

REMEDICATION AND REVALIDATION

REPORT AND RECOMMENDATIONS

THE ACADEMY REMEDIATION WORKING GROUP
DECEMBER 2009

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1. INTRODUCTION

Revalidation is the process by which doctors will have to demonstrate to the General Medical Council (GMC) that they are up to date and fit to practise and comply with the relevant professional standards. The information doctors will need to provide for revalidation will be drawn by doctors from their actual practice, from feedback from patients and colleagues, and from participation in Continual Professional Development (CPD). This information will feed into doctors' annual appraisal. The outputs of appraisal will lead to a single recommendation to the GMC from the Responsible Officer in their healthcare organisation, normally every five years, about the doctor's suitability for revalidation.

For most doctors revalidation should be a straightforward process. However, a small number of doctors may find that preparing for or undertaking appraisal and revalidation raises questions or concerns about their practice with a subsequently identified need for remediation.

2. THE ACADEMY REMEDIATION WORKING GROUP

As part of its revalidation project, the Academy of Medical Royal Colleges (the Academy) established a cross-specialty Remediation working group (the working group) to consider the potential interrelationship between remediation and revalidation.

2.1 Aims and Objectives of the working group

It was agreed that the objectives of the working group were to:

- Consider and describe how remediation and revalidation processes can interrelate
- Identify a list of organisations that provide remedial support
- Identify and define guidance and support processes that doctors can utilise when concerns are raised about their performance.

It was felt that the main function of the working group was to identify those issues or triggers within the revalidation process that could lead to some form of remedial support from simply talking to a colleague (small 'r') through to more formal types of remediation (big 'R'). The aim was to support the development of a revalidation process that was sensitive and robust and through the use of remedial support, would have a limited number of false positive concerns raised about individual doctors. The working group agreed that they would try to cover the spectrum of remediation and identify ways that it could be used to support doctors through the process of revalidation. However, within this, they also agreed that they would keep in mind the role and purpose of the Colleges and Faculties and not recommend any involvement in remediation that would be inappropriate or undeliverable the working group developed principles underpinning remediation which includes information on how to identify and address a remedial need. This report also outlines some models of remediation and provides some example case studies where remediation was identified and delivered.

2.2 Method of Working and Areas Covered

The working group met for the first time in June 2008 and then on three further occasions.

Key Questions

The working group considered the following questions:

- When and where a concern about a doctor's performance might arise?
- How is a concern identified?
- Who might be in a position to identify a concern?

- At what point does an informal concern become an established concern?
- At what point should remedial support be initiated?
- Who should make the decision to offer remedial support?
- Who is responsible at each stage of the remediation process?

Remediation Survey

For remediation support to be effective, it was recognised that appropriate resources will be necessary at all levels. To enable the working group to identify what processes and local support mechanisms need to be in place for remediation and retraining, and to develop some generic principles of good practice, a survey of Colleges, Faculties and Deaneries was completed.

The results of this consultation raised the following points:

- Problems/deficits identified may be initially identified as clinical/craft concerns but are often more wide-ranging
- Existing systems are mainly based on dealing with craft and clinical concerns. Not many colleges currently provide support to deal with behavioural problems
- There is a lack of clarity about the role and responsibilities of Colleges in remediation
- Colleges/Faculties are membership organisations. There is concern that the relationship between a College and its members should not change and Colleges should not move to a more 'policing' role of individual performance or concerns
- Mechanisms currently exist to identify or provide evidence that an individual's practice requires remediation, and also to make recommendations to deal with the identified deficit. These mechanisms could be better supported and more robust. Often, the implementation of remediation recommendations is where difficulties arise. It is unfair to expect a practitioner to undertake recommendations which are not feasible
- Often remediation is poorly documented and concerns and actions are not communicated effectively
- There appears to be reluctance to deal with concerns at an early stage due to a lack of, or uncertainty about, the robustness of evidence
- There is a lack of quality assurance of present systems.

2.3 Membership

Chair

Dr Mike Cheshire

Dr Jane Adam
Dr Has Mukh Joshi
Dr Simon Keightley
Ms Yvonne Livesey
Dr Peter Old
Ms Paula Robblee
Dr Anna-Maria Rollin
Professor Alastair Scotland
Dr Kirstyn Shaw
Dr Rob Thornton
Mr Alan White

Royal College of Physicians London

Royal Colleges of Radiologists
Royal College of General Practitioners
Royal College of Ophthalmologists
Academy of Medical Royal Colleges
National Clinical Assessment Service
General Medical Council
Royal College of Anaesthetists
National Clinical Assessment Service
Academy of Medical Royal Colleges
Faculty of Occupational Medicine
Patient/Lay Representative

3. PRINCIPLES OF REMEDIATION AS PART OF THE REVALIDATION PROCESS

For the purposes of this section, the following definitions are adopted:

Remediation is the process of addressing performance concerns (knowledge, skills, and behaviours) that have been recognised, through assessment, investigation, review or appraisal, so that the practitioner has the opportunity to return to safe practice. It is an umbrella term for all activities which provide help; from the simplest advice, through formal mentoring, further training, reskilling and rehabilitation:

- **Reskilling** is the process of addressing gaps in knowledge, skills and/or behaviours which result from an extended period of absence (usually over 6 months) so that the practitioner has the opportunity to return to safe practice. This may be, for example, following suspension, exclusion, maternity leave, career break or ill health (but see below)
- **Rehabilitation** is the process of supporting the practitioner, who is disadvantaged by chronic ill health or disability, and enabling them to access, maintain or return to practice safely.

