Assessing performance 8:
How to avoid a competence review

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Keywords

Competence, performance, assessment, isolation

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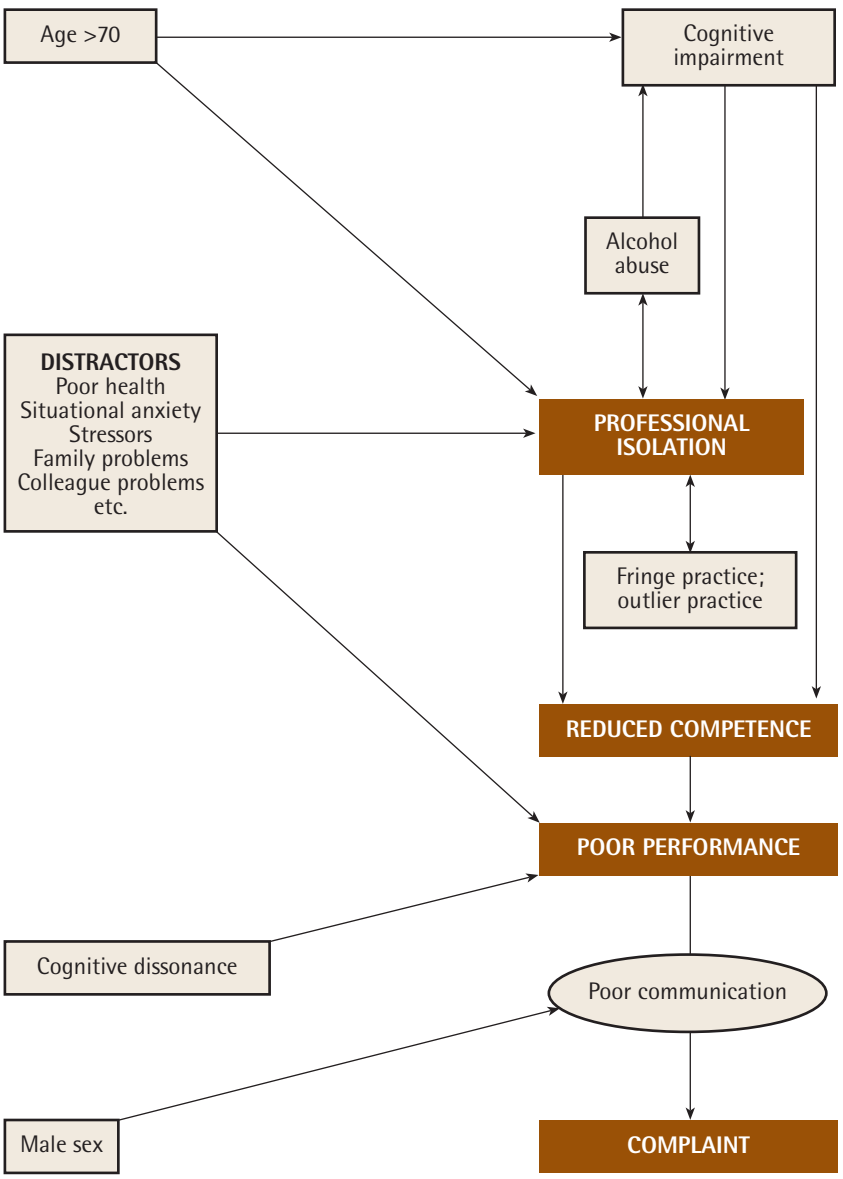
Quality has been the catchword of the nineties, and it continues to dominate health policy agenda. But *'remarkably quiet in this quality movement has been the physician...The traditional physician approach to quality, i.e. certification, has received minimal notice within the new quality movement.'*[1] 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 hugely more importance than practice processes, premises and protocols.

In the course of this series of papers I have mentioned 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

Figure 1. Factors affecting professional performance



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 and far fewer are about women).[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. Wayne 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]

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]

Table 1. Definitions and 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 attender at regular group meetings (e.g. 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)**.

While there is no denying the negative impact, at least in the early stages after notification, of the original complaint or concern on their lives and practices, 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 Ontario, an assess-

ment, 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.[8]

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.[9]

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.

Disclaimer

These are the author's views, not necessarily those of the Medical Council of New Zealand or its members or other staff.

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