

Assessing doctors' performance

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Contents

Chapter

1. There but for the Grace of God go I	5
2. How should the underperforming doctor be identified?	11
3. How well can peers and patients rate a doctor's performance?	17
4. Reviewing communication skills (with Elizabeth Farmer)	24
5. Assessing knowledge	30
6. Reviewing proceduralists (with Jonathan Beard)	34
7. Reviewing the doctor who practises complementary and alternative medicine (CAM)	39
8. How to avoid a performance review	45

Chapter 1: There but for the Grace of God go I

Discipline
Competence and performance
Review

Discipline

My title is a cliché, yes, but that is how those of us on the Medical Council of New Zealand in the late 1980s often felt when the full weight of the disciplinary process was brought down on a doctor who had made a simple mistake; we had all made mistakes like that, but nobody had complained. In the cases we were hearing the complainants as often as not didn't want their doctor punished either: "I just wanted to be sure this didn't happen to somebody else" they would tell us. The ponderous processes of law weighed everyone down – and good doctors sometimes sank.

Medical discipline has its proper place – for those who take financial, sexual or other advantage of vulnerable patients, for those who break the law, for those who are careless to the point of negligence – but it was an unwieldy weapon against doctors whose perceived errors resulted from failures of systems, or from simple underperformance. That recognition led to the competence clauses in the NZ Medical Practitioners Act 1995, now extended to all registered health professionals in the NZ Health Practitioners Competence Assurance Act 2003.

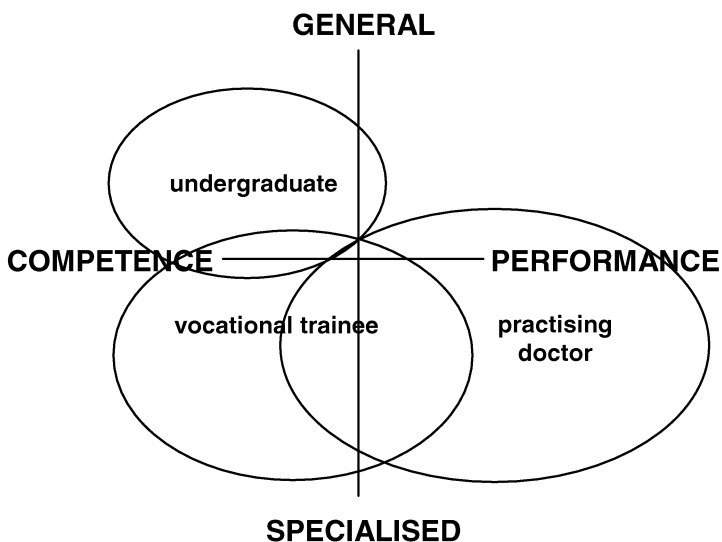
Competence and performance

The Acts allow the Council to review the competence to practise medicine of any medical practitioner, whether or not there is reason to believe the practitioner's competence may be deficient. The Council decided to take an essentially educational approach to that work; competence assessments would adhere to principles established in the international medical education literature, would assess by the standards of performance of the practising doctor, and remedial education would be prescribed for those found at review to need it.

The Act envisaged a review of competence as well as performance: "...in conducting the review, the Council shall consider (a) whether the practitioner has the skill and knowledge.... (competence), and (b) whether the practitioner's practice of medicine meets the standard.... (performance)". In other words, the *ability* to practise well was not enough: the review should also show that a doctor actually *was* practising well.

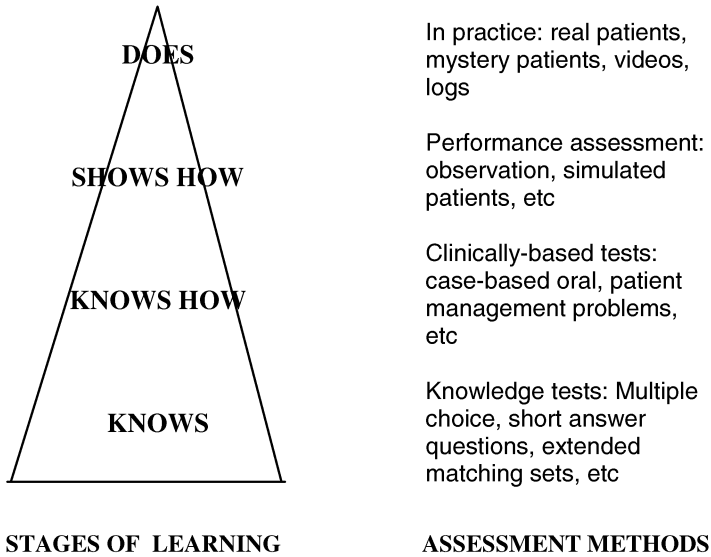
We therefore wanted to assess not only general and specialised competence, but also specialised performance, and the tools we developed had necessarily to extend from those used to assess the general competence of undergraduates, or even the specialised competence of vocational trainees (Fig.1). Van der Vleuten's application of different assessment tools¹ to the stages of Miller's learning pyramid² (Fig.2) provides a visual representation of those concepts, but we needed to assess all of Miller's stages.

Figure 1: whereas it is largely the general competence of the undergraduate, and the specialised competence of the vocational trainee that should be assessed, for the practising doctor it is all of these, with an emphasis on specialised performance.



In 2001 the Council, with the Australian Medical Council, hosted a landmark international “Competence/peer assessment workshop” in Wellington. As a result, a core group formed IPAC, the International Performance Assessment Coalition, which has met annually since then, to exchange evidence and opinion among a number of countries and organisations involved in similar work. Those meetings have informed changes and refinements to the NZ competence review process.

Figure 2: van der Vleuten¹ applied different assessment methods to different stages of learning, thus extending Miller's² learning pyramid.



Review

Because the idea of competence assessment arose out of complaints, it was natural our first efforts would be to assess doctors about whom concerns were expressed to the Council. Furthermore, the review would be restricted to those domains of practice that formed the substance of the concern. They are the same domains of practice (see box) that form the headings in the Council's booklet *Good medical practice*,³ and *Cole's medical practice in New Zealand*.⁴

How would the assessments be conducted? Practice-based assessment is more likely to reflect performance than centre-based assessment, so the Medical Council decided that wherever possible reviews would be conducted at the doctor's practice, and the assessment tools used would reflect that environment (later papers in this series will describe those tools).⁵ Furthermore the reviewers would be the doctor's peers – vocationally registered colleagues from the same discipline, and the same kind of practice, augmented by the perceptions of a lay reviewer.

They would spend a day at the doctor's practice, interviewing doctor and co-workers, examining records and systems and observing the doctor at work. They would write a thorough report. That report, along with the doctor's comments on it, would inform the Council's decision on whether

or not the doctor should undergo remedial education to upgrade skills or remedy deficiencies.

Table 1: Domains of competence

<p>Clinical expertise diagnostic and management skills (skills that may be specific to each branch of practice, or may be generic to several - such as prescribing, surgical skills, psychotherapy) expert advisor skills</p>
<p>Communication with patients and families with colleagues medical recordkeeping</p>
<p>Collaboration teamwork</p>
<p>Management personal management (including insight and recognising limits) management within systems use of time and resources</p>
<p>Scholarship life long learning teaching research critical appraisal</p>
<p>Professionalism honesty integrity probity respect for patients (including cultural competence w.r.t. gender, race, boundaries, and New Zealand's biculturalism) respect for colleagues moral reasoning & ethical practice</p>

What would be the standard? If this were a criterion-referenced test we might have a set of published criteria by which a doctor's performance would be assessed, but it is not, and clinical practice is too complex an activity for there ever to be more than token, easy-to-measure indicators of performance. Instead we decided the informed opinions of competent well-trained colleagues and lay people would set the standard, a position reinforced by a recent Medical Practitioners Disciplinary Tribunal statement, "The reasonableness of the standards applied must ultimately be for the Court to determine, taking into account all the circumstances

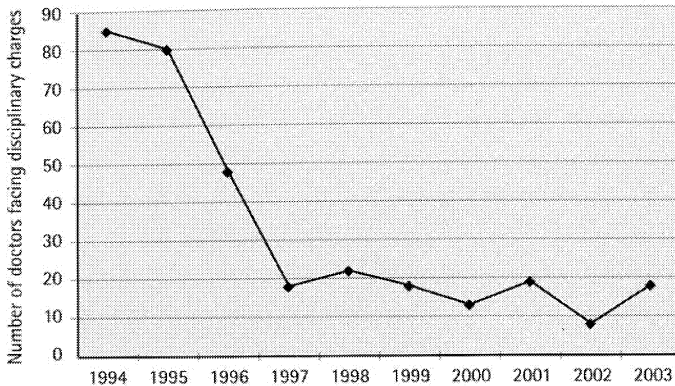
including not only usual practice but patient interest and community expectations...”⁶

The report would also identify the presence of distracters – those stressful events and circumstances that might prevent a competent doctor from performing well (illness, life events, family functioning, fatigue, isolation for instance) - which should be addressed before remedial education would likely have any effect.