For most doctors appraisal and revalidation will be a straightforward process. A small number (perhaps 1%–1.5%) of doctors, however, will find that the process raises concerns about their performance and/or ability to revalidate without participation in some remedial activity. The Remediation Work Group felt their main function was to identify those issues or triggers within the revalidation process that could lead to some form of remedial support with the aim of supporting the development of a remediation process for revalidation that was sensitive and robust. The working group identified remediation principles for the Academy which could, at later date be developed in guidance. This section sets out these principles.

3.1 Issues affecting a doctor's performance

It is recognised that a doctor's performance can be affected by a complex range of issues. All of the issues listed below can affect performance, but not all will be amenable to remediation:

Skills and knowledge deficit – for example:

- A lack of training and education
- Lack of engagement with continuing professional development and/or maintenance of performance
- A doctor trying to take on clinical work that is beyond their current level of skill and experience.

Behaviours and attitudes – for example:

- Loss of motivation, interest or commitment to medicine or the organisation through being stressed, bored, bullied
- Being over-motivated, unable to say no, overly anxious to please
- Poor communication skills
- Poor timekeeping
- Poor leadership/teamworking skills.

Context of work – for example:

- Team dysfunction
- Poor managerial relationships
- Poor working conditions
- Poor or absent systems and processes.

Environment – for example:

- Marriage/partnership break up
- Financial concerns.

Health concerns including capacity and/or capability – for example:

- Physical conditions including drug and alcohol misuse
- Psychological conditions including stress and depression
- Cognitive impairment/deterioration.

Probity – for example:

- Boundary issues
- Altering clinical records
- Conflicts of interest.

Criminal behaviour – for example:

- Falsifying expenses
- Theft
- Assault.

3.2 Identifying the need for remedial interventions

Performance concerns usually emerge through clinical governance processes and are unlikely to become apparent for the first time at appraisal. The appraiser should be made aware of these concerns and, in addition, details, feedback, reports etc, should form part of the supporting information for evaluation at appraisal. Similarly, the Responsible Officer should be informed of any ongoing concerns when considering the doctor's revalidation recommendation.

Appraisal, as the process that gives doctors an opportunity to formally discuss their professional roles and clinical practice¹ has a dual role:

- To improve on good performance and
- To recognise poor performance at an early stage.

Where concerns do arise through the appraisal process either:

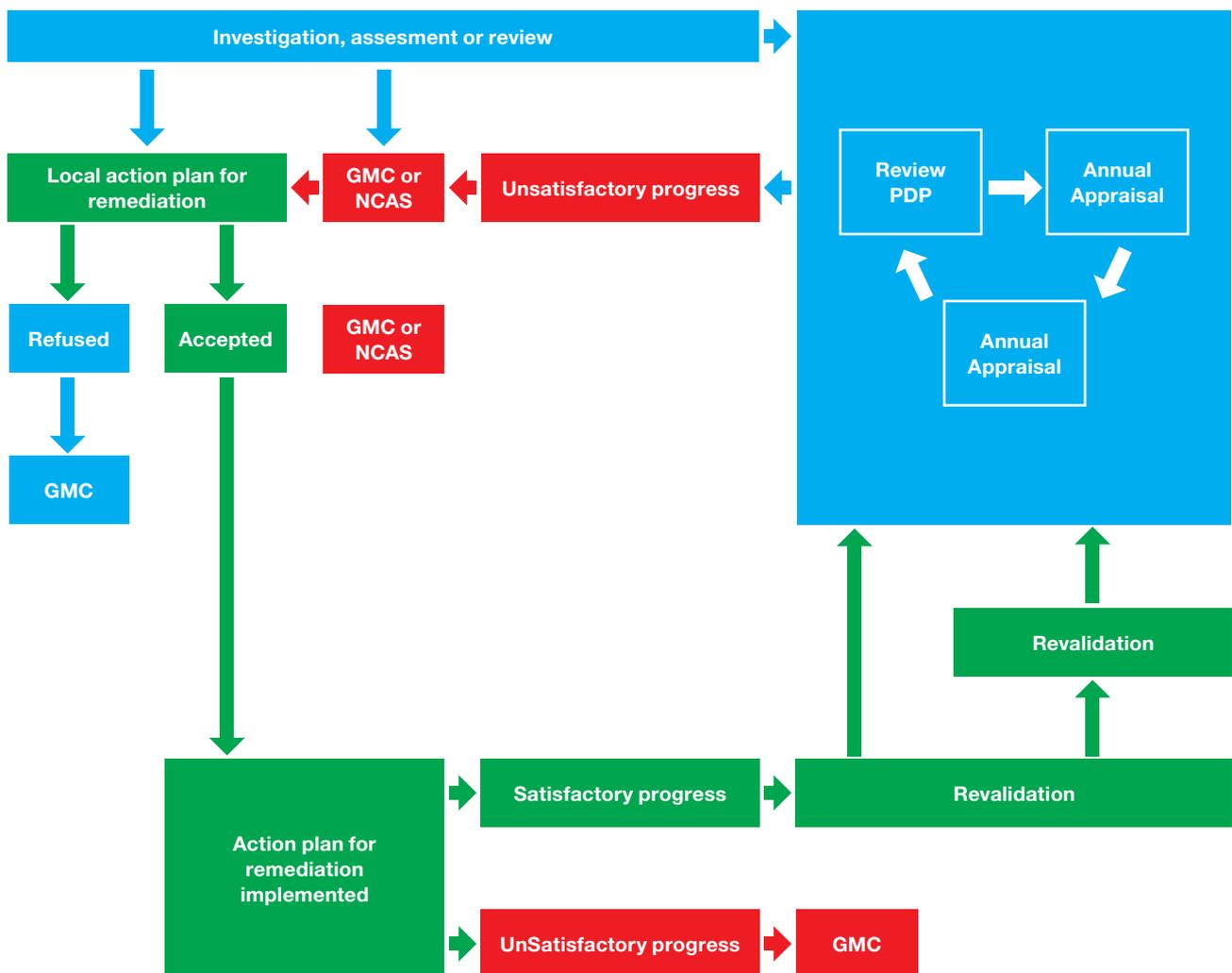
- The doctor will recognise, during their preparation, that their performance might give cause for concern or that they are unable to provide suitable/satisfactory evidence to support revalidation or
- The appraiser will make such an assessment during the appraisal discussion.²

Remediation may be needed to address concerns raised through either route.

