Assessment of Professional Performance: where doctors tread, will lawyers dare to follow?

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Some of us can't see the wood for the trees. That was brought home to me fairly forcefully a few years ago when I was in San Francisco and went to a joke shop — they have joke shops in San Francisco. In the back of the joke shop was a whole lot of those little pads of post-its that you tear off and write something on. These all had a little joke across the top. The joke that took my eye was "Trust me, I'm a doctor".

Trust me, I'm a doctor

I was there on a postgraduate fellowship. I took myself and my profession very seriously, and the idea that people would make a joke out of "Trust me, I'm a doctor" was completely alien. I had been brought up with the radio program, "At the frontiers of science they march: the brain surgeons, the research workers, the family doctors – heroes in the Drama of Medicine". I can still hear that Australian voice at the beginning of each story.

Images of family doctors

My old family doctor, Dr Bartrum, looked like this avuncular fellow from Norman Rockwell's cover for the *Saturday Evening Post*. I suppose that was everybody's image of a family doctor in those days. You would think that the Rembrandt up in the top left-hand corner would be the anatomy lesson of Dr Tulp, but it isn't.

In fact, it is the Clock Makers Guild. Why he should have that there I don't know, but there we are.

So this was my image, the family doctor sitting up at night with a sick child, watching over her with care and skill.

There are more modern images now of family doctors.

Why the lack of trust?

So what happened? Why did "Trust me, I'm a doctor" become a joke? Why have we reached a condition where technology is so mistrusted that direct-to-consumer advertising of thoroughly tested drugs is banned, but there is no restriction, for example, on advertising fake remedies.

Well, I think a number of things have happened. Firstly there was Los Alamos. These words from an Indian holy scripture came into the mind of Robert J Oppenheimer, as he observed the explosion of the first atomic bomb at the original Ground Zero in the Nevada desert, "I am becoming death, the destroyer of worlds". The world that he destroyed was the trust in science and in technology. We had, until that time, thought that this was the great guiding light of the future, but then we discovered that science and technology could be as destructive as that.

Thalidomide and other factors

In medicine, of course, it was thalidomide that destroyed trust in pharmaceutical companies and drugs and to an extent in Medicine. In New Zealand, it was the scandal at the National Women's Hospital, where women with abnormal cervical smears were followed as a research project for several years by senior academics without being kept fully informed. That resulted in the Cartwright inquiry. In New Zealand, post-Cartwright, there have come into being things like informed consent and ethical research and so on.

I add to that list so-called 'economic rationalism'. The concept that medical services are no different from services provided by the garage mechanic or the fishmonger or the grocer has, I think, upset the balance between entrepreneurialism and altruism in my profession — in favour of entrepreneurialism. That is certainly so in New Zealand and I suspect that it is happening in other places as well. That series of important signal events has damaged trust in doctors.

Of course, the final blow was Dr Harold Shipman — again a delightful, avuncular general practitioner in the British midlands, loved by his patients, but probably the most successful mass murderer Britain has ever known.

This man put to sleep probably 200+ patients. We will never known the total number. These weren't old dying people — they were healthy people.

"Everyone believes their doctor, don't they? He had been our doctor for 20 years. We trusted him. When our children were poorly, he was there. He treated them. He treated me. He did so much for us all", and as the son of one victim said, "He was the perfect family doctor. It's just that he killed my father."

Monitoring and measuring doctors' performance

Well, I am here to talk about monitoring and measuring doctors' performance. That is a task of the Medical Council in New Zealand under the Health Practitioners Competence Assurance Act. The principal purpose of the Act is to protect the health and safety of members of the public by providing mechanisms to ensure that health practitioners are competent and fit to practise their profession.

The mechanisms we use are the four 'R's:

- restriction of medical practice to those who meet the qualifications;
- registration of new doctors who work under supervision for a period;
- recertification of practising doctors, who, each year or periodically, have their continuing professional development (CPD) assessed and who declare every year anything which might impact on their fitness to practice; and
- reviewing practising doctors reactively, when concerns and complaints arise in regard to their health, their conduct and their competence.

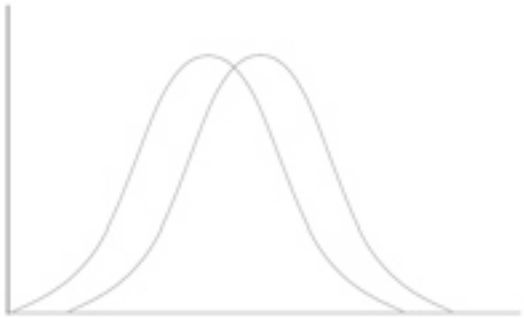
We have competence provisions in the Act which allow us to do assess performance.

