Performance appraisal – a need or a want?

Jim Vause MBChB FRNZCGP

An Otago graduate, Jim Vause practised firstly in Central Otago and, since 1985, in Marlborough. He has served in various roles with the RNZCGP since 1991, firstly in CME, and then Quality, Professional Development and College Submission coordinator. Currently in his first year as President of the College, Jim represents the RNZCGP in various national projects, with a personal focus on quality and performance indicators.

The very thought of performance appraisal induces trepidation for many general practitioners. Conditioned through years of university assessments to a variety of appraisal formats be it oral, practical or written tests, for many general practitioners the very word 'appraisal' is likely to induce exam nightmares. However, the reality is that we already have a basis for performance testing for the medical profession in New Zealand.

I refer not to the College's MOPS programme, for that focuses on assuring that general practitioners are participating in some formal programme of professional development, but to the Medical Council's competency testing. Performance appraisal is likely to be an evolution of this, going beyond knowledge and competence testing, hopefully moving closer to assessing what we are actually doing or have done, not what we say we'll do in ideal circumstances. *'...think of it, wish it done, will it to boot, but do it? No'* – Peer Gynt.[1]

In formal appraisal, there is always a temptation (and some need) to test a general practitioner's knowledge, something of a tradition in medicine, at worst exemplified as the 'spot the thimble' competition of our training days. The value of knowledge testing, especially for practising general practitioners, surrounded by terabytes of ever changing medical information available at the click of a mouse, is somewhat limited, except in areas of core knowledge. Of greater importance is competency testing, especially of consultation and disease management skills, core activities for general practitioners. But, while any formal appraisal of practising general practitioners cannot ignore knowledge and competency, any assessment or appraisal should focus on actual performance.

Performance appraisal can be divided into two groups by its end use. One is minimum standards... the other is improving performance

Why do we need this? What are the drivers?

Performance appraisal can be divided into two groups by its end use. One is minimum standards – the weeding out of the bad apples. The other is improving performance – the continuous quality improvement ideology.

The former often originates from discipline, from the investigation of complaints and medical errors. It may also arise from a desire for the profession to be seen to be doing something about its bad apples.

The latter, improving performance, is almost synonymous with continuous quality improvement. This is already widespread in general practice, in areas such as prescribing, lab utilisation, disease management projects and various other IPA, practice and individual based review programmes. It is usually driven by the desire to improve, be it organisational, practice or individual. Thus the drivers are sticks for minimum standard and carrots for improvement.

Under some circumstances, continuous quality improvement performance appraisal may contain a number of sticks and vice versa for minimum standards, for the boundaries between the two are, at best, blurred. However, the very important issue of acceptance of process by the profession is dependent upon the drivers for a given performance appraisal methodology. Such acceptance will also be influenced by finer process points, for example how closely the body performing the appraisal is to the professional ethos. How good is the quality of the data, its presentation and the individualisation of the feedback?

Let us focus for this *NZFP* on the minimum standards performance appraisal, the 'stick end' of the performance wedge.

Superficially, the minimum standards process seems unlikely to be widely welcomed by those subjected to its machinations. But are there other options?

Consider medical discipline. This has improved significantly from earlier years. Although many more doctors are subject to enquiry nowadays, the majority of these are low level, relatively informal processes that help separate out systems errors and simple knowledge mistakes from blatant wrongdoing.[2] While the processes are by no means free of stress on the doctor being investigated, the results are substantially better, especially in terms of improving the health care system, from the more disciplinary focused processes of yesteryear.

Performance appraisal, if combined with a focus on improvement, could well shift the focus of discipline well away from penalty towards improvement, presuming that it can correctly identify the truly bad apples. This should be acceptable for not only the profession, but for most of the community.

Acceptance will also depend on the quality of the appraisal process. Is it reliable and valid? Can it stand scrutiny of its sensitivity and reproducibility? What is its ability to accurately define the accepted standard based on the reality of current performance? Does it fulfil these criteria across the different practice and population environments in New Zealand? It will also need to cover the core areas of general practice in a reasonably comprehensive manner and it will need to be implemented without significant difficulty or cost. These may seem stiff requirements to fulfil but they will be essential for performance appraisal to be acceptable and effective.

To the acceptance problem we can add the two 'whos':

Who should do the appraisal and who should be appraised?

The current MCNZ competence appraisal applies to doctors identified through complaints, mistakes and errors. To this could be added other identifiers such as peer identification and performance indicators. However, the sticky question is whether competence appraisal should be applied to all doctors in order to detect those who need remedial work before problems occur as well as to provide a focus for professional development. In some OECD countries this is the case, for example the American Boards routinely test all their family physicians by examination.[3]

The sticky question is whether competence appraisal should be applied to all doctors in order to detect those who need remedial work before problems occur as well as to provide a focus for professional development

The second question: *who should do this?* Which body has the professional mandate to be a policeman, to deal with complaints and mistakes? While the RNZCGP has briefly flirted with some minimum standards issues, such as minimum requirements for MOPS and resuscitation, currently it is the Medical Council that has the mandate for this work. The College's likely role, besides supporting GPs through the appraisal process, will be ensuring that any performance appraisal is acceptable to our members in terms of its rigour and process.

Which is where the performance appraisal issue becomes more interesting. If it can clearly separate out the really bad apples from the honest mistakes we can all make, if it can become a learning needs analysis tool for all general practitioners, closely related to professional development, then we are blurring the minimum standards/continuous quality improvement boundary and thus the role of the RNZCGP in performance appraisal.

As a college and vocational branch, we need to explore performance appraisal, we need to participate in developing and testing its tools, and to be familiar with its problems and benefits in order that the future direction of performance appraisal can be commensurate with our kaupapa, the philosophy of general practice.

References

1. Ibsen H. Peer Gynt. ISBN 0486426866.
2. Paterson RJ. Annual Report of the Health and Disability Commissioner Te Toihau Hauora Hauatange. Oct 2003. p 2.
3. American Board of Family Practice. Information available online at https://www.abfp.org/index.aspx