3.3 Pathways into remediation

Employers and contractors will already have pathways in place for dealing with performance concerns. The pathway for dealing with the concerns arising from appraisal/revalidation should be integrated with existing governance processes (see Figure 1 below).

Figure 1: Remediation Support Flow Chart



3.4 Issues for consideration when developing multi-stakeholder guidance for remediation

The Academy supports the Guiding Principles for remediation in the National Clinical Assessment Service (NCAS) *Back on Track framework*³ for return to work programmes. These principles should be considered and incorporated into any multi-stakeholder guidance that is developed for remediation. They are summarised below:

Principle One: Clinical governance and patient safety

Patient safety should be the paramount consideration in any return to work programme. The following key elements must act as a touchstone for the policies, procedures and practical arrangements:

- The needs and safety of patients
- The governance and integrity of the clinical service
- The needs and well-being of the practitioner.

Principle Two: A single framework guiding individual programmes

The framework governing individual return to work programmes should use common principles and approaches, and be applicable as far as possible across different organisational settings and types of case.

Principle Three: A comprehensive approach

This will involve:

- Clarifying and addressing the key stakeholders' expectations and aspirations, taking into account the need at all times to protect patient safety
- Addressing fully the practitioner's training needs as well as all the factors that may be affecting performance, whether these focus on the individual, the immediate clinical team or the wider organisation.

Principle Four: Fairness, transparency, confidentiality and patient consent

As far as possible, the confidentiality of the practitioner and the immediate clinical team should be protected. However, this need for confidentiality should be balanced against the need to ensure that information is passed to colleagues where appropriate, and patients are properly informed before giving consent to care from a practitioner undertaking a return to work programme.

Principle Five: Ongoing and consistent support

Any return to work programme should include personal and professional support for the practitioner, for the team they are working in and for the organisation managing the programme.

Principle Six: Success and failure

Any framework must recognise and address the possibility of failure as well as success.

Principle Seven: Local resolution drawing on local and national expertise

Local structures, policies and programmes should support local resolution of a case and provide opportunity for local sharing of expertise with access to national expertise.

3.5 Principles for remediation as part of revalidation

In addition to those principles outlined by the *Tackling Concerns Locally*⁴ the working group identified the following principles which should underpin remediation as part of revalidation:

- Remediation is the responsibility of the doctor
- It must be easy to access
- It must be developmental not punitive
- It must be available by self referral or through mutual agreement with the appraiser, Responsible Officer, Royal College, Deanery or other relevant body
- It must be focused, discrete and clearly defined (the ‘diagnosis’, ‘prescription’ and ‘exit strategy’ must always be clear)
- It may be intermittent or continuous
- It should be provided locally wherever possible
- It is a process related to, but separate from, revalidation
- It is there in support of the doctor in difficulty with any aspect of performance, appraisal or revalidation.

3.6 Roles and responsibilities in remediation

Once performance concerns are identified and it is agreed that remediation is appropriate, support from a range of individuals or external agencies will be necessary. The expected roles and responsibilities of a range of stakeholders in relation to the revalidation and remediation are set out below:

Doctors are responsible for ensuring that they are able to demonstrate, through the appraisal process, that they are meeting the described standards and are making use of the measurements generated to identify their development needs.⁵ If remediation is necessary doctors are responsible for demonstrating that the concern, deficit or issue has been resolved.

Appraisers will need to ensure they have adequate training and support to undertake their role. If they determine that the doctor needs to undertake remediation the appraiser will need to be clear about their recommendations, the objectives and the evidence they will expect to see and the timescales by which they expect to undertake a review.

Clinical Supervisors may be asked to work with a doctor whose clinical skills or knowledge is giving cause for concern. As part of remediation direct clinical supervision is unlikely to be necessary (it is more suitable following an extended period away from the clinical environment or when deficits have been identified through assessment) but may be occasional or 'professional'. Professional supervision in this context is defined 'as participation in regular and supported time out to reflect on the delivery of professional care to identify areas for further development and to sustain improved practice'.

Mentors will, it is anticipated, be an important element of any remediation programme, providing personal support, challenge and help developing reflective skills. The mentoring relationship is **not intended as a line management role**. Mentoring is a developmental process where a more experienced individual ('mentor') helps a less experienced individual ('mentee') in his/her personal and professional development. It does **not** include formal supervision; it is outside the direct reporting line and has no formal input to the appraisal or revalidation process.

Employers/contractors have a role in providing a supportive environment which allows remediation to take place without putting patients, the public or the doctor at risk. Clear policies and procedures must be in place to identify and address performance concerns arising outwith the revalidation process. Remediation processes should be an integral part of these local policies and procedures.

Occupational Health Services have a role when the doctor's health is giving cause for concern. Onward referral to more specialist services may be necessary.

Royal Colleges and Faculties are responsible for standard setting for their specialty. They have a direct role if the concerns relate to a clinical service or department rather than an individual. The Colleges will, however, provide advice about standards, courses and supervision.