Recertification

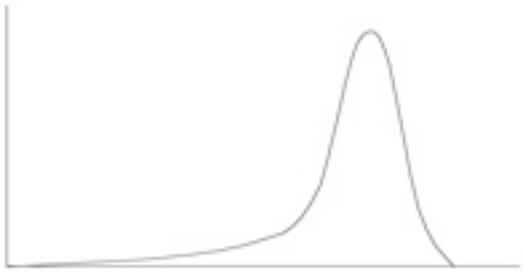
All doctors are now required to recertify periodically. That requires evidence of participation in an approved continuing professional development program – continuing medical education (CME), audits of certain practice activities and peer review.

Shifting the Bell curve

The vernacular of the quality movement has been applied to medicine.

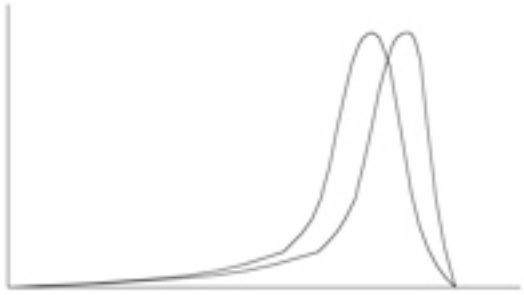


Its theory is that the normal distribution curve of ability is shifted to the right when people undertake continuing professional development. The idea that this theory, which arose in American automobile plants, should be transferable to professionals working in isolation is, in my view, naive and misleading. However, that's what we have.



For a start, the distribution curve for professional performance isn't normal. It is a negatively skewed curve, with most of us being high achievers. But there is a significant tail down on the left of under-performers.

Here, as an example are interpersonal skills scores for a group of advanced vocational trainees in general practice in New Zealand (unpublished work). Almost everyone scores well, but there is a tail.



So continuing professional development has little measurable effect.

Clearly, the best and worst performers are unmoved. "The CME credit-hour requirements for licence renewal … compete with altruism in the real world of medical practice. … the relationship between learning and practice becomes distant….conventional credit-hour CME does not improve the care of patients."[i]

Assessing performance

If CPD isn't enough, what about assessing doctors' performance? We need to be sure that that is what we are doing, that we are not assessing simple competence. Competence is what doctors can do in certain controlled situations, as in the examination room, but performance assessment measures what doctors actually do do in their place of work.

Miller's learning pyramid illustrates that. A doctor over time moves from *knowing* towards *knowing how* towards *being able to show how* towards *doing and incorporating the doing in their actual work*. Various tests can measure parts of that progression. A test of knowledge might be multiple-choice questions, but testing whether or not the doctor actually does it requires diaries, videos, sitting in on consultations, inspecting practice premises and so on.

Performance assessment could be periodic. We might do as we do for pilots and assess the performance of every doctor say ten years after graduation and at 65 or 75 or whatever. That's the American model, but it's expensive and difficult to do if we are to be thorough. Or performance assessment could be reactive on receipt of a concern, as in New Zealand and New South Wales and in many other jurisdictions that I'm familiar with.

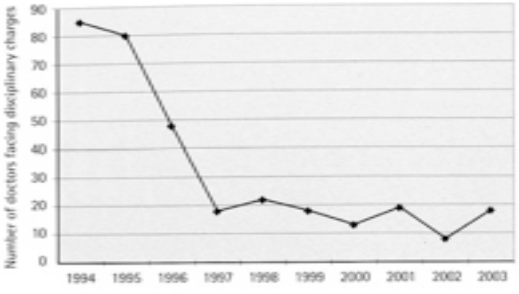
Our assessment process in NZ

If a concern is considered significant it is referred by Council staff to the Council, which might ask the doctor to provide a practice profile. A three-person performance assessment committee is appointed, one lay person and two medical people doing work similar to that done by the doctor. If it is a country doctor, there will be a country doctor, if a surgeon there will be a surgeon and so on.

This is a general review, not just of the domains of the concerns. If the concern is about communication skills, we don't just review communication skills, but we do a general review. This is because it has been shown that doctors who are under-performing in one area are very likely to be under-performing in other areas. It takes a day. There are formal terms of reference in terms of the people involved and the instruments we use. Because 40 percent of the doctors in the country are general practitioners, 40 percent of the concerns are about general practitioners.

The report to the Council is detailed, with written recommendations. Either the doctor is fine or is under-performing and needs to do some voluntary work or the doctor is under-performing to a serious degree and a formal remedial educational program needs to be put in place. For only a small percentage is a formal education program or remedial education put in place.

These are educational processes. The performance processes are not about complaints, they are not about investigating a specific complaint, they are not about involving a complainant and hearing evidence. We inform the complainant about what is happening, but no more than that. The remedies don't include punishment or apologies or conditions or any of those things.