The review of a doctor’s performance by the Council is in many ways similar to the Royal New Zealand College of General Practitioners’ Fellowship assessment visit, or the review of a doctor’s premises and systems envisaged by the College’s *Aiming for excellence* proposals, except that here it is the doctor’s personal competence and performance that are being assessed. The assessment is followed by suggestions for change. You can apply a clinical model (make a diagnosis and prescribe treatment): assess educational needs and prescribe an educational remedy. The necessity for high quality educational diagnosis becomes obvious when a review discovers a doctor whose performance is so far below what is expected that the public is endangered – especially when that doctor lacks the ability to make changes.

Then the Council has to fall back on its powers to restrict the doctor’s practice, or even to remove the doctor from practice. The financial, personal, family and community implications of such a step are enormous. The stakes are therefore very high, and high stakes means the methods must be so good they are fully defensible in law.

Figure 3: the number of doctors facing disciplinary charges has fallen contemporaneously with the introduction of the Medical Council’s competence reviews.



The dramatic graph in the Health and Disability Commissioner’s Annual Report for 2003 (Fig. 3) illustrates the effect of, among other factors, the Medical Council’s competence reviews on reducing the

number of doctors facing disciplinary charges. As the Commissioner wrote, “The New Zealand system emphasises rehabilitation of practitioners, rather than punishment, and is consistent with modern understanding of the nature of error and the importance of a culture of learning to improve patient safety”.⁷

I have reported an analysis of the competence reviews the Council has undertaken since 1998 elsewhere.⁸ Interested readers may find useful reviews of the subject listed below.⁹⁻¹³.

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Chapter 2: How should the under-performing doctor be identified?

Screening

- A high risk group?
- Population screening?
- A combined approach

I wrote in the introduction to this series¹ that the Medical Council's statutory duty to review the competence of doctors should naturally (since it had arisen out of the movement to reform disciplinary processes) start with doctors about whose performance concerns are raised. Certainly any national review programme should at least do such "responsive" work, and on the face of it that might seem to suffice.

Actually though, when all doctors are assessed, those whose performance has *not* been the cause of expressed concern are just as likely to be performing poorly as those about whom concerns *have* been raised,² and this is congruent with the observation that even poor clinicians may not attract complaints if they communicate well.³ I am not talking about psychopaths here, but read this: "I remember the time Shipman gave to my Dad. He would come around at the drop of a hat. He was a marvellous GP apart from the fact that he killed my father".⁴

How then should the Medical Council address its statutory duty to "ensure" the competence of all doctors? Does MOPS help, or must we, if we are to "protect the public", find ways quite specifically to identify the underperformers?

Universal quality assurance notions from industrial quality gurus, such as continuous quality improvement (CQI) and total quality management (TQM), have their place, but the concept of a shift of a whole gaussian distribution of performance toward the right (Fig.1), while collegial in the questionable sense of protecting the anonymity of poorly performing doctors, is naively optimistic.

Indeed the notion that doctors' performance has a gaussian or normal distribution in the first place is open to question: most performance measures show a negatively skewed distribution peaking at the high-performing right; as an example see the Interpersonal Skills Index (ISI) scores for general practitioners in advanced vocational education (Fig.2).

What evidence we do have suggests CQI activities, while possibly improving the performance of the bulk of us in the peak of a negatively skewed curve, leave the high fliers and the thin tail of poor performers unmoved (Fig.3). If true that is still a good thing for the bulk of us, but current MOPS activities will not improve the worst performers if they remain anonymous.

Fig.1: Interpersonal Skills Index scores (percent) for 219 general practitioners in advanced vocational education (data supplied with the RNZCGP's permission)

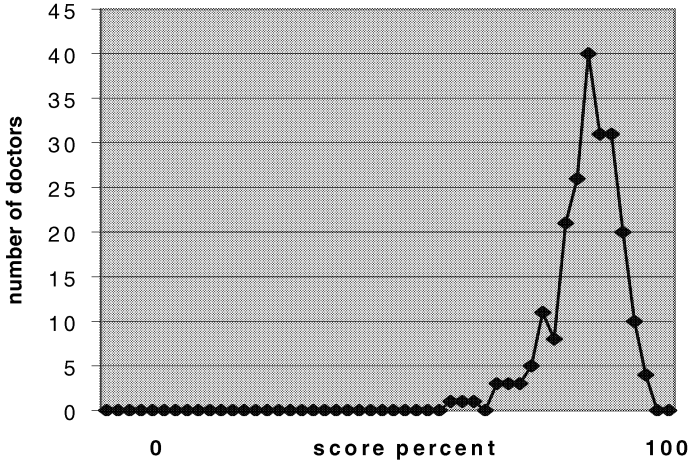


Fig.2: how do CQI activities influence the range of performance? Is a whole normal distribution shifted to the right?

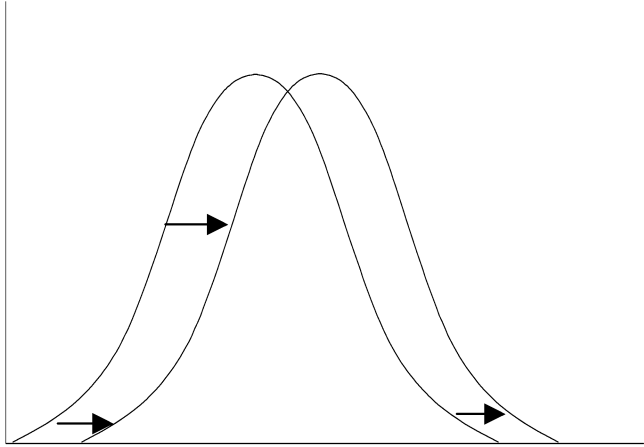
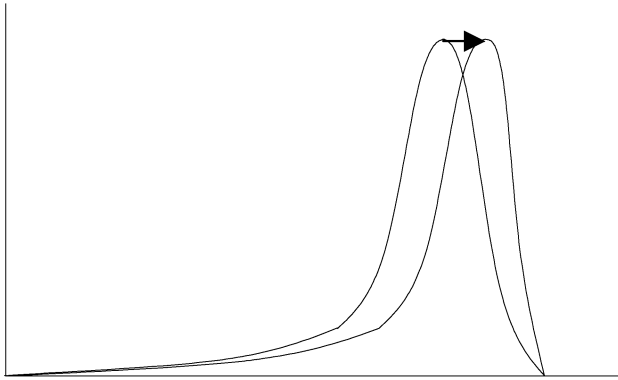


Fig.3: how do CQI activities influence the range of performance?is it just the middle of a skewed curve that is moved?



Underperformers have to be identified to be helped, and that is congruent with many observations: we need others to help us identify our deficits. “People tend to hold overly favorable views of their abilities in many social and intellectual domains. People who are unskilled in these domains suffer a dual burden: not only do they reach erroneous conclusions and make unfortunate choices, but their incompetence robs them of the cognitive ability to realise it. Paradoxically, improving their skills, and thus increasing their cognitive competence, helps them recognise the limitations of their abilities”.⁵

Screening

If responding to concerns does not identify all the poor performers, we might extend the clinical metaphor of educational diagnosis and educational treatment to consider screening for presymptomatic conditions. Here that condition would be poor clinical performance, and we should see whether we can

- identify a high-risk group for special attention, or
- justify population-based screening (the periodic assessment of all doctors).

A high risk group?

Defensibly thorough assessment procedures are time-consuming and expensive, so we might be most cost-effective if we concentrate on doctors at high risk for poor performance. Such an approach would be justified if we knew and could access all the indicators of high-risk status, and if all poor performers were reliably found in the high-risk group.

Alas, while we can now recognise personal and practice indicators *associated with* poor performance, we cannot discover them all, and anyway none is specific to poor performers.

The eloquent 1980s sex lecturer Domeena Renshaw (a friend asked at the time, “Is that *Misdemeanour* Renshaw?”) used to say the causes of most erectile dysfunction were the three As: alcohol, anxiety and age. It is the same for clinical performance. Substance abuse or other medical conditions, and distractors such as family, business or practice dysfunction, can diminish even the most competent doctor, and increasing age is associated with deteriorating performance, independently of associated variables.^{6,7} A uniquely important risk factor is professional isolation, suggested perhaps by rural practice, solo practice, nonmembership of organisations^{7,8} like the College or IPA or PHO, or (in New Zealand) failure to attain vocational registration,⁹ or a pattern of prescribing, test ordering or referral well outside that of colleagues. Furthermore, just as alcohol, anxiety and age may not be independent, so substance abuse, distractors, cognitive failure, increasing age, and professional isolation may act together to lessen one doctor’s performance.

The Medical Council has a Health Committee to help doctors whose performance is reduced by medical conditions.¹⁰ Human rights legislation prohibits assessing doctors solely on the basis of their reaching a certain age, and privacy legislation restricts access to data – collected for a different purpose – on prescribing, referral or other activities. (Some overseas jurisdictions, notably Quebec, have easy access to such outlier data,¹¹ as of course do some Independent Practitioner Associations in New Zealand). There remain other accessible indicators of professional isolation that are likely to be associated with poor performance.