Deaneries mainly have a role with training grade doctors. In relation to career grade doctors, they may, however, assist in:

- Planning remedial clinical training (particularly in primary care)
- Arranging clinical supervision
- Arranging a mentor
- Identifying and supporting doctors in training placements (unlikely to be necessary as part of the revalidation process)
- Offering access to supportive interventions such as coaching, counselling, career counselling.

NCAS will provide, through its action planning support service, advice and support in developing remediation, reskilling and rehabilitation programmes, monitoring progress and developing exit strategies. As part of the revalidation process NCAS will provide advice and support to the doctor, appraiser, Responsible Officer and employer/contractor. NCAS should be contacted:

- If there are general concerns about a doctor's performance, conduct or competence
- If there are concerns that might require exclusion or suspension
- In any other situation outwith the revalidation process where the local organisation is unsure how to proceed.

The GMC's role in revalidation is closely linked to the output of the appraisal process. A recommendation will be made to the GMC by the Responsible Officer about the doctor's suitability for revalidation. If the concern identified, whether performance, health or conduct, is so serious as to call into question the doctor's licence to practise, then the GMC's advice should be taken. This will form part of the local performance policies and procedures.

4. RECOMMENDATIONS

The Group acknowledges that the recommendations set out in this document may evolve as the processes and implementation of revalidation are more clearly defined. Following their deliberation, the working group have the following recommendations:

4.1 Resources for Remediation

Remediation is a process that can require significant investment of both financial and non-financial resources. Time, money, manpower and expertise must be identified for remediation for it to be effective. As resources pervade all parts of the revalidation and remediation processes the group decided to include reference to resources throughout all of their recommendations rather than include a specific recommendation.

4.2 Remediation Provision

The working group supports the recommendation included in the *Tackling Concerns Locally*⁴ report that “the DH, as part of their work in support of revalidation, should provide or commission operational guidance for healthcare providers on the steps needed to ensure access to remediation for all healthcare professionals who need it” (page 51).

Recommendations:

- *The Departments of Health in the UK need to establish information about the existing provision of remediation. In particular, they should:*
 - *Collect information from Healthcare Providers, Deaneries and Professional Bodies about their existing remediation strategy including how much resource is currently allocated for remediation and how it is used.*
 - *Identify where there are gaps in the provision of remediation*
 - *Define the nature of such gaps*
 - *Outline what is required to ensure that any identified gaps are addressed including financial and non-financial resources*
 - *Develop a strategy for ensuring the consistent provision of remedial support across healthcare providers.*
- *The DH in conjunction with NCAS and the Academy of Medical Royal Colleges should develop detailed guidance on remediation following the implementation of revalidation.*

4.3 Remediation and the Introduction of Revalidation

The introduction of revalidation is likely to lead to an increase in the number of doctors requiring remedial support. Healthcare Providers and organisations that provide remediation programmes need to be prepared for the introduction of revalidation and its potential impact.

Recommendation:

- *The Departments of Health in the UK need to further explore and evaluate the potential impact of revalidation on remediation programmes.
This could be achieved in a number of ways:*
 - *The incorporation of a remediation data collection and evaluation component in any appraisal and revalidation pilot conducted by the UK Departments of Health, Revalidation Support Team, General Medical Council; British Medical Association and Academy of Medical Royal Colleges*
 - *The inclusion of an exploration of remediation in any Impact or Cost/Benefit Analysis studies of revalidation*
 - *A historical analysis of changes in the demand for remediation support following the introduction of annual appraisal in 2001 and 2002. Such information could provide an initial indication of the level of increased demand that may follow the introduction of revalidation.*

4.4 Ongoing Provision of Remediation and Quality Assurance

Ensuring adequate remediation support is in place for the introduction of revalidation is only the beginning. Appraisal and Revalidation will be ongoing processes that are likely to identify new remediation needs at regular intervals. The provision of remediation will need to be maintained and should be quality assured.

Recommendation:

- *It is essential that the provision of remediation is monitored, maintained and quality assured to a level where it continues to support appraisal and revalidation.*

Careful study of remediation following the implementation of revalidation and its consequences are essential to patients, the public and the profession.

- *Research must be commissioned to study the outcomes and costs of remediation following the introduction of revalidation*
- *The research body must be independent and have access to confidential anonymised data of all doctors who undergo remediation*
- *Data should be collected and analysed regarding the age, gender, ethnicity, speciality, region, nature of problem, remediation support, required resources, length of time support is required and eventual outcome*
- *Evaluation should identify and consider themes, outcomes, weaknesses and strengths of the whole remediation process and define minimum standards for the provision of remediation*
- *It is anticipated such a study will require a significant time scale for conclusions to be reached. This could then transform to a continuous data base for monitoring and quality assuring the remediation process.*

APPENDIX 1: CASE STUDIES

These case studies illustrate a wide range of performance difficulties. Most of them should be identified and managed through local performance procedures. Information about the concerns and steps to address them will need to be included in the information made available to the appraiser and responsible officer. The points in each case study which propose possible handling are indicative and should not be seen as Academy guidance on good practice.

They have been organised according to the domains outlined by the GMC for appraisal and revalidation that are based on Good Medical Practice (Table 1). The cases show how problems may be analysed and potentially resolved. Take note of how many of the illustrative cases have “domain drift”. Often when a remedial need is identified, it is presented in a way that may look as if it is linked to one domain, however, on further investigation the issue may cover a range of the domains. Often, cases will have issues in each domain but of different proportions. There should be a conscious effort to consider each of the domains for each case. They are often interdependent and may impact on one another.

The analogy is a clinical case history where careful interviewing may identify whole new areas of importance and of course we have a systems review to ensure that nothing important has been missed. The doctor concerned needs as careful an assessment as if he or she were presenting as a patient. Determine the presenting complaint, its history, previous problems, a systems review, social history and very importantly drugs and alcohol. If you get the basics right then the rest will usually follow. Never jump to conclusions.

