Assessing performance 3:

How well can peers and patients rate a doctor's performance?

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Introduction

In my first paper[1] I introduced the notion of reviewing the performance of practising doctors as an educational assessment exercise, and in the second[2] discussed ways of identifying the poorly performing doctor. This paper examines one tool for assessing performance – multisource feedback – and one special application of that tool – the assessment of the disruptive doctor.

We can select an appropriate kit of assessment tools from an available range – from tests of what a doctor actually does in practice (direct observation, videos, mystery patients), of what the doctor can show in controlled simulations of practice (OSCEs, simulated surgeries, role plays), of whether the doctor knows how (case based oral examination, patient management problems), or of whether the doctor knows (multiple choice questions, extended matching sets, short answer questions). No single tool covers all the domains of performance.

Multisource feedback

One way to assess performance is to ask the people the doctor works with – patients, medical and non-medical co-workers – what they think: and to compare their views with those of the doctor. The method, often now called multisource feedback (MSF), or 360-degree evaluation, has been well reviewed by Lockyer.[3] MSF is a questionnaire-based assessment method in which key performance behaviours are rated by peers, patients, and co-workers. It has been widely used in industrial settings to assess employee performance, but is now gaining acceptance as a quality improvement method in health care.

MSF is most likely to succeed and result in changes in performance when attention is paid to psychometric as well as structural aspects of programme design and implementation. Thus the behaviours examined must be appropriate, the communication (including feedback of results) clear, and the threats minimised. The instruments must be reliable, have face and content validity, and distinguish between factors related to the doctor's performance and factors beyond the doctor's control (for instance management systems).

Reliable data can be generated with a reasonable number of respondents, and doctors do use the feedback to contemplate and initiate changes in practice. Results may be affected by familiarity between rater and doctor, and sociodemographic characteristics, but little of that variability is explained by factors outside the doctor's control. So far there has been no published research on the sensitivity of the tool in terms of its ability to detect change over time.

Peer ratings refers to the results of a questionnaire answered by other doctors and co-workers about the quality of a doctor's practice. The questionnaire covers characteristics such as medical knowledge, clinical and communication skills, as well as humane qualities including respect, integrity and compassion.

The doctor is asked to identify ten other doctors who could give an opinion about these characteristics, either as they have an impact on patients, on colleagues, or both. The doctor is also asked to identify five other people, including practice staff and allied health professionals, who could give a similar opinion.

Peer ratings have been used to screen the performance of practising doctors in Alberta,[4] as an optional part of MOPS for the Royal Australasian College of Physicians, and will be used by the General Medical Council as part of its revalidation procedures.[5] The original questionnaires were developed by Ramsey for the American Board of Internal Medicine, and most questionnaires are based on his validated work.[6] The whole team – receptionists, nurses, allied health professionals, and doctors who receive or make referrals, can be questioned.

Patient satisfaction questionnaires it seems, have always been a subject of contention: there is a huge literature on them, much of it exhortative rather than scientific. The questions asked in such surveys are important and well validated,[7] and instinctively we feel they must be measuring something important. Yet Vuori found no evidence they improve care, and asked why they should be taken seriously.[8] He answered himself thus: patients are partners in health care; they are the best judges of amenities and interpersonal relations; we are in a consumers' market and measurement of needs is part of the definition of quality; and in a democracy, patients should have the right to influence activities affecting them.

Those are all politically sound and valid reasons (and there are others), but are these instruments reliable enough to be used in assessing the performance of individual doctors? In general practice a range of variables, several unalterable by the doctor, may reduce patient satisfaction – for instance in the UK: higher list size, no personal list, training practice, more patients booked per hour, older patients, more male patients, older doctors.[9] The level of satisfaction may depend on whether patients are surveyed in the surgery or by post,[10] though it doesn't seem to matter whether a postal survey comes from the doctor or another agency.[11]

Interpersonal Skills Indices (ISI) are measures of patient satisfaction, and can be derived from the Doctors Interpersonal Skills Questionnaire (DISQ); some doctors in an independent practitioners' association took the test before and after attention to communication skills, and the pre- and post-tests showed no differences (unpublished data). Either the test is not reliable or the communication skills education didn't work.

Do doctors act on the feedback obtained from patient satisfaction surveys? Less than a quarter of Massachusetts primary care physicians found patient satisfaction data useful for improving patient care, and even fewer reported using such data to change their practice.[12] Some Australian and British regulatory jurisdictions have found patient satisfaction data the least useful of performance indicators (Farmer E, personal communication; McAvoy P, personal communication).

Nonetheless Lockyer concluded that multisource feedback, while not a substitute for audit when clinical outcomes should be assessed, is one of the better tools that may be adopted and implemented to provide feedback and guide performance when interpersonal, communication, professionalism, or teamwork behaviours need to be assessed and guidance given.[3]

The disruptive doctor

Those very behaviours are awry in the disruptive doctor, and co-workers will usually have plenty to say about him (I use the masculine purposefully). Disruptive behaviours include repeated episodes of sexual harassment; racial or ethnic or sexist slurs; loud, rude comments; intimidation or abusive or offensive language; persistent lateness in responding to work calls; throwing instruments; sarcasm or cynicism; threats of violence, retribution, litigation; demands for special treatment; refusal to treat. *'Disruptive behaviour by a physician has a deleterious effect upon the health care system and increases the risk of patient harm'*.[13]

Understanding and approaching the disruptive doctor may need one or more conceptual models, for instance health, discipline, competence, employment, or dispute resolution.