Population screening?

The principles of screening for disease (see box)¹² might aptly be applied to screening the whole population of doctors for poor performance. The “condition” (poor performance) is serious, we know interventions (targetted and personalised remedial education) improve performance,¹³ and though we do know doctors undergoing competence reviews find the process disruptive to their personal and professional lives, we believe that the stigma would lighten if all doctors underwent the process, and anyway, that patient safety is a more important consideration. So far no single suitable, reliable, valid and practical test is available, however. Furthermore there is little evidence from randomised controlled trials that screening all doctors is effective, and no certainty the Council could support all the elements of such a programme. Social, ethical and cost-benefit issues have been considered, but their consideration is far from complete.

The introduction of any programme to screen all doctors periodically should therefore be in the nature of a pilot – and that should mean it is

restricted temporally and geographically, researched thoroughly, and extended only if the outcomes of the research justified an extension.

Criteria for assessing screening programmes¹²

1. The condition is a suitable candidate for screening.
2. There is a suitable test.
3. There is an effective and accessible treatment or intervention for the condition identified through early detection.
4. There is high quality evidence, ideally from randomised controlled trials, that a screening programme is effective in reducing mortality or morbidity.
5. The potential benefit from the screening programme should outweigh the potential physical and psychological harm (caused by the test, diagnostic procedures, and treatment).
6. The health care system will be capable of supporting all necessary elements of the screening pathway, including diagnosis, follow-up, and programme evaluation.
7. There is consideration of social and ethical issues.
8. There is consideration of cost benefit issues.

A combined approach

For those reasons the pure concept of periodic screening all doctors for poor performance has given way in most jurisdictions who have considered the issue, to a combined approach including universal continuous quality improvement activities, some form of periodic screening, enhanced surveillance of high-risk groups, and responsive reviews after receipt of concerns. Alongside this go employer credentialling activities.

In Britain¹⁴ there is a three-pronged approach – the General Medical Council has a responsive programme of competence reviews, and has revalidation processes based on a doctor's portfolio of quality activities assessed at an annual practice visit. Of British doctors independently surveyed, over 80% think revalidation is a good idea. The National Health Service, as employer of most doctors, has introduced its National Clinical Assessment Authority (NCAA) which responsively reviews doctors' competence after complaints.

Every five years, the performance of each doctor in Alberta is reviewed by questionnaires completed by 25 patients, 8 physician colleagues and 8 nonphysician healthcare coworkers (the Physicians Achievement Review program, PAR¹⁵). An independent research firm then provides the doctor with detailed personal responses, and compares these with summary information on all doctors with similar practices. The questionnaires cover clinical knowledge and skills, communication skills, psychosocial management, office management and collegiality. PAR profiles are then reviewed by a nine-member Council-appointed group. Should the PAR surveys flag a potential problem, the group will work with the doctor

from a quality improvement perspective: peer office reviews or other competence assessment tools may be used in these processes.

In New Zealand a pilot programme, to be trialled alongside the existing responsive programme, is currently under discussion. It is likely to combine periodic screening of two groups – the first: a sample of all doctors; and the second: an outlier group (doctors who do not complete recertification activities). The screening “test” will be patient and coworker rating interviews. Those doctors whose performance is questioned by those processes would proceed to a formal competence review. The Council would continue to rely on Branch Advisory Bodies (one of which, the RNZCGP, advises the Council on general practice) to monitor and audit approved recertification programmes for their Fellows. Many hospitals and PHOs will have additional credentialling and outlier surveillance activities.

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Chapter 3: How well can peers and patients rate a doctors' performance?

Multisource feedback
The disruptive doctor

In my first paper¹ I introduced the notion of reviewing the performance of practising doctors as an educational assessment exercise, and in the second² discussed ways of identifying the poorly performing doctor. This paper examines one tool for assessing performance – multisource feedback - and one special application of that tool – the assessment of the disruptive doctor.

We can select an appropriate kit of assessment tools from an available range – from tests of what a doctor actually *does* in practice (direct observation, videos, mystery patients), of what the doctor can *show* in controlled simulations of practice (OSCEs, simulated surgeries, role plays), of whether the doctor *knows how* (case based oral examination, patient management problems), or of whether the doctor *knows* (multiple choice questions, extended matching sets, short answer questions). No single tool covers all the domains of performance.

Multisource feedback

One way to assess performance is to ask the people the doctor works with – patients, medical and nonmedical coworkers – what they think: and to compare their views with those of the doctor. The method, often now called multisource feedback (MSF), or 360-degree evaluation, has been well reviewed by Lockyer.³ MSF is a questionnaire-based assessment method in which key performance behaviours are rated by peers, patients, and coworkers. It has been widely used in industrial settings to assess employee performance, but is now gaining acceptance as a quality improvement method in health care.

MSF is most likely to succeed and result in changes in performance when attention is paid to psychometric as well as structural aspects of programme design and implementation. Thus the behaviours examined must be appropriate, the communication (including feedback of results) clear, and the threats minimised. The instruments must be reliable, have face and content validity, and distinguish between factors related to the doctor's performance and factors beyond the doctor's control (for instance management systems).

Reliable data can be generated with a reasonable number of respondents, and doctors do use the feedback to contemplate and initiate

changes in practice. Results may be affected by familiarity between rater and doctor, and sociodemographic characteristics, but little of that variability is explained by factors outside the doctor's control.

Peer ratings refers to the results of a questionnaire answered by other doctors and coworkers about the quality of a doctor's practice. The questionnaire covers characteristics such as medical knowledge, clinical and communication skills, as well as humane qualities including respect, integrity and compassion.

The doctor is asked to identify ten other doctors who could give an opinion about these characteristics, either as they have an impact on patients, on colleagues, or both. The doctor is also asked to identify five other people, including practice staff and allied health professionals, who could give a similar opinion.

Peer ratings have been used to screen the performance of practising doctors in Alberta,⁴ as an optional part of MOPS for the Royal Australasian College of Physicians, and will be used by the General Medical Council as part of its revalidation procedures.⁵ The original questionnaires were developed by Ramsey for the American Board of Internal Medicine, and most questionnaires are based on his validated work.⁶ The whole team – receptionists, nurses, allied health professionals, and doctors who receive or make referrals, can be questioned.

Patient satisfaction questionnaires it seems, have always been a subject of contention: there is a huge literature on them, much of it exhortative rather than scientific. The questions asked in such surveys are important and well validated,⁷ and instinctively we feel they must be measuring something important. Yet Vuori found no evidence they improve care, and asked why they should be taken seriously.⁸ He answered himself thus: patients are partners in health care; they are the best judges of amenities and interpersonal relations; we are in a consumers' market and measurement of needs is part of the definition of quality; and in a democracy, patients should have the right to influence activities affecting them.

Those are all politically sound and valid reasons (and there are others), but are these instruments reliable enough to be used in assessing the performance of individual doctors? In general practice a range of variables unalterable by the doctor may reduce patient satisfaction – for instance in the U.K: higher list size, no personal list, training practice, more patients booked per hour, older patients, more male patients, older doctors.⁹ The level of satisfaction may depend on whether patients are surveyed in the surgery or by post,¹⁰ though it doesn't seem to matter whether a postal survey comes from the doctor or another agency.¹¹

Interpersonal Skills Indices (ISI) are measures of patient satisfaction, and can be derived from the Doctors Interpersonal Skills Questionnaire (DISQ); some doctors in the College's advanced vocational education (AVE) programme have had ISI measured twice; their scores in the first test were not related to the second; some doctors in an independent practitioners' association took the test before and after attention to

communication skills, and the pre- and post-tests showed no differences [unpublished data]. Either the test is not reliable or communication skills education doesn't work.

Do doctors act on the feedback obtained from patient satisfaction surveys? Less than a quarter of Massachusetts primary care physicians found patient satisfaction data useful for improving patient care, and even fewer reported using such data to change their practice.¹² Some Australian and British regulatory jurisdictions have found patient satisfaction data the least useful of performance indicators [Farmer E, personal communication; McAvoy P, personal communication].

Nonetheless Lockyer concluded that multisource feedback, while not a substitute for audit when clinical outcomes should be assessed, is one of the better tools that may be adopted and implemented to provide feedback and guide performance when interpersonal, communication, professionalism, or teamwork behaviours need to be assessed and guidance given.³

The disruptive doctor

Those very behaviours are awry in the disruptive doctor, and coworkers will usually have plenty to say about him (I use the masculine purposefully). Disruptive behaviours include repeated episodes of sexual harassment; racial or ethnic or sexist slurs; loud, rude comments; intimidation or abusive or offensive language; persistent lateness in responding to work calls; throwing instruments; sarcasm or cynicism; threats of violence, retribution, litigation; demands for special treatment; refusal to treat. "Disruptive behaviour by a physician has a deleterious effect upon the health care system and increases the risk of patient harm".¹³

Understanding and approaching the disruptive doctor may need one or more conceptual models, for instance health, discipline, competence, employment, or dispute resolution.