The case studies are referred to in the right hand column of Table 1 by number and are then described in the following text. Although the situations have been taken from real life they have all been altered substantially so that no one case represents a single doctor.

Table 1. Case Studies according to the GMC

LEVEL OF REMEDIATION	ORGANISATION	EXAMPLES OF SUPPORT	GMC DOMAINS			
			KNOWLEDGE, SKILLS AND PERFORMANCE	SAFETY AND QUALITY	COMMUNICATION, PARTNERSHIP AND TEAMWORK	MAINTAINING TRUST
R	INFORMAL SUPPORT	<ul style="list-style-type: none"> • MENTORING • READING • CPD 	CASES 1, 4, 12	CASE: 4	CASES: 4, 8	CASES: 4, 5
R	LOCAL GOVERNANCE	<ul style="list-style-type: none"> • WARD ROUNDS • MENTORING • RESKILLING • CPD • SHADOWING 	CASES: 6, 7, 8, 9, 10, 11, 13,15	CASES: 6, 8, 10, 11, 12, 13,15	CASES: 3, 6, 9, 10, 11, 12, 13,15	CASE: 6
R	<ul style="list-style-type: none"> • COLLEGES • DEANERIES • SPECIALTY SOCIETIES • INDEPENDENT PROVIDERS 	<ul style="list-style-type: none"> • INVITED SERVICE REVIEWS • PEER REVIEW • RESKILLING • CPD • LEARNING SUPPORT • MANAGEMENT SKILLS • TEAM DEVELOPMENT 	CASES: 5, 14	CASES: 5, 14	CASES: 5, 14	
R	NATIONAL CLINICAL ASSESSMENT SERVICE	FORMAL ASSESSMENT	CASE: 2	CASES: 2, 7	CASE: 7	CASE: 8
R	GENERAL MEDICAL COUNCIL	FITNESS TO PRACTISE	CASE: 2	CASE: 3	CASE: 7	CASE: 3

Case Studies

CASE 1: Does not provide documentation

A GP has not provided the appropriate documentation for revalidation. She states that she has been too busy to document all the information and has no support from the Trust to do so. She is said to be competent by peers and patients alike.

It is essential that this is addressed and resolved at an early stage.

A diagnostic interview will perhaps reveal more that meets the eye. Why would a competent GP not be able to provide information? Is this wide spread in the PCT concerned? Is there an issue likely to arise if clear information is provided? Is she simply too busy and her job plan and activities need to be altered? Are there things in her outside life that mean that she is completely overwhelmed with private practice, family or other issues?

You may need to involve a local expert or a representative from the Royal College of GPs.

CASE 2: Needs further training, but expensive and may not be employable

A newly appointed consultant surgeon with an interest in colorectal disease has a serious untoward incident following laparoscopic resection of a rectal cancer. The patient subsequently dies and post-mortem reveals significant damage to the ureter in addition to an anastomotic leak. An audit of cases demonstrates a series of clinical issues which suggest that performance might be impaired.

NCAS is informed and an individual invited review from the Royal College of Surgeons is undertaken. Following the review recommendation for further training in laparoscopic techniques is advised.

This is a serious issue which could drift into GMC fitness to practise if not addressed. Problems may arise with the costs of retraining and then re-employment after this has successfully been completed.

A range of external help is needed including the Royal College of Surgeons, NCAS and another trust and surgeon for retraining. At the time this document is produced there is no clear advice about who should fund retraining.

CASE 3: Needs further training and is dishonest

A gynaecologist involved in an operation that results in a serious untoward incident fails to see the patient in the post-operative period and deliberately alters the operating note and clinical notes in an attempt to avoid blame. She shows no insight into her errors.

She is referred to the GMC, undergoes an appearance before the fitness to practise committee and is required to undertake further training and has restrictions on her practice until that had been completed. Supervised training will take place in another trust.

The GMC recommends that this type of training is under the supervision of the local deanery. Not all deaneries are willing to accept this responsibility. The employing trust may not always take the further trained gynaecologist back into practice. This may be a professional disaster for the doctor concerned, she could easily have rendered herself unemployable.

CASE 4: Does not provide documentation

Dr A is a 47 year old consultant in occupational medicine and former GP. He now works as a single independent practitioner with a portfolio career. The only other person working in his practice is his wife who provides administrative support. He works 5 days a week with different employers who have no relationship one to another.

Dr A has recently started to pay for an appraisal through the Society of Occupational Medicine Quality Assured Appraisal Scheme. His appraiser has no concerns about Dr A's performance but has equally no information to demonstrate that he is competent. The issue has been discussed during two annual appraisals but Dr A still struggles to provide any sort of meaningful evidence because of the nature of his work. He has produced examples of letters he has written to colleagues and managers and a single complaint that was made about him by one employer. He has attempted to use MSF to get feedback from colleagues, but apart from two nurses has failed to persuade anyone else to contribute. He has considered giving patients questionnaires to complete but is worried that the results will be negative because many of his patients are unhappy with the outcome of his consultation, as they did not get the decisions they wanted about early retirement.

In summary, there is no reason to suggest that Dr A is not a good doctor but he is also unable to demonstrate that he is competent. He needs to identify others in a similar situation. It is likely that a coordinating role will be undertaken by the Faculty of Occupational Health Medicine in conjunction with the Society of Occupational Medicine. As yet there is no effective mechanism of addressing this issue.