Having said that, the number of cases which have gone to the Medical Practitioners Disciplinary Tribunal fell dramatically with the introduction of this legislation in 1996 and has remained low. Having been involved in some of the disciplinary hearings before that date, I would say that many were about issues of competence and performance, not bad behaviour.

Diagnosis and treatment

The performance processes are about making an educational diagnosis, a performance assessment. Is the doctor under-performing? If so why? Is there a distraction, such as being on drugs, a troubled marriage, a health issue — depression or diabetes? I say "he" because very few women are the subject of these sort of concerns. Or is it a competence issue which requires re-education.

We then apply an educational treatment if it is necessary or we can restrict the doctor's practice. Very often the doctor will do that voluntarily. There is a second assessment after the period of education.

Is it sufficient to respond to complaints?

Is it enough to assess performance in response to complaints? A key study suggests that it isn't. Ontario researchers checked the performance of family doctors who had been complained about and a control group of age- and sex-matched doctors who hadn't. The performance of those who hadn't had complaints was just as bad or just as good as the performance of those who had had complaints. So reliance on complaints is not a great method of ensuring the performance of doctors.

What next?

If continuing professional development and responsive performance assessment aren't enough to do what the Act requires us to do, namely to ensure that doctors are competent and fit for practice, where do we go next?

I think the first thing to say is that, if 97 percent of doctors are practising competently, many feel very set upon by many of the processes now in place to ensure that we continue to practise competently. Demonstrable accountability is fine, but it might be time for professionalism to come back and take its place.

Risk-based regulation

Having said that, there is a small percentage, perhaps two percent of doctors who are under-performing and who pose a danger to the public. We need to work out ways of finding out who they are and helping them. And so we come to something which the General Medical Council in Britain is talking about — risk-based regulation.

Predictors of under-performance

We know the predictors of underperformance — poor medical school performance, professional isolation, people who aren't Fellows of their college, solo practitioners, particularly solo practitioners in cities, but also solo rural practitioners, and international graduates (I don't mean that in any racist or xenophobic sense, but some doctors who are mobile tend to be mobile for very good reasons: they are running from something; so those who graduated overseas are a high-risk group); men — 90 percent of our performance reviews are on men (that might be because women doctors communicate better); people with difficult personalities; ageing doctors; and outliers in performance indicators. For example, primary health organisations in New Zealand now look at doctors' prescribing and test ordering habits. The outliers are at risk for under-performance. Lastly, the itinerant. My colleague, Andre Jacques, of the Medical Council of Quebec, says that if a doctor changes address three times in their second decade of practice they do a performance review. End of story.

Triggers for under-performance

We also know the triggers for under-performance: reduced capacity, learning deficit, lack of motivation, and distraction, alienation and organisational stresses. Goodness knows, those are

common enough now. We might be able to identify doctors at high risk early and to monitor and support them in an attempt to ensure that they are protected from some of those triggers.

Population-based or risk-based prevention?

I will extend my earlier medical metaphor. If we are looking for a disease like cancer of the bowel and wanting to catch it before it kills a person, then we can take a 'population preventive' approach. This says, "Let's educate everybody in the country about a high fibre diet, let's make sure that they report symptoms early, investigate blood in the stools, etc, let's do screening examinations on everybody over a certain age or a certain stage or colonoscopies regularly if they can afford it." Alternatively. we can take a 'high-risk approach' and say, "There is a group of people out there who are really at high risk for developing bowel cancer. They are over 40, with a family history of bowel cancer or a family history of colonic polyps etc and we will have a really intensified education program for them. We will screen them with colonoscopies regularly after the age of 40 and have a recall system to make sure they come back."

I think we might do the same for under-performance in Medicine because it is just as dangerous.

The population approach is what we are doing now. We are trying to prevent poor performance by our current continuing professional development activities, investigating complaints and doing performance assessments, early detection and screening. There are various apparently valid ways of seeking the opinions of patients and colleagues (so-called 360s, or multi-source feedback), or having other periodic assessments of performance. But there is no short way that is reliable, nor is there any long way that is cheap.

Alternatively, we could take the high-risk approach and look at undergraduate behaviour, professional isolation, the person who is not professionally registered, with a difficult personality, an itinerant male, over 65, etc, and apply intensive continuing professional development, regular assessment of performance and monitoring and support.

So a new package to ensure that the performance of doctors might therefore be five Rs rather than the present four: restriction, registration, re-certification, risk-based regulation and review.

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[i] Narhrwold DL. CME reform for competency-based education and assessment. *J Cont Ed Health Prof* 2005; 25: 168.