Assessing performance 1:

There but for the Grace of God go I

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Keywords

Competence, performance, assessment

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Discipline

My title is a cliché, yes, but that is how those of us on the Medical Council 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 Medical Practitioners Act 1995, now to be extended to all registered health professionals in the 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 (Figure 1). Van der Vleuten's application of different assessment tools[1] to the stages of Miller's learning pyramid[2] (Figure 2) provides a visual representation of those concepts, but we needed to assess all of Miller's stages.

In 2001 the Council, with the Australian Medical Council, co-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 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.

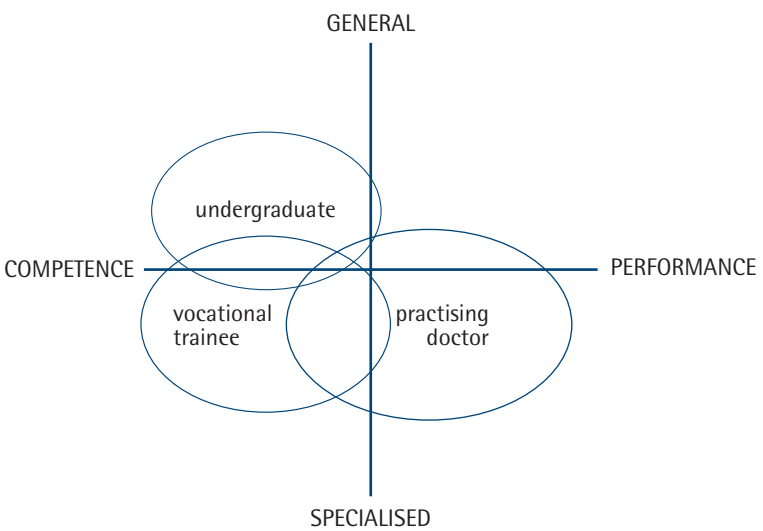
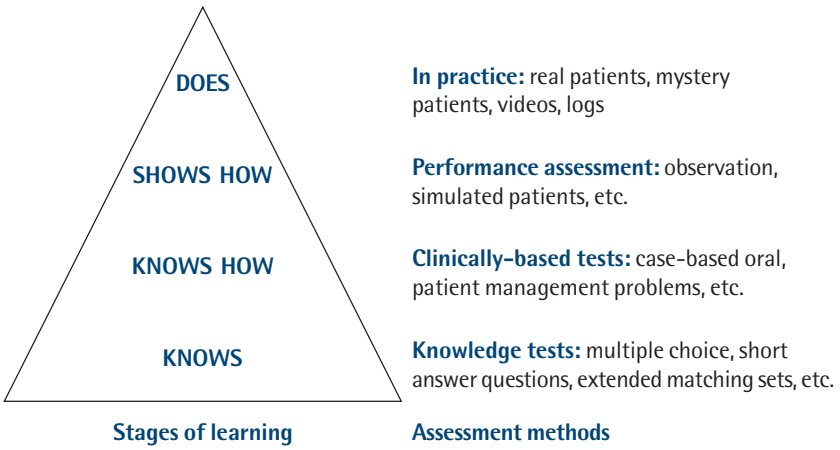


Figure 2. van der Vleuten[1] applied different assessment methods to different stages of learning, thus extending Miller's[2] learning pyramid.



Domains of competence

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

Communication
- with patients and families
- with colleagues
- medical recordkeeping

Collaboration
- teamwork

Management
- personal management (including insight and recognising limits)
- management within systems
- use of time and resources

Scholarship
- life-long learning
- teaching
- research
- critical appraisal

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 and ethical practice

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 (the identification of a high-risk group, or periodic review of all doctors' practice, ideally by some simple screening test, will be the subjects of another paper in this series). 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 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 the 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.

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 col-

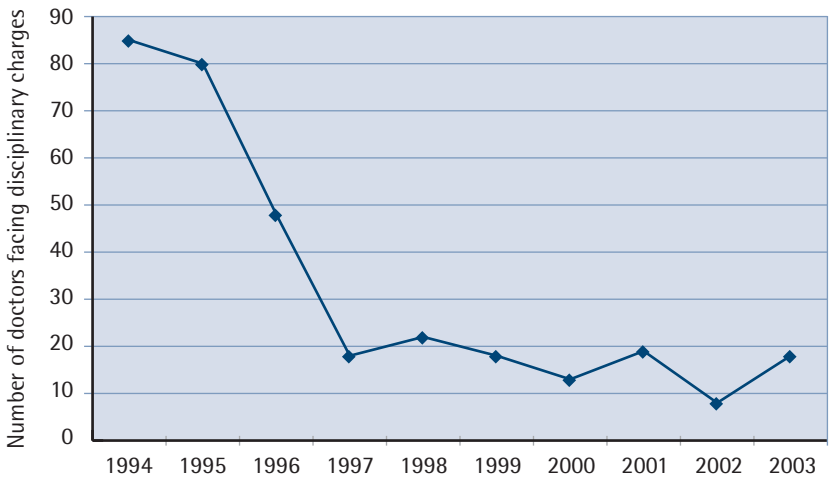
leagues and lay people would set the standard, a position reinforced by a recent Medical Practitioners Disciplinary Tribunal statement, *'The reasonableness of the standards applied must ultimately be for the Court to determine, taking into account all the circumstances including not only usual practice but patient interest and community expectations...'*[6]

The report would also identify the presence of distractors – 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 College's 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 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 (Figure 3) illustrates graphically 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]

The papers in following issues of *NZFP* will describe current assessment practices, proposed changes, and ideas for the future. 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]

This series will include papers on:

- Tools for assessing the competence and performance of the practising doctor
- Screening for underperformance
- Remedial education and reassessment
- An updated analysis of the Council's competence reviews.

Disclaimer

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

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