Disruptive doctors may have an unusual personality trait/disorder, or be suffering from affective disorder (depression, bipolar), substance abuse/dependency, evolving dementia/delirium, schizophrenia, sleep deprivation/fatigue, other distractors (situational maladjustment, anxiety), or diabetes.¹⁴ In such cases their disruptive behaviour may be seen as a health issue. On the other hand personality disorder is a controversial diagnosis, and personality trait even more so.

The Commonwealth of Massachusetts Board regards disruptive behaviour as a disciplinary matter. "Behaviour of a physician that is disruptive, and compromises the safety of medical care or patient safety, could be grounds for Board discipline".¹³

Here are two cases:

A 63 year old provincial surgeon is identified by his manager and senior colleagues as having an unacceptably high rate of complications, and using techniques that others feel are somewhat

dated. In addition he is unapproachable, belittles women and junior staff, is angry when called at night, and equally so when not consulted about apparently trivial matters. He shouts at “disobedient” patients.

The partners of a middle aged GP complain formally he often makes prescribing mistakes and has neglected to examine several patients when their clinical presentation indicated it. The partnership has now broken up acrimoniously amid accusation and counter-accusation by all parties. The doctor has written to all “his” patients from the partnership complaining his former partners will not release their records to his new practice. Attempts at mediation have ended in further acrimony.

A clinical performance review would appear to be sensible in each case, but should the disruptive behaviour itself be seen as a competence issue? Perhaps so: honesty, integrity, probity, respect for patients, respect for colleagues and ethical practice are important attributes of professional performance.

In the assessment of a disruptive doctor, then, is the issue health? discipline? competence? employment? a dispute for mediation? All or some of these together?

“Hard evidence” is hard to get: in Alabama only 32 of 122 complaints could be dealt with – because fear of retribution, or other inability to gather evidence, prevented any approach to the others.¹⁴ These are often powerful, isolated, narcissistic and litigious men.

The important question for health is, “Has there been a *change*? Is the behaviour *new*?” If so, an assessment is needed – an interview looking for distractors, a psychiatric and/or neurological or other health assessment. If not, then it is unlikely to be a behaviour pattern related to a health issue. The best judges of change are the doctor’s colleagues at work.

The Council should act only when patient care could be compromised, and should not be concerned with minor behavioral differences from some “norm”. How persistent is the behaviour? How consistent? How bad?

The peer rating questionnaire the Medical Council has used is appended.

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Questions to address (these may be put as additional questions to work associates) -

- How bad is this? Is this urgent? Is patient safety at risk?
- Is the situation so disruptive the doctor needs to be taken out to "cool off"?
- Have there been clear concerns raised about **competence**?
- Is there a systems problem requiring an approach involving an **employer**?
- Does the doctor have a physical or mental **health** problem? Are there distractors? What help is needed? Should the Health Committee be involved?
- Do the behaviours betray negligence, breaches in professional standards, or poor ethics, that indicate a **disciplinary** referral may be appropriate?
- Is this a case for conflict resolution – **mediation**? Would the parties consent to that? have they already tried it?

Peer rating questionnaire

The Medical Council has received concerns about alleged disruptive behaviour by Dr _____. The doctor has given permission for me to approach a number of work associates to assess the concern. Your answers will be confidential.

***Over months or years have you noticed any change in behaviour?
Any NEW behaviour of concern?***

YES NO

The behaviour brought to the attention of the Medical Council is

Are there similar behaviours you know of?

How bad and how frequent is such behaviour?

What effect has that had on the work of others in the team?

How has it impacted on patient care or safety?

Comments

Now please rate this doctors behaviour and performance as follows: a score of **1** would indicate this doctor is the worst you have worked with; **2** that he or she is among the bottom few for this characteristic; **8** that the doctor is among the top few you have worked with for this characteristic, and **9** he or she is the single best. Please just say if you are unable to answer that question.

Respect: Does this doctor show respect for the rights and choices of patients?

1 2 3 4 5 6 7 8 9 UA

Communication with doctors: How does the doctor relate to other doctors?

1 2 3 4 5 6 7 8 9 UA

Communication with team: How does the doctor relate to other staff & members of the health care team?

1 2 3 4 5 6 7 8 9 UA

Responsibility: How well does the doctor accept responsibility for his or her own actions (not blaming patients or other health professionals)?

1 2 3 4 5 6 7 8 9 UA

Integrity: How would you describe this doctor's honesty and trustworthiness in dealing with others?

1 2 3 4 5 6 7 8 9 UA

Compassion: Does the doctor get involved with patients' and families' special needs?

1 2 3 4 5 6 7 8 9 UA

Psychosocial aspects of illness: How well does the doctor respond to the psychological, social and cultural aspects of illness?

1 2 3 4 5 6 7 8 9 UA

Critical appraisal: How well does the doctor critically assess information, risks and benefits?

1 2 3 4 5 6 7 8 9 UA

Medical knowledge: How would you describe this doctor's medical knowledge?

1 2 3 4 5 6 7 8 9 UA

Skills: How would you describe this doctor's manual and technical skills?

1 2 3 4 5 6 7 8 9 UA

Overall: Would you be comfortable if this doctor were caring for you or a close loved-one?

1 2 3 4 5 6 7 8 9 UA

Chapter 4: Reviewing communication skills

With Elizabeth Farmer, who is an Associate Professor in the Department of General Practice at Flinders University, Adelaide, where she is the Director of the Primary Health Care Research Evaluation and Development (PHC RED) Program. She has a special interest in assessing communication skills.

The adverse effects of poor communication
What is good communication?
How do you assess communication?

“Doctors make mistakes, I know that – they’re only human. And I wouldn’t have minded, if only he’d said something – talked to me – even acknowledged it had happened.”

The adverse effects of poor communication

You have to be blind, illiterate, or at best conservative to a reactionary degree, if you still think good communication is just the icing on the good clinical skills cake. It is much more than that: the evidence is unambiguous: poor communication by doctors reduces the effectiveness of medical treatment, leads to dissatisfaction in patient and doctor, and triggers complaints.

Stewart and others found patient-centred communication skills were associated with better recovery from symptoms and concerns, better emotional health scores, and fewer tests and referrals. They concluded that patient centred practice improved health status and increased the efficiency of care.¹

Arora recently reviewed key findings linking physician communication behaviour with cancer patients’ health outcomes and drew similar conclusions.²

The same team of investigators conducted three related RCT studies of the relationship between clinical communication and patients’ health outcomes in chronic disease (ulcer disease, hypertension and diabetes). After enrolment, audiotape recordings of doctor – patient communication were obtained to provide baseline data. Communication was divided into 30 codes. Patient questionnaires, pain measures, blood pressure, and HbA1c measurements were obtained as outcomes. Patients were randomised to control and intervention (the latter were taught to ask more questions, seek more information and express themselves more fully). At follow up 6-12 months later there was a consistent relationship between changes in doctor-

patient communication and changes in health outcomes. Physiological and functional measures improved when patients were provided with more information about their problem, were able to show more emotion (especially ventilating negative emotion), and when they improved their effectiveness in eliciting information from doctors. Patients had worse outcomes with doctors who allowed patients less involvement in history taking, gave less information, and who expressed negativity.^{3,4,5}

Seventy percent of litigation in the USA is related to poor communication: initiated by patients who feel they have been deserted, devalued, misunderstood, or have not been told everything.⁶

Bunting and others found that adverse outcomes, iatrogenic injuries, inadequate care, mistakes, incorrect care and system errors were unlikely to lead to litigation if there were no “predisposing” factors - like rudeness, delays, inattentiveness, miscommunication, apathy, or even no communication.⁷

What is good communication?

Which communication skills are critical in medical consultations?

Positive factors in the history-taking phase include doctors asking questions about patients’ concerns, understanding, expectations, impact and feelings, doctors showing support and empathy, patients involved in full expression of their concerns, and patients’ perception that there has been a full discussion. Positive factors in the management phase include patient information seeking and question asking, being successful in obtaining information, a willingness by the doctor to share decision making, agreement about the nature of the problems and the need for follow up.

When an error has occurred, patients want full disclosure (“truthfully and compassionately”) of all harmful errors: to be told what happened, why, how the consequences will be mitigated, how recurrence will be prevented; they want an apology, and they need emotional support; they are upset, angry and scared. (Doctors want to disclose “truthfully, objectively, and professionally” but not when “harm is trivial, the patient cannot understand error, or does not want to know”; they want to “choose their words carefully”, avoid stating an error has occurred, why, how it might be prevented, they worry an apology might create legal liability, are upset too, but don’t know where to seek emotional support).⁸

These critical skills should be included when assessing practising doctors’ communication. In its competence reviews, the Medical Council of New Zealand also emphasises the role of the lay as well as the professional assessor in assessing the doctor’s communication at interviews, during the case based oral assessment, and while observing consultations.

How do you assess communication?