CASE 5: Needs further training but there may be issues of gender bias and ineffective local governance

Dr A returned to work after an extended period of maternity leave, her second since her appointment to a consultant post in anaesthesia and pain medicine three years previously. It was apparent that there were many underlying issues. The clinical director thought that the doctor was inadequately trained, and suggested that she should not have been awarded a CCT. There was resentment that she had not been able to 'hit the ground running' after appointment, and that she had spent a great deal of time on maternity leave. The doctor felt that her non-interventional approach to pain therapy was at odds with the more aggressive approach of the established members of the department. She felt sidelined. On questioning, she also admitted to some anxiety about her technical skills.

The college advisor was approached and involved. Suggested remediation included internal mentoring, a short period of assessment, further training in an external department, changes in her job plan to make it easier to maintain technical skills and the active support of the Regional Adviser in Pain Medicine.

However it also became apparent that the department would be the subject of complaint from the doctor concerned on the grounds of inequity and gender bias. Other male staff had made substantial changes to their job plans and had been trained to take on new roles without the charges of incompetence that had come her way.

Do take care to ensure that apparent underperformance is not the result of putting your staff in impossible situations for which they are subsequently blamed. The department was aware of her skills on appointment and also should be aware that prolonged periods of absence may reasonably generate the need for considerable support on return. As the needs of patients and the department change then further training becomes inevitable.

Is this a department governance issues or one of revalidation? It could be either, clarify the facts very carefully.

CASE 6: Rude and competent, his license is at risk

Doctor A is always late for ward rounds. He is rude to the nurses, discourteous to the junior staff and rushes away without finishing. He has an extensive private practise; rumour has it that this is his main activity. Post take rounds are often missed or cut short. He is clinically competent and has an excellent research record. To most observers he neglects his NHS practice.

This is a situation which requires substantial skill to address in a direct interview. Ideally he should have a further interview by a senior and skilled interviewer, probably appointed by the college who will be able to enable him to understand that he is failing in diligence to his NHS patients and cannot be recommended for revalidation unless there are positive improvements.

The complex issue here is that he may be competent but is failing to address his duties as specified in his trust. He is crossing the line on personal performance and his license is in jeopardy.

His performance and attendance should be positively monitored by a senior colleague and it may be that this should be by a doctor outside his area of practice so that objectivity might be maintained, personal argument limited and relationships not threatened. He needs SMART targets.

CASE 7: A very bad tempered doctor who may have gone a step too far

Doctor B has a dreadful temper. He is a competent doctor, and has a nationally prominent position. There have been informal stories for years about his tantrums but nothing written down. Things come to a head after a heated argument with a trainee who ends up on the floor, opinions vary as to whether she was pushed or fell. Doctor B simply says it was not his problem and continues his work that day. Attempts by managers to talk with him about the incident fall on deaf ears. A written complaint is sent and is lodged in his e-portfolio and is the subject of discussion.

This could escalate into a full performance review at GMC. Skilled external counselling is essential but the difficulty will be to enable him to accept that he has a problem. Discussion with college and probably GMC affiliate with counselling in mind should be the aim. That counselling should consist of a diagnostic interview and prescription with the express aim of stopping these outbursts, which without intervention may lead to serious repercussions for him. The case also highlights what happens when continuing problems are not addressed at an early stage. Do not ignore small problems, they can so easily cause major issues for patients and the doctor concerned if not addressed properly.

CASE 8: A change in behaviour

Doctor C is a law unto herself. She does not attend governance meetings, has no audit activity and is regarded as a bit of a loner. Her e-portfolio is blank in matters of performance improvement. History suggests that she was not always like this but seemed to change about two years ago. Before that she was active in education, audit and had a reputation as a keen and active team member.

A skilled appraiser should be able to identify a change two years ago. The doctor needs help and may have a range of undiscovered issues outside or inside medicine. She needs access to a sensitive diagnostic interview probably organised by the royal college concerned. She may well then be discovered to have problems with health needing help from sick doctor scheme or NCAS. There is a track record of success in this area involving NCAS and ill health.

CASE 9: Isolated and just about acceptable

Doctor D is simply there. He does what is required, generates no feelings of any description amongst the clinical staff he works with, arrives, stays and leaves at the end of the day. He performs his on-call to the letter, will not cover colleagues for their leave and never asks for their help in any matters clinically or in any other way. At the appraisal he complains that he has been passed over for several years for clinical excellence award points and feels that he is being picked on.

The skilled appraisal again is key to identification of the issues which underlie this behaviour which probably does not affect his revalidation potential but certainly is affecting his performance and his reaction to others and ultimately to himself. He ideally needs partnering with a role model who can sensitively help. It may be of course that he is an extreme example of an insular personality and that nothing will change. This would be disappointing but not unknown; as time passes his problems (if that is what they are) will slowly get worse and may eventually result in underperformance largely due to his insularity. An external interview may be worth while if he will agree.

CASE 10: Probably competent but disliked

Doctor E is charming to the staff and disliked by his patients many of whom say he does not smile, and are upset by his lack of engagement in their problems. He is clinically OK but nothing special so rumour would have it. Since he works in medicine there are no easy outcome measures with which to compare him with others and except in simple numbers and throughput there is no real information about performance. There have been several low key complaints which have reached the Trust about dismissive attitude. These complaints are discussed in the appraisal at which time Doctor E attempts a charm offensive once more. He is not aware that he has a problem and becomes somewhat abrasive when it is suggested that his attitude with patients is a low key issue at present and should be addressed before it becomes a major concern.

Be very careful. There is a problem with governance, if there is nothing to measure then there is nothing to compare. Why is he disliked? The complaints about attitude should be raised at the appraisal and he should be offered external counselling. Remediation might well result in the use of a reflective diary and perhaps weekly discussion with the senior nurse on the unit about his relationships with staff and patients. If the right nurse is chosen this may be very constructive. It is a sad reflection on training that this long term issue has not been addressed previously. There is a long term issue; it is well known that those doctors with poor communication skills are more likely to be sued and more likely to be the subject of serious complaints. For his sake his problems need to be addressed now.

