Assessing performance 2:

How should the underperforming doctor be identified?

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Competence, performance, assessment, screening, high-risk group

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I wrote in the introduction to this series[1] 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.

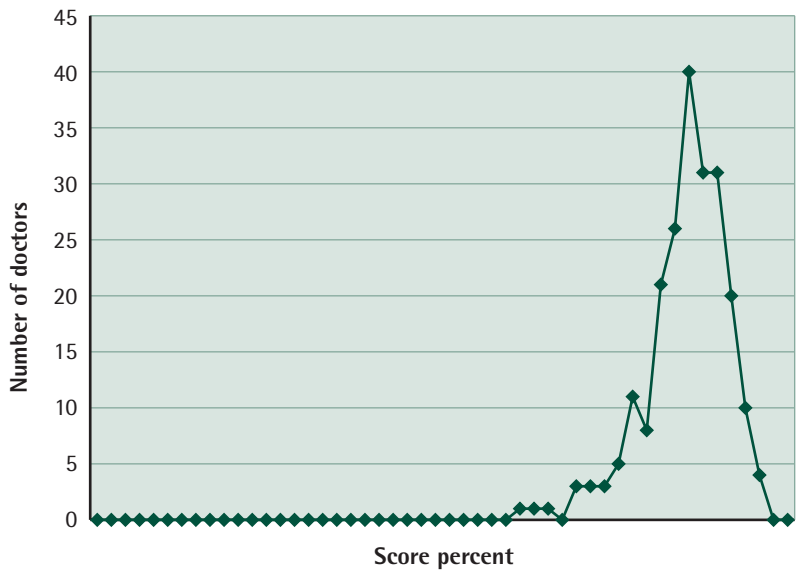
Actually though, when all doctors are assessed, those whose performance has not been the cause of expressed concern are just as likely to be performing poorly as those about whom concerns have been raised,[2] and this is congruent with the observation that even poor clinicians may not attract complaints 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, 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 (Figure1). 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 (Figure 2). 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.

They have to be identified to be helped, and that is congruent with many observations: that we need others to help us identify our deficits. *'People tend to hold overly favourable 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 also their incompetence robs them of the cognitive ability to re-*

Figure 1. ISI scores (per cent) for 219 general practitioners in advanced vocational education (data supplied with the RNZCGP's permission)



alise 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).

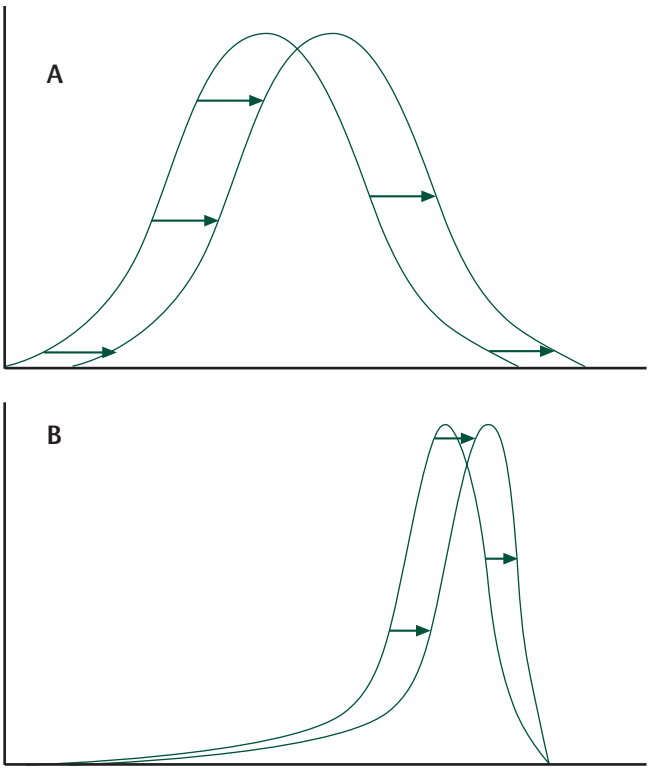
A high-risk group?

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. 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,[10] 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.

Figure 2. how do CQI activities influence the range of performance? Is a whole normal distribution shifted to the right (A)? Or is it just the middle of a skewed curve that is moved (B)?



Population screening?

The principles of screening for disease (see box)[11] might aptly be applied to screening the whole population of doctors for poor performance.

The 'condition' (poor performance) is serious, we know interventions (targeted and personalised remedial education) improve performance,[12] 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, 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.

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 Britain[13] 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, eight physician colleagues and eight nonphysician health care co-workers (the Physicians Achievement Review program, PAR[14]). 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 co-worker 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.

Criteria for assessing screening programmes[7]

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.

Disclaimer

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