Defensible methods of assessing communication should reflect the considerable evidence concerning the validity and reliability of the assessment process.

The communication skills of practising doctors are usually assessed by standardised tests using (in rough order from least to most realistic) simulated patients in an objective structured clinical examination (OSCE) setting, direct observation in the practice, video analysis of real consultations by trained raters, and unannounced simulated patients (also known as “mystery shoppers”).

Simulated or standardised patients are lay people or actors who are trained to portray a medical problem with a high degree of realism and accuracy. Simulated patient-based competence testing involves direct observation of the doctor’s hands-on clinical behavior with such patients under standardised test taking conditions (the New Zealand College Primex clinical examination is a good example). The consultation is observed by an examiner, and marked on the spot. Simulated patients may also contribute to marking. Generalisability ratios (a measure of reliability) reach an acceptable level of 0.8 only with about 20 consultations (or about four to five hours of testing⁹), and more than one examiner – so to be done reliably the method requires a good deal of resource. The simulated patient consultations can be videotaped, but “assessment ... of family physicians’ practices by video observation in daily practice is superior to video assessment in a simulated setting using standardised patients”.¹⁰

Direct observation involves assessing communication skills as part of an assessment visit, using a short evidence-based rating scale with numeric values and/or qualitative data. It is done in the context of the entire consultation, including diagnosis and management – and can be contrasted with competency testing (which examines discrete tasks). While patient consent can be an issue, there should be at least ten observed consultations. There is an “observer effect” which may affect a doctor’s usual behaviour – for better or worse! Global rating scales based on expert judgement are better than checklist scoring systems because the latter tend to trivialize the complex nature of the consultation.¹¹

Videotaping of consultations in practice also stumbles at times on the issue of patient consent, but it is attractive because it is cheap, the doctor does the work, it examines encounters with real patients in context, the “observer effect” diminishes over time, quality control of raters is possible, the material is readily available for research, and “norms” can be determined with experience. The Royal Australian College of General Practitioners’ (RACGP) Fellowship by Practice-based Assessment (PBA) requires 140 consultations (involving videotaping for over a week), with a logbook which takes about a minute per encounter. Two raters then view 15 consultations, selected from a blueprint to cover a range of clinical concerns, core knowledge, skills and attitudes, first-time and return visits, age and gender. Consultations are rated using a generic scale for history, diagnosis and management. There is a risk of selection bias by the doctor (this diminishes with large numbers of consultations), and there are still

issues around rating scales, consultation variation, “observer effect”, patient consent, and the need for double cameras to allow for recording physical examination technique. Nonetheless, “Video assessment of GPs in daily practice according to the procedures described is a valid and reliable method, one which is useful for education and quality improvement. As always, there is a trade-off between feasibility on one hand and validity, reliability and credibility on the other hand”.¹²

Mystery shoppers (unannounced simulated patients) have not been used by the Medical Council for performance assessment, but the method is well recognised.^{13, 14} John O’Hagan, Calder Botting and Lanktree Davies were the first to report its use in New Zealand in 1989, after they had trained actors to simulate asthmatic patients on visits to Christchurch general practitioners - who had agreed beforehand to participate.¹⁵ The doctors’ performance is likely to be close to real life, a wide range of clinical scenes can be simulated, including those involving complex, difficult patients: more than one person at the consultation, cultural issues, mental health, and longitudinal care (an actor can visit the doctor more than once). Accurate recording of both communication and management advice is possible, and the degree of “patient centredness” measured by the actor; management can be assessed against predetermined standards based on evidence. Issues include concepts of the “use and abuse of deception¹⁶”, the consent of the participating doctor, and the doctor mistakenly identifying a real patient as a simulator and “springing” them (though they are rarely detected¹⁷). The method is unreliable without rigorous selection and training of the actors, and it falls into disrepute when abused by news media trying to catch doctors behaving badly. The actor must be undetected, the scenario must fit to the practice, and processes in case of “detection” should be clear and agreed. Health insurance, billing, geography, address and phone can create difficulties. The actor has to be a “new patient” but can present more than once. There is significant cost in attaining the numbers of consultations needed to obtain reproducible results.

So what?

Remedial education in communication skills does work. You can teach an old dog new tricks, so the identification of poor communication skills can have a positive outcome for all. If a doctor has been the subject of complaint, and performance assessment shows poor communication skills, he (we use the pronoun advisedly, for “Female primary care physicians and their patients engage in more communication that can be considered patient centred and have longer visits than do their male colleagues”¹⁸) can learn to communicate more effectively.^{19, 20, 21}

Conclusions

- Communication skill influences patient health outcomes and the likelihood of complaint;

- Performance based testing should critically appraise and build on those observations (content validity);
- Communication skill testing tools should be able to be applied in different testing situations (flexibility);
- Reliability depends on the size of the sample;
- Assessing communication skills is educationally sound because remedial education can improve communication skills.

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Chapter 5: Assessing knowledge

Knowledge and clinical performance
Tools for testing knowledge
Cognitive dissonance

Knowledge and clinical performance

Why assess knowledge? Haven't we gone past the protracted multiple-choice questions of medical school? Surely if we are to assess anything we should assess actual clinical performance? Are we not more concerned with what the doctor actually "does" in practice and less concerned with what a doctor "knows"?¹ Aren't we properly more concerned with performance than with competence?

But just a minute here. You cannot perform well unless you are competent. In Ontario one third of doctors who performed at a substandard level at competence review were found on cognitive testing to be impaired.² That is an important observation if remedial education is to be considered. There is thus at least a theoretical necessity to assess knowledge before anything else, and indeed, the National Competence Assessment Authority in Britain does just that – it requires NHS doctors who are about to undergo a performance assessment to have a specialty-specific knowledge test at the outset.³

At least as far as general practice is concerned, they are on firm evidential ground. Maastricht researchers compared the predictive values of written-knowledge tests and a standardized multiple-station examination (OSCE) for the actual medical performance of general practitioners.⁴ Their subjects underwent a general medical knowledge test, a knowledge test on technical skills, a multiple station examination using standardized patients and a video assessment of a real surgery. The predictive value of medical knowledge tests, (0.43 to 0.56 - Pearson correlation disattenuated), proved to be comparable with the predictive value of the multiple-station examination for actual performance (0.33-0.59). The researchers concluded that medical knowledge tests can predict actual clinical performance as well as a multiple-station examination. A knowledge test may thus be a good alternative to an OSCE for assessing a large number of practising GPs.

Norcini studied intensivists and found "that performance on a cognitive examination is related to performance in practice. Of course, this type of examination is not a substitute for rigorous evaluation of practice outcomes, nor is it broad enough to include important aspects of competence such as communication skills and professionalism. Nevertheless, until better measures are available for high-stakes use, the cognitive examination is a reasonable alternative".⁵

In 2002 Quebec researchers examined 912 family physicians who passed the Quebec family medicine certification examination between 1990 and 1993 and entered practice, and their practice performance for 3.4 million patients.⁶ They looked at existing data on mammography screening rate, continuity of care index, disease-specific and symptom-relief prescribing rate, contraindicated prescribing rate, and consultation rate. They found scores in examinations at the end of medical school showed a sustained relationship with indices of preventive care and acute and chronic disease management.

Evidence of success in knowledge tests in general practice in NZ is College membership, leading to vocational registration; vocationally registered general practitioners are under-represented in competence review statistics here compared with those who remain generally registered.⁷ In Ontario general practitioners without professional affiliations were more likely to be practising at a substandard level.⁸ In the United States Sharp and others reviewed papers exploring the relationship between Board certification and actual clinical outcomes: of the 33 papers fulfilling their criteria, 16 demonstrated a significant positive association between certification status and positive clinical outcomes.⁹

Tools for testing knowledge

What tools then, do we use to test knowledge in the Medical Council's competence reviews? We have chosen the case-based oral (CBO, aka chart-stimulated recall, CSR) as our primary assessment tool. This bears little resemblance to written multiple-choice examinations—not that we have any quarrel with MCQs: they are well established reliable knowledge tests; but we doubt their acceptability in reviews of practising doctors. Nor does the CBO bear any resemblance to the traditional anatomy orals of our youth (“What we don't cover in the lectures we do cover in the examination”); there are no silly games or unkind surprises here.

The reviewers examine a sample of the doctor's own files, looking for clinical knowledge in longitudinal care. With the file in front of him or her, the doctor responds to questions exploring knowledge of the conditions encountered. The questions are based on the doctor's own cases. Salvatori and others described the development of the test for reviewing occupational therapists, “The CSR tool... taps global domains of competence: use of theory, assessment, program planning, intervention, discharge planning, follow-up, program evaluation, clinical reasoning and professional behaviours. ... (it) is not only reliable and valid, but also sufficiently generic to be used in a variety of practice settings as a global measure of on-the-job performance”.¹⁰

Cognitive dissonance

There may be a mismatch between knowledge and its application. You will recognise this doctor – young, probably overseas-trained, with dispersed thinking.¹⁰ The features of dispersed thinking are

- The doctor has abundant knowledge – a differential diagnosis list is readily generated, and new ones may be generated for each new finding; but the list is static – it is not challenged by the actual findings;
- The diagnoses are not appropriate in this clinical context – for this patient with these issues; They are not articulated in the context of the patient as a whole;
- The doctor takes a long history, an exhaustive examination, suggests many diagnoses, but no working diagnosis; no clear direction emerges as each symptom and sign is considered; the doctor misses the obvious – cannot see the wood for the trees.
- The reasoning and discourse are dispersed; there is little or no resolution of the problem;

Assessment of such doctors is often difficult – they rightly protest their knowledge is exhaustive, and their dispersed thinking itself impedes their ability to understand its impact on their clinical reasoning.

