. We are left with the disturbing reality that we will work with colleagues whose departures from the local standard of care leave us baffled, where our patients are placed at risk of serious harm or death. We are also faced with the sense that these situations may be unavoidable – how many times must a clinical protocol be presented before it can safely be assumed to be understood?

I would argue that we must be exceptionally wary of holding either of these perspectives.

Indeed, while the circumstances presented here may appear extreme, we should *assume* (acknowledge?) that our perceived 'standard of care' is highly vulnerable to the training received, and the protection and personnel we place around it. Furthermore, while an error may seem unavoidable at first glance, we are obliged to closely examine where we might have better safeguarded our patients from human error.

It is incumbent upon every doctor to realise that the Australian system is only one way of practicing medicine. The idea that a junior doctor would ever consider their role as an intern to be *'like a robot'* as Dr H described, should be an anathema to all of us. Yet I have personally worked in systems overseas where for a junior doctor to question a senior doctor seeking clarification or understanding, was viewed as a direct challenge to the senior doctor's authority.

It was to be avoided at all costs. Any questions about process or knowledge were to be resolved in your own time – a shared and adequate understanding of the patient's care and decisions made were not central to the junior/senior relationship. We should be alert to the different assumptions about our profession and ways of practicing that our colleagues may hold.

The quality and extent of supervision of junior doctors varies widely. A junior doctor may enjoy a highly supportive unit with intentional, intensive and immediate engagement between junior and senior staff. The following rotation then may be jarred by a disconnection to their next supervisor who is more distant, may be less accessible due to unit culture and structure, may vary throughout the shift and even, at times, be difficult to identify.

What can a junior doctor do to seek proper supervision or guidance?

1. Firstly, commit to the process of seeking this supervision, regardless of your comfort in the role you are currently playing. Heed the prudence of the adage 'you don't know what you don't know' and embrace the potential to learn from senior doctors.

2. Choose vulnerability. We have all had the temptation to mask our deficiencies and project knowledge and confidence beyond our true capacity at times. Choosing humility and vulnerability is difficult, however, it is the most effective path to clinical wisdom and acumen.

3. If structured supervision is not embedded in the unit be proactive about creating it. Identify regular times of day for discussing patient concerns, ensure you understand the escalation process for supervision in your unit, and ask how to access unit protocols and processes. Be prepared to raise concerns about inadequate supervision to your consultant, unit head, or education and workforce units – patient care is contingent on the support provided to your role.

4. Actively seek higher learning opportunities. Ask senior doctors if you may present not just your findings, but your formulation and your plan. When presented with a list of instructions, choose to repeat them back, and include why you think they are required. Specifically request that you might lead a part of a ward round or assess a patient in front of a senior. Know that in all of these situations you will be opening yourself up to the evaluation which is critical for growth.

Junior doctors are of course developing their own capacity to supervise. This task should be treated with respect. Excellent supervision of medical students or other doctors does not end at advising them that they should 'feel free to ask questions', nor is it obviated by clearly-written, accessible protocols and thorough orientation – important as these are.

What strategies can be utilised when supervising a medical student or doctor new to the unit?

1. Avoid the tendency amongst this busy workplace to simply instruct and convey orders. Instead, be a curious collaborator. Enquire about their assessment based on the information you have gleaned together; how they would summarise the issues of concern for the patient, and the investigations and management they would propose. Walking with a clinician through their assessment and decision-making offers useful insight into their clinical competencies and areas for improvement.

2. Ask the clinician to summarise and repeat back clinical discussions you have had. You may be surprised what has been missed or misunderstood. Review notes made on ward rounds or after a patient's assessment, particularly to discern whether they have an understanding of the patient's formulation and can accurately describe the team's clinical reasoning. This will assist you in assessing their receptive communication – and be enlightening about the effectiveness of your own communication.

3. Create opportunities to directly observe their interactions with patients and staff – let them 'lead' a patient interaction. When encouraged to do this in a supported environment they will have unparalleled opportunities to grow, and you will be able to assess how they handle the dynamics of the clinical environment.

The hospital system must always be aware of the limitations and vulnerabilities of junior doctors, and how best to protect staff and patients. Reasonable ward patient loads (twenty patients may be ideal, thirty workable in highly The hospital system must always be aware of the limitations and vulnerabilities of junior doctors, and how best to protect staff and patients. Reasonable ward patient loads (twenty patients may be ideal, thirty workable in highly supervised environments) should be advocated for and safeguarded. Clear hierarchies of support are critical.

A dedicated registrar for every intern (and patient) is essential – not simply to reduce the frequency of error-prone clinical handovers, but to improve the effectiveness and individualisation of clinical supervision. There are significant hierarchical barriers to approaching even the most

welcoming of consultants – a dedicated registrar is an important safety mechanism and mentor for junior doctors.

In the case presented, we see the concerns raised about Dr H's performance, but must not underestimate the complexities associated with the discontinuity of supervision, and particularly when underperforming doctors move between supervisors, units, hospitals, systems and even states. Disincentives that actively prevent a junior doctor's progress or impede remediation are substantial, and include negotiating difficult conversations, increased workloads in already stressed systems, reduced staff availability and even the threat of legal action. Yet we have an ethical burden to our patients and indeed to our colleagues' future careers and proficiency – how then can we proceed?

A robust system begins in medical training (where similar disincentives may exist), incorporates International Medical Graduates into Australian systems, demands committed, honourable hospital leadership and necessitates similarly principled, active health regulators. There may be value in anonymous reporting systems from within hospitals that mandate partnership between external regulators and hospital leadership in assessment and remediation. The junior doctor's responsibility in this area includes having the integrity to raise concerns, providing clear, detailed and dispassionate information about those concerns, and escalating to senior staff in the relevant clinical and ancillary units. The wisdom of a trusted senior colleague outside of these reporting structures may be invaluable in negotiating this process.

Excellent supervision, support and remediation needs adequate staffing and time embedded within clinical, education and workforce Units. These resources are continually under threat. Our advocacy for the maintenance and improvement our profession's future 'standard of care' must begin in the crucible of the junior doctor's development of competency and communication.

Further Reading

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3. The Anaesthesia Collective (2 Feb 2022) 'The Power of Mentors' The Anaesthesia Collective, cited 2 May 2023. https://www.anaesthesiacollective.com/the-power-of-mentors/
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Comments From Our Peers

"In busy units as a junior member of a team, it is extremely important to both communicate with your peers and escalate to your seniors if you are feeling in need of support. Likewise, senior members and colleagues of teams have an obligation to support their junior staff."

"It is essential that junior doctors feel supported by their senior colleagues […] as they often know the patients better than anyone else."

"Every member of the team holds an important role in keeping our patients safe and progressing their care."

"There is always something to learn – receiving support from a senior colleague or supervisor might not just help the patients we care for but also help build our own skills and expertise. There should be no obstacles to reaching out for that support."

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