Disruptive doctors may have an unusual personality trait/disorder, or be suffering from affective disorder (depression, bipolar), substance abuse/dependency, evolving dementia/delirium, schizophrenia, sleep deprivation/fatigue, other distractors (situational maladjustment, anxiety), or diabetes.[14] In such cases their disruptive behaviour may be seen as a health issue. On the other hand personality disorder is a controversial diagnosis, and personality trait even more so.

The Commonwealth of Massachusetts Board regards disruptive behaviour as a disciplinary matter. *'Behaviour of a physician that is disruptive, and compromises the safety of medical care or patient safety, could be grounds for Board discipline'*.[13]

Here are two cases:

A 63 year old provincial surgeon is identified by his manager and senior colleagues as having an unacceptably high rate of complications, and using techniques that others feel are somewhat dated. In addition he is unapproachable, belittles women and junior staff, is angry when called at night, and equally so when not consulted about apparently trivial matters. He shouts at 'disobedient' patients.

The partners of a middle aged GP complain formally he often makes prescribing mistakes and has neglected to examine several patients when their clinical presentation indicated it. The partnership has now broken up acrimoniously amid accusation and counter-accusation by all parties. The doctor has written to all 'his' patients from the partnership complaining his former partners will not release their records to his new practice. Attempts at mediation have ended in further acrimony.

A clinical performance review would appear to be sensible in each case, but should the disruptive behaviour itself be seen as a competence issue? Perhaps so: honesty, integrity, probity, respect for patients, respect for colleagues and ethical practice are important attributes of professional performance.

In the assessment of a disruptive doctor, then, is the issue health? discipline? competence? employment? a dispute for mediation? All or some of these together?

'Hard evidence' is hard to get: in Alabama only 32 of 122 complaints could be dealt with – because fear of retribution, or other inability to gather evidence, prevented any approach to the others.[14] These are often powerful, isolated, narcissistic and litigious men.

The important question for health is, 'Has there been a change? Is the behaviour new?' If so, an assessment is needed – an interview looking for distractors, a psychiatric and/or neurological or other health assessment. If not, then it is unlikely to be a behaviour pattern related to a health issue. The best judges of change are the doctor's colleagues at work.

The Council should act only when patient care could be compromised, and should not be concerned with minor behavioral differences from some 'norm'. How persistent is the behaviour? How consistent? How bad?

The peer rating questionnaire the Medical Council has used is appended (see Appendix 1).

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.

Appendix 1

Peer rating questionnaire

The Medical Council has received concerns about alleged disruptive behaviour by Dr _____ . The doctor has given permission for me to approach a number of work associates to assess the concern. Your answers will be confidential.

1. Over months or years have you noticed any change in behaviour? Any NEW behaviour of concern? Yes ☐ No ☐

The behaviour brought to the attention of the Medical Council is _____

_____

2. Are there similar behaviours you know of? _____

_____

3. How bad and how frequent is such behaviour? _____

_____

4. What effect has that had on the work of others in the team? _____

_____

5. How has it impacted on patient care or safety? _____

_____

Comments:

_____

_____

_____

Now please rate this doctor's behaviour and performance as follows: a score of 1 would indicate this doctor is the worst you have worked with; 2 that he or she is among the bottom few for this characteristic; 8 that the doctor is among the top few you have worked with for this characteristic, and 9 he or she is the single best. Please just tell me if you are unable to answer that question.

Rating scale

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**UA**
lowest score								highest score	

Respect: Does this doctor show respect for the rights and choices of patients?

1 2 3 4 5 6 7 8 9 UA

Communication with doctors: How does the doctor relate to other doctors?

1 2 3 4 5 6 7 8 9 UA

Communication with team: How does the doctor relate to other staff & members of the health care team?

1 2 3 4 5 6 7 8 9 UA

Responsibility: How well does the doctor accept responsibility for his or her own actions (not blaming patients or other health professionals)?

1 2 3 4 5 6 7 8 9 UA

Integrity: How would you describe this doctor's honesty and trustworthiness in dealing with others?

1 2 3 4 5 6 7 8 9 UA

Compassion: Does the doctor get involved with patients' and families' special needs?

1 2 3 4 5 6 7 8 9 UA

Psychosocial aspects of illness: How well does the doctor respond to the psychological, social and cultural aspects of illness?

1 2 3 4 5 6 7 8 9 UA

Critical appraisal: How well does the doctor critically assess information, risks and benefits?

1 2 3 4 5 6 7 8 9 UA

Medical knowledge: How would you describe this doctor's medical knowledge?

1 2 3 4 5 6 7 8 9 UA

Skills: How would you describe this doctor's manual and technical skills?

1 2 3 4 5 6 7 8 9 UA

Overall: Would you be comfortable if this doctor were caring for you or a close loved-one?

1 2 3 4 5 6 7 8 9 UA

Questions to address (these may be put as additional questions to work associates):

- How bad is this? Is this urgent? Is patient safety at risk?
- Is the situation so disruptive the doctor needs to be taken out to 'cool off'?
- Have there been clear concerns raised about competence?
- Is there a systems problem requiring an approach involving an employer?
- Does the doctor have a physical or mental health problem? Are there distractors? What help is needed? Should the Health Committee be involved?
- Do the behaviours betray negligence, breaches in professional standards, or poor ethics, that indicate a disciplinary referral may be appropriate?
- Is this a case for conflict resolution – mediation? Would the parties consent to that? Have they already tried it?

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