Experienced doctors possess elaborated networks of knowledge fitted to their tasks: these are called scripts. Key features are the elements of a problem that are crucial to its successful resolution. Key feature problems and examinations are used for testing clinical decision making skills. One such examination is the script concordance (SC) test.¹⁰⁻¹⁵

This examines whether knowledge is efficiently organised for clinical actions. It measures the degree of concordance between examinees' scripts and the scripts of a panel of experts. Charlton and others describe the principles of construction of a SC test.¹⁴ It is a simple and direct approach to testing organisation and use of knowledge. It is relatively easy to construct and use and can be made machine-scorable. It can be either paper or computer-based and with careful preparation can be incorporated into the case based oral:

“OK, you have told us what you were thinking when you managed this case; now, what if the patient had also had joint pains?”....

“Now, what would you think if he told you he had recently been duckshooting in Australia and had suffered a lot of bites by unusually aggressive mosquitos?”

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Chapter 6: Reviewing proceduralists

With Jonathan Beard, who works as a consultant vascular surgeon at the Sheffield Vascular Institute. He has a longstanding interest in technical skills training and assessment. He is Programme Director for Higher Surgical Training and works with the UK General Medical Council's Performance Procedures and the National Clinical Assessment Authority.

Measurement of outcomes
Other measures

General practitioners are the doctors about whom most competence concerns are expressed to the Medical Council (Table 1). However, when the number in each specialty is taken into account, proceduralists occupy four of the top five places, representing a total of 56 (20%) of the 285 concerns the Medical Council has received. (We know that it is the combination of substandard performance with poor communication that leads to complaints about doctors, and we tend to stereotype surgeons in this mould; but after competence review, only 6 [18%] of the 34 doctors found to be practising at a substandard level were surgeons. That is the same percentage as received complaints, so the competence concerns about surgeons were similar to other doctors). Surgery is, of course, the stuff of drama, and some of these surgeons have been accorded very high profiles by the media. At high risk are the patients of surgeons who do few procedures, in hospitals that do few procedures: the relationship between volume of procedures and outcome is now well established.¹

Table 1: competence concerns received by the Medical Council of New Zealand, by specialty

Specialty	No. with APC	No. of Concerns	Percent
General Surgery	196	23	11.7
Obstetrics and Gynaecology	200	17	8.5
GP (Gen Reg)	1304	104	7.8
Otolaryngology	77	5	6.5
Orthopaedics	171	11	6.4
GP (Voc Reg)	2098	93	4.4
Psychological Medicine	327	11	3.4
Radiology	237	4	1.7
Internal Medicine	580	10	1.7
Anaesthetics	422	7	1.7

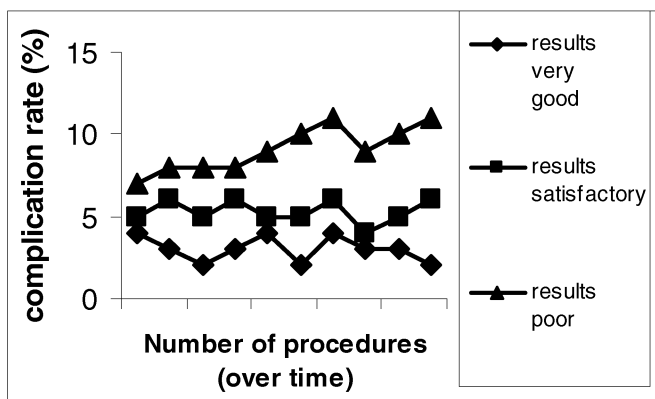
Cuschieri questioned UK master surgeons about competence and revalidation, using a Delphi survey.² The group agreed on the need for competence checks during the professional careers of surgeons, covering knowledge, as well as clinical, operative and humanistic skills, and they thought an external agency should do the assessments. However, they were concerned about the validity and reliability of existing systems. How then should the Council go about assessing procedural performance?

Measurement of outcomes

The history of surgical audit is outlined by Wright.³ Audit implies measurement (counting complication rates and other outcomes), and publication (for peer review).

Let's look at a hypothetical procedure where the acceptable complication rate is 5%, and try to assess a surgeon according to outcomes (Fig.1). Large numbers of procedures are necessary for reliability: at fewer than 10 there are insufficient data to make an analysis. Beyond that a numerical audit of procedures will show complication rates with increasing accuracy, and even a retrospective audit can be useful in assessing surgical performance. As with all things, prospective audits can be designed for specific purposes, and have advantages over retrospective ones – and of course surgeons practising at a substandard level will often have substandard recording of their outcome audits.

Figure 1: assessing the outcome of a procedure



Simple outcomes have limited meaning, unless stratified for surgical risk, and various methods have been devised for such adjustments.^{4,5} Outcomes are also dependent on the whole surgical team (not just the surgeon) so they measure performance rather than competence.⁶ A competent surgeon may

perform poorly because of problems with the team, hospital, health service or because of illness or stress.

Other measures

There are other important measures to be considered apart from outcomes: knowledge, clinical and communication skills in the outpatient department or clinic, case selection, manual dexterity, hand-eye coordination, and disruptive behaviour (poor team player) for instance.

For such assessments in New Zealand we have chosen a kit of review tools, including the case-based oral, record review, interview, sitting in on clinics, obtaining ratings from peers and co-workers, and direct observation of procedures. Objective assessment of surgical skills can be undertaken in the clinical skills laboratory, on virtual reality (VR) simulators, by direct observation in theatre, or by video recording. Tests of psychomotor skill have a limited place as 75% of events in an operation concern decision making ability and 25% relate to manual dexterity.⁷ However, more advanced simulations can also test decision making ability.

In Britain, the General Medical Council's proposals include a "Phase 1 peer review" of all doctors, comprising extended curriculum vitae, structured interview, medical record keeping, case based discussion, observation of consultation, third party interviews, site tour (two medical and one lay assessor). For surgeons who appear to be practising at a substandard level at Phase 1, there are "Phase 2 tests of competence", comprising a knowledge test (200 items, matching sets format), communication skills (ten simulated patients), technical skills (nine or ten OSCE stations, seven generic & two or three specialty specific).⁸

The OSCE for technical skills is renamed OSATS (Objective Structured Assessment of Technical Skills).⁹ The generic simulations test scrubbing & gowning, preparing the patient, knotting, suturing, vessel ligation, tissue dissection, and hand eye coordination. The tests have been shown to discriminate well between volunteer surgeons, and those performing at a substandard level.¹⁰ The specialty specific simulations test more advanced (integrated) procedural skills such as laparoscopic cholecystectomy. Task-specific checklists are useful for simple simulations but global ratings are better for complex procedures, especially when assessing experts.¹¹

Sophisticated virtual reality (VR) simulators are available for anaesthetics and may be the only way to assess an anaesthetist's performance in response to an emergency objectively. Endoscopy simulators are now available for bronchoscopy, fiberoptic intubation, gastrointestinal endoscopy, ureteroscopy and angiography. Validation studies have shown significant differences in bronchoscopy simulator performance among novices, intermediates and experts.¹² testing on a VR laparoscopic simulator also correlates well with intraoperative assessment during laparoscopic cholecystectomy.¹³ VR simulators are not yet available for open procedures, partly because of the problems of providing tactile (haptic) feedback. However advances in computer processor power mean that such simulators

are now on the horizon. VR simulators provide automated scoring systems that avoid the risk of observer bias.

Direct observation in theatre is probably the “gold standard”, and has good inter-rater reliability.¹⁴ However, direct observation is costly in terms of assessor time and can have positive or negative effects on performance (audience effect).¹⁵ Direct observation also requires thorough training of the assessor to prevent observer bias (halo effect).¹⁶ Blinded video recording tends to avoid both effects and can be quicker because of the ability to “fast-forward”, but there may be some loss of information compared with direct observation.¹⁷

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Chapter 7: Reviewing the doctor who practises complementary and alternative medicine (CAM)

The WHO says “Complementary and alternative medicine (CAM) refers to a broad set of health-care practices that are not part of a country’s own tradition and not integrated into the dominant health care system. Other terms sometimes used to describe these health care practices include ‘natural medicine’, ‘non-conventional medicine’ and ‘holistic medicine’.”¹

In a recent decision the Medical Practitioners Disciplinary Tribunal (the MPDT) stated, “There is an onus on the practitioner to inform the patient not only of the nature of the alternative treatment offered but also the extent to which that is consistent with conventional theories of medicine and has, or does not have, the support of the majority of practitioners....”²

The MPDT went on, “The Tribunal recognises that persons who suffer from chronic complaints or conditions for which no simple cure is available are often willing to undergo any treatment which is proffered as a cure. As such, they are more readily exploited.”