CASE 11: An impossible team player

Doctor F is odd. She teaches assiduously but is quick to run down any attempts to measure performance, use audit, guidelines or other modern tools of quality improvement. Her patients like her. Whenever she is approached to take part in initiatives or new ways of working she says yes, then passively resists. Colleagues in clinical management find her very difficult and challenging since she is never outwardly negative about anything. Her e-portfolio is pristine with small audits of no significance, reflection of Dickensian proportions but no performance to match her eloquence in the written word. Adverse comments are missing from her e-portfolio but all know that she is a force for history and not the future.

She will not have a problem with revalidation but may on occasions have problems with her 360 degree multisource feedback. She has probably been in post for many years and it is probably going to prove impossible to change her. Doctors arrive in this situation as a result of years of unskilled lack of attention. They eventually believe that they are in step and the rest are not.

CASE 12: A caring out of date doctor

A 57 year old surgeon was noted to have concerns from colleagues, especially surgical and anaesthetics about poor outcomes, complications and untoward incidents. He needed repeated help when operating; and yet seemed not to recognize the need, raising concerns about clinical judgement as well as technical skill. The issue had been difficult to handle locally since he appeared to be lacking in insight and reacted badly to criticism and challenge.

He was referred to NCAS which found a committed, caring, motivated clinician but with widespread poor clinical performance across all domains. The deficits were estimated to require at least 12 months intensive supervised training in a specialist training centre. He lacked acceptance of the breadth of poor performance and felt badly treated and misunderstood by his employer

This situation may have several possible outcomes depending on local and personal circumstances. The outcome looks very difficult to handle, he may not accept further training, or fail to benefit or he may benefit but not be acceptable to his employer. He has been in practice for many years and the problems identified late. There may be no easy solution if he continues to wish to operate, he may be better in a non surgical or clinic only role if he will accept it.

CASE 13: A simple case of poor specialist radiological reporting-or is it?

A radiologist at annual appraisal was identified as making repeated errors in one area of work, the interpretation of CT scans of the acute abdomen were particularly problematic.

The appraiser suggests spending time with the local acute abdominal CT expert radiologist until they mutually feel that sufficient additional experience has been gained.

But this solution is a large cost to the department. It requires release of the individual from normal duties and additional time from the expert. If the case is a simple one off, then it may be carried within a department but in a large department then it is likely that this may become a more frequent scenario with significant resource implications.

As the requirement for more sophisticated investigations is expanded to evenings, nights and weekends then what appears at face value to be a simple issue becomes complex. Who judges the CT scan for thrombolysis of stroke and how is this quality assured? Should we expect the non-expert to be expert on call?

CASE 14: Errors by an individual doctor reflecting a poorly functioning department

A pathologist is accused by colleagues of making excessive number of errors. The individual blames excessive workload, poor leadership and poor working relationships. This issue is raised informally during the year and is highlighted at appraisal but not supported by written evidence.

The College is invited to perform a service review to assess the department including individual workloads and overall function. Problems at all levels and suggestions for improvement are made. A single high quality annual appraisal brought to light issues in a whole department.

This is a problem which is not easy to resolve. Where does responsibility for performance lie and what is the balance between the individual and the department? Is there really an issue of underperformance or is it more to do with team work and leadership? Is it simply resource, not enough staff? Is this an issue for individual remediation or for department remediation, a concept that currently does not exist but is being increasingly discussed?

There is no solution proposed here. It can be seen that local management, leadership, data, are all important in the analysis of the problem. Moreover it may be suggested that the individual should be referred to NCAS for underperformance.

High quality local governance is essential for revalidation, in its absence then issues such as this may arise with serious consequences for doctors and patients alike.

CASE 15: GP Case Scenario

This case concerns a GP (Dr G) in group practice. He is in his sixties. He started his career as a single handed general practitioner in 1974. Dr G joined the group practice in the area in early 1980s. He became a trainer in the practice in 1985. He stopped being a trainer in 1996. Lately the younger members in the practice feel that Dr G is not pulling his weight and making minor errors, his note keeping has become worse and is turning up rather late for surgeries. Partners have been able to cover for his errors but are concerned that unless something is done Dr G may run in to a major trouble.

However, there's been a major complaint about him from the relatives of a patient that he failed to diagnose rectal cancer despite the symptoms of rectal bleeding, alteration in bowel habit and loss of weight.

The practice manager has had a letter from Dr G's appraiser that Dr G has been late to submit for his appraisal which was due some five months ago.

Issues:

- 1. Knowledge skills and performance*
- 2. Safety and Quality*
- 3. Teamwork*
- 4. Health.*