The 2004 competence review, in response to concerns raised, of a doctor practising complementary and alternative medicine (CAM) highlight the necessity for a specifically designed kit of tools for assessing the performance of such doctors. As most CAM doctors are also general practitioners, such a kit should be able to review orthodox general practice capability as well as CAM practice.

A proper review of the efficacy of a specific CAM practice is however beyond the expertise of most orthodox reviewers, and thus beyond the scope of a performance assessment: whether homeopathy or naturopathy is effective is for others to determine. But for the most idiosyncratic practices an assessment will be necessary – and of course some methods have already been discredited elsewhere, and some simply amount to medical fraud.³

Objectives of a performance assessment

- To assess the doctor’s general competence in orthodox medicine.
- To assess the doctor’s adherence to the Medical Council’s *Guidelines on complementary, alternative or unconventional medicine*;⁴
- To assess the doctor’s competence in assessing evidence relating to such practice (critical appraisal skills);
- To determine whether a detailed retrospective audit of cases is necessary to ensure patients have not been harmed;
- To determine whether the doctor should be referred for assessment to the Council’s Health Committee or for investigation by the Health & Disability Commissioner.

Patients who consult registered medical practitioners who use alternative methods have stated they do so to “get the best of both worlds”.⁵ As most CAM doctors are general practitioners, their competence in orthodox general practice medicine is therefore as important as their alternative practice.

Some doctors restrict the scope of their practice exclusively to CAM, while others continue orthodox practice while either using CAM for their own patients, or accepting outsiders, either from other doctors or without formal referral.

There should be a clear understanding and agreement about who is providing continuity of orthodox care - the care of continuing problems, preventive medicine and health education. Where the CAM practitioner is exclusively practising CAM, or is accepting patients from outside his or her own practice, there should be clear and specific communication from the CAM doctor to the patient’s usual general practitioner – except where an individual patient demands otherwise (though even then the CAM doctor should be prepared to accept the risk of not keeping the usual doctor informed).

In other words the CAM doctor should be either a provider or a collaborator in continuity of orthodox care: CAM should not be provided in isolation or secrecy, and should not require disengagement from orthodox care or carer.

In reviewing doctors’ use of CAM investigations or treatments, the Medical Council requires that

1. In **assessing** patients doctors must
 - (a) perform a pertinent history and physical examination of patients, sufficient to make, or confirm, a generally recognised diagnosis, and in this meet the standard of practice generally expected of the profession
 - (b) reach a diagnosis by using a diagnostic system demonstrated by appropriate research methodologies to have a high level of accuracy and proven benefits to patients
 - (c) advise patients of the evidence based and conventional treatment options, their risks, benefits and efficacy, as reflected by current knowledge
 - (d) document all of the above in accordance with sound practice.

2. In **treating** patients and in engaging in health promotion, doctors must
 - (a) ensure that the treatment is efficacious, safe and cost effective
 - (b) have current knowledge and skills in their area of practice
 - (c) be competent in the practices they employ
 - (d) act honestly and in their patient’s best interests according to the fundamental ethics of the profession
 - (e) provide sufficient information to allow patients to make informed choices, and to refer to, or consult with, others when patients request it, when the doctor

requires assistance or when the standard of practice requires it. (Where there is no reason to believe such a referral would expose the patient to harm there is no barrier to making a referral to a CAM practitioner or to utilising a CAM treatment)

- (f) not misrepresent information or opinion. Patients must be made aware of the likely effectiveness of a given therapy according to recognised peer-reviewed medical publications, notwithstanding the doctor's individual beliefs
- (g) obtain informed consent to any proposed treatment.

3. In **advancing knowledge**, and providing treatments in areas of uncertainty where no treatment has proven efficacy doctors must:

- (a) ensure that their patients are told the degree to which tests, treatments or remedies have been evaluated, and the degree of certainty and predictability that exists about their efficacy and safety
- (b) be prepared to collaborate in the collection of information that can be appraised qualitatively or quantitatively, so that new knowledge is created, to be shared with, and critically appraised by, the profession.

One of the reviewers is always a CAM practitioner, otherwise the team, as usual, consists of two doctors and one lay person. The instruments used to assess the doctor's competence include structured interviews, case-based oral,⁷ a standard records review, and review of communication skills,⁸ and may include a peer rating.⁹ They will be interested in finding out...

What are the diagnostic methods? Does the doctor move from open to increasingly focussed questioning, make diagnoses on the probabilities, exclude serious disorders? Or does he or she leap to a favorite diagnosis without these steps?

To what degree does the CAM doctor question scientifically, or accept criticism? Are special medicines offered for sale? What are the professional values? Is there evangelism? A claim of exclusiveness of methods? Does the doctor appear to be a zealot? A cult figure? Is there the stance that other doctors are all wrong? Is there paranoia? Does the doctor have a proper grasp of reality?

The initial interview

This is perhaps the most important tool. The doctor is interviewed using an open, nonthreatening way - entrapment or a leading style of interviewing is avoided. The interview is nonetheless carefully structured. The reviewers are advised

- Ask the doctor to describe how he or she started in alternative practice; the situation in which he or she works in terms of type of patients, whether referred or not, what kinds of conditions are treated.
- Does the doctor see him/herself always as the patient's general practitioner? If not how much of the doctor's practice is CAM? what is the communication arrangement with the patient's GP and how clear is that to the patient?
- Ask the doctor to explain the kinds of alternative therapies used, and the specific training for them. What are the limitations of this CAM? When would the doctor advise discontinuation of the CAM because of nonresponse? What would be the plan after that? Is this CAM unsuitable, ineffective or contra-indicated for any conditions?
- What is the scientific basis for this method? Is it supported by a scientific rationale?
- What are the doctor's fees? What are the doctor's promotional claims? What are the benefits of this kind of CAM for the patient (compared with orthodox medicine)?
- Ask the doctor to describe the CME, audit and quality improvement activities he or she has been involved in during the previous year (both in orthodox and CA medicine). Explore the doctor's contribution to professional groups, teaching and research.
- Is there any particular stress that may have affected the doctor's practice (e.g. fatigue/burnout, mental illness, colleague relationships, professional isolation, domestic factors, overload, systems stressors, physical illness)?

The next part of the interview contains some standard questions. The interview should be as explorative as possible: the concepts covered include provision of information to patients, patient consent, power sharing, patient rights. The issues can be explored in different ways – e.g. role plays, case scenarios.

Provision of information to patients

What is the extent of the information you think it is appropriate to provide patients when informing them about an alternative investigation or treatment?

If you suspect a patient has cancer, at what stage would you tell them this?

In what circumstances do you think you might withhold health information from a patient?

If something goes wrong in a patient's treatment, how much should they be told?

Do you ever admit mistakes to your patients? When might you and when might you choose not to?

Patient consent

Please describe how you seek your patient's consent for:

- *Examining them*
- *Alternative investigations*
- *Alternative procedures*
- *Prescribing of alternative therapies*
- *If you sell medicines from your practice, describe how you inform patients.*

Power sharing

How much do you think patients should be involved in decisions about their care?

What is your response if a patient asks you for a second opinion or to be referred to another doctor?

If the patient does not wish to follow your advice, what would your response be?

Patient rights

In what way do you ensure patients you see are informed of their rights?

What are patients you see told about what to do if they have a concern about the way they have been treated?

Communications with colleagues

How would you describe the relationship between yourself and other doctors in the region?

Do you meet with other doctors regularly in a peer discussion group?

With whom do you discuss problem cases?

The interview is followed by a standard records review, case-based oral, review of communication skills (observation of actual practice), and a closing interview. The possibility of a detailed followup audit of cases is available as a recommendation from the review team if they are concerned about patient safety.

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Chapter 8: How to avoid a performance review

Quality has been the catchword of the nineties, and it continues to dominate health policy agenda. But “remarkably quiet in this quality movement has been the physician.... The traditional physician approach to quality, i.e. certification, has received minimal notice within the new quality movement”.¹ It shouldn’t have to be said, but the clinical competence and performance of doctors is a key factor in quality health care: in my opinion *the* key factor, of greatly more importance than practice processes, premises and protocols.

In the course of this series of papers I have tried to highlight the characteristics of a doctor’s practice that are associated with diminishing performance. They (and a few others) are summarised in Figure 1, and it is clear that professional isolation, primary (personality trait) or secondary to other factors, is a common factor to many “pathways”.

Thus the ageing doctor (cognitively impaired or not), the solo practitioner (rural or not), the nonjoiner and nonattender at CME, and the alienated fringe practitioner (alternative medicine apologist, entrepreneurial self-promoter, or outlier in prescribing or referral), may all find themselves professionally isolated and beginning to perform poorly. The competent but distracted doctor and the knowledgeable doctor with cognitive dissonance may underperform too.

But it is professional isolation that seems to be the big issue. A group of experienced New Zealand performance assessors rated the importance of different markers of professional isolation, and their opinions are shown in Table 1, along with their subjective views of the relative importance of each (scored out of 5).² You will recognise these doctors, and perhaps you will recognise yourself. If so, it is time to rejoin medical society.

Chances are, however, you will not recognise yourself here, and that may be because you lack the insight, including the insight that you should change.³

Poor performance, when combined with poor communication, leads to complaint (indeed, perceived inadequate communication may be the reason that by far the majority of complaints, and concerns leading to competence reviews, are about men).⁴ Predisposing factors such as medical errors rarely lead to complaint without precipitating factors such as inadequate communication about the error.⁵

Complaints are stressful, no doubt of that. Cunningham wrote, “...in the immediate period after receiving a complaint, (doctors) experienced emotions including anger, depression, shame, guilt, and reduced enjoyment of the practice of medicine. Around one in three doctors reported reduced trust and sense of goodwill towards patients (other than the complainant), and reduction in tolerance of uncertainty and of confidence in clinical practice”.⁶

Figure 1: Factors affecting professional performance

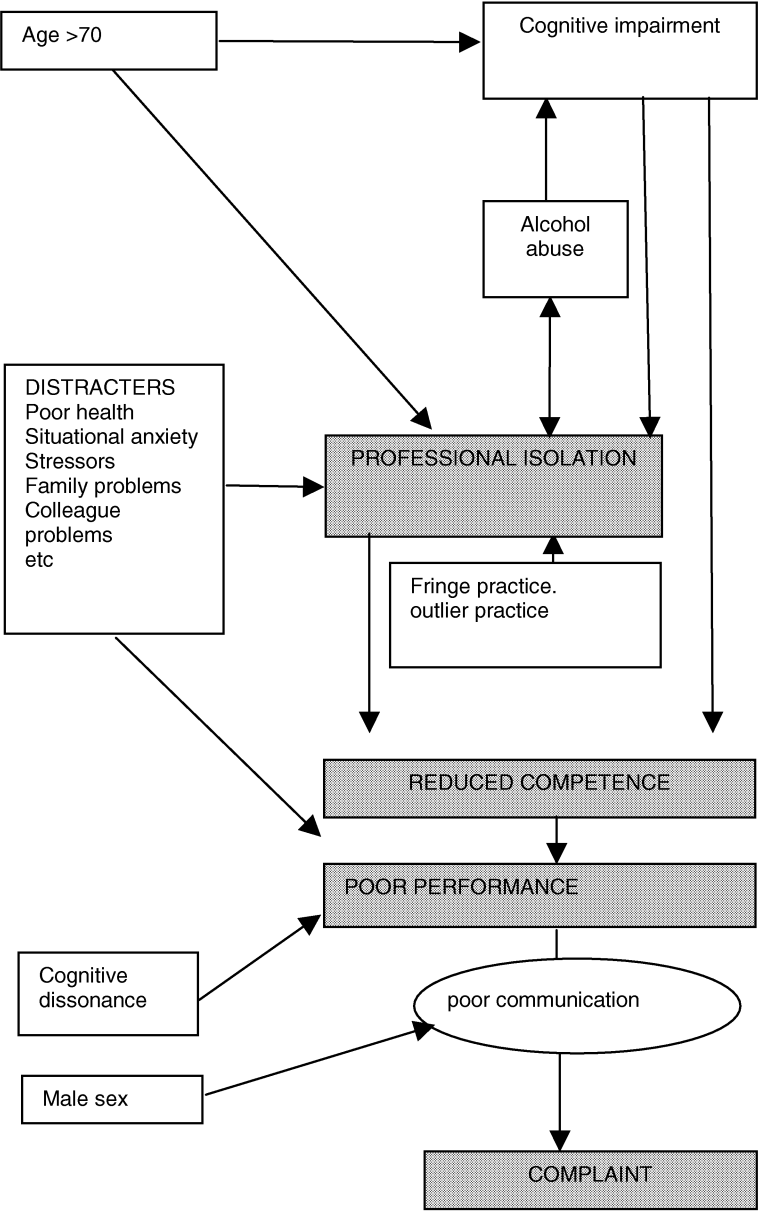


Table 1: Definitions & weights of top ten markers of professional isolation

- 1. Personality and behaviour (4.6):** Ranges from self-sufficient, independent personality, through lack of insight, self importance, lack of humility (arrogance), to work attitude such as “I know it all anyway, I have no need to engage colleagues in discussion”, “I don’t like change, so I will avoid it”, suspiciousness and difficulties in accepting feedback, to inappropriate physical or sexual behaviour, aggressiveness or bullying, and personality disorder.
- 2. Solo practice (4.4):** Prolonged solo rural or geographically isolated practice of any kind, including specialist or rural GP; specialist in small provincial city particularly when the doctor chooses to do this – and especially people who choose to work as solo practitioners in urban areas.
- 3. Poor colleague relationships (4):** “Difficult” doctor who does not establish local or national collegial relationships; awkward, unlikeable person; poor communicator; not a member of professional group (e.g. college).
- 4. Outlier practice (4):** Doctors displaying or expressing techniques or beliefs outside current accepted practice, such as engaging in complementary or alternative medicine; overprescribing, over-investigating.
- 5. MOPS or CME failure (3.9):** Doctor fails to attain education points, has done minimum continuing professional development (CPD) in the last two years, is an irregular or infrequent attendee at regular group meetings (eg audit, morbidity and mortality meetings), has limited access to peer reviews and grand rounds, or cannot because of isolation attend colleague discussions; outdated technology – no net access or email contact with colleagues.
- 6. Specialist in only private practice (3.5).**
- 7. Stress, no relief, complaints, job dissatisfaction (3.5):** Serious, continuing emotional stress (family, work, financial) or health concerns; drug use; on 1:2 call with limited locum cover or no locums available; fatigue through work overload; a tragic patient outcome or patient complaints; job dissatisfaction; has fallen out with, or has unsupportive employer; uncooperative business partners.
- 8. Locum, itinerant or part-timer (3):** includes frequent changes of practice.
- 9. Cultural barrier (3):** From country or culture with a less collegial approach than that in this country; or isolated by language barrier.
- 10. Male gender (3).**

Rob Henderson wrote, “Rural doctors... found the accusations of incompetence and the prolonged disciplinary process very threatening. ... a few doctors developed a post-traumatic stress like disorder – being unable to cope with threatening situations; some doctors left and were difficult to replace, while others lost their enthusiasm for their work and adopted defensive medical practices... setting up barriers to access, working more

slowly, ordering more investigations and referring more people to secondary care”.⁷

While there is no denying the negative impact on their lives and practices in the early stages after the original complaint or concern, curiously enough most doctors experience the actual competence review as nonstressful, helpful and reasonable (Medical Council of NZ, unpublished survey data).

Several have in fact made comments such as, “This is something every doctor should undergo,” and indeed the formal periodic assessment of performance, routine among airline pilots, is seen by many doctors as a constructive option, replacing the profitless tedium of “approved” CME and point-counting. Moreover it identifies poorly performing doctors, something “Maintenance of Professional Standards” activities cannot, and was never designed to do.

In Britain Dame Janet Smith has, in the wake of the Shipman affair, called for major reforms of the General Medical Council’s revalidation of doctors in order to reassure the public that doctors are competent:

“The purpose of GP appraisal must be made clear. A decision must be taken as to whether it is intended to be a purely formative (i.e. educational) process or whether it is intended to serve several purposes: part formative, part summative (i.e. pass/fail) and/or part performance management.

“If appraisal is intended to be a clinical governance tool, it must be ‘toughened up’. If that is to be done, the following steps will be necessary. Appraisers should be more thoroughly trained and should be accredited following some form of test or assessment. Appraisers should be trained to evaluate the appraisee’s fitness to practise. GPs should be appraised by GPs from another Primary Care Trust (PCT). Standards should be specified, by which a GP ‘successfully completes’ or ‘fails’ the appraisal. All appraisals should be based on a nationally agreed core of verifiable information supplied by the PCT to both the appraiser and the appraisee.”⁸

In Ontario, an assessment, interview, and educational intervention undertaken by the licensing authority produced an improvement in practice in the short term in the bottom 10-15% of doctors reviewed, an improvement that was sustained for more than six years.⁹

These essays have traversed some of the tools that might be used in such assessments. There is an excellent review, with key references, in a recent book.¹⁰

Nobody knows how often a doctor should be assessed, of course - the usual three to five year MOPS cycle was a relatively poorly informed guess. Twice in the first twenty years of practice makes logical sense to me, then perhaps increasingly often with advancing age.

How do you avoid a performance review? Turn these observations around: keep in touch with your colleagues, communicate well with your patients (especially after you have made an error), have a voluntary formal external review of your own performance periodically, and act on the findings.

Simple really.

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