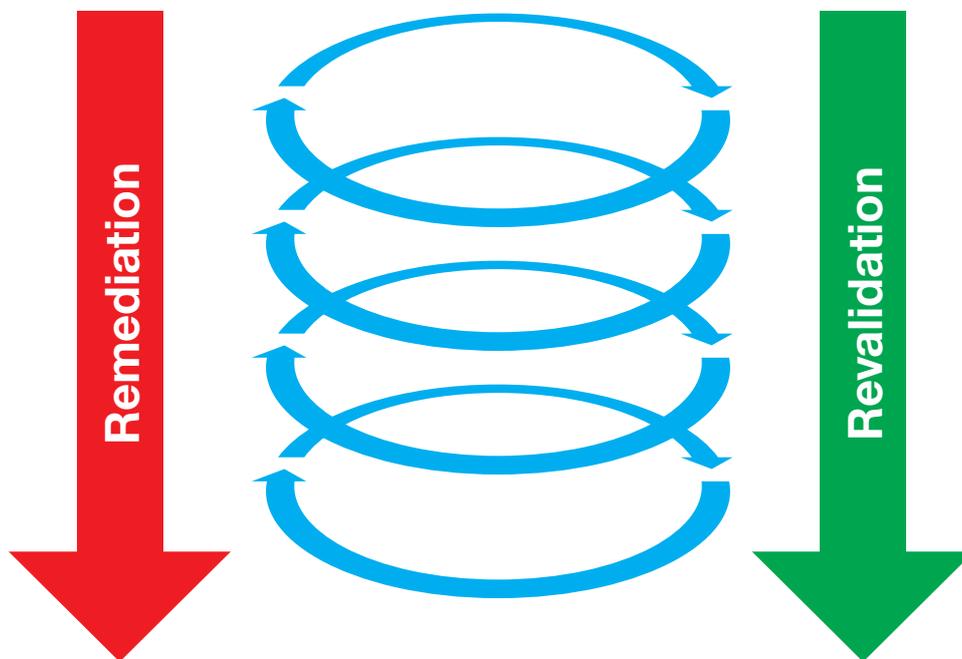
Remediation measures: Local

- The partners need to explore the issues with Dr G possibly through a meeting with him. Identify issues with Dr G's personal life or health and convince him to see his GP and ensure that he does not see patients*
- Make him aware that he needs to address the issues arising from the complaint made by the relatives of a patient and seek help from the defence organisation*
- Make Dr G aware that they need to report his performance problems to the PCT so that a proper diagnosis and action plan to remediate could be put in to action.*
- Pastoral care through local faculty of the RCGP or the LMC.*

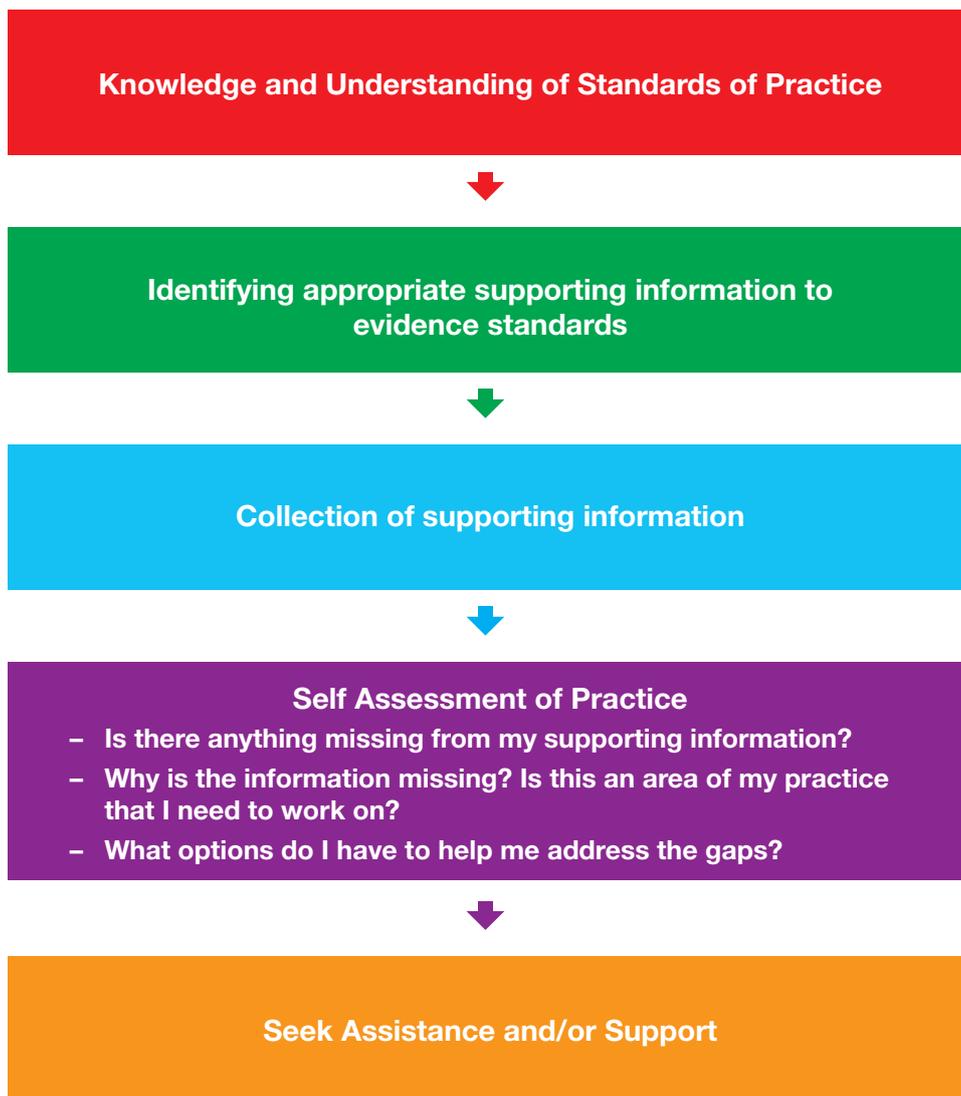
APPENDIX 2: MODELS OF REMEDIATION

Below are four models which reflect different ways of thinking about remediation. They are complimentary but not mutually exclusive. The models are tools to help understand the wide ranging issues covered by remediation including health, behaviour, clinical knowledge and skill. They do not prescribe what should be done or how but are tools to help identify and analyse a need for remediation and guide the provision of a remedy.

Model 1. Remediation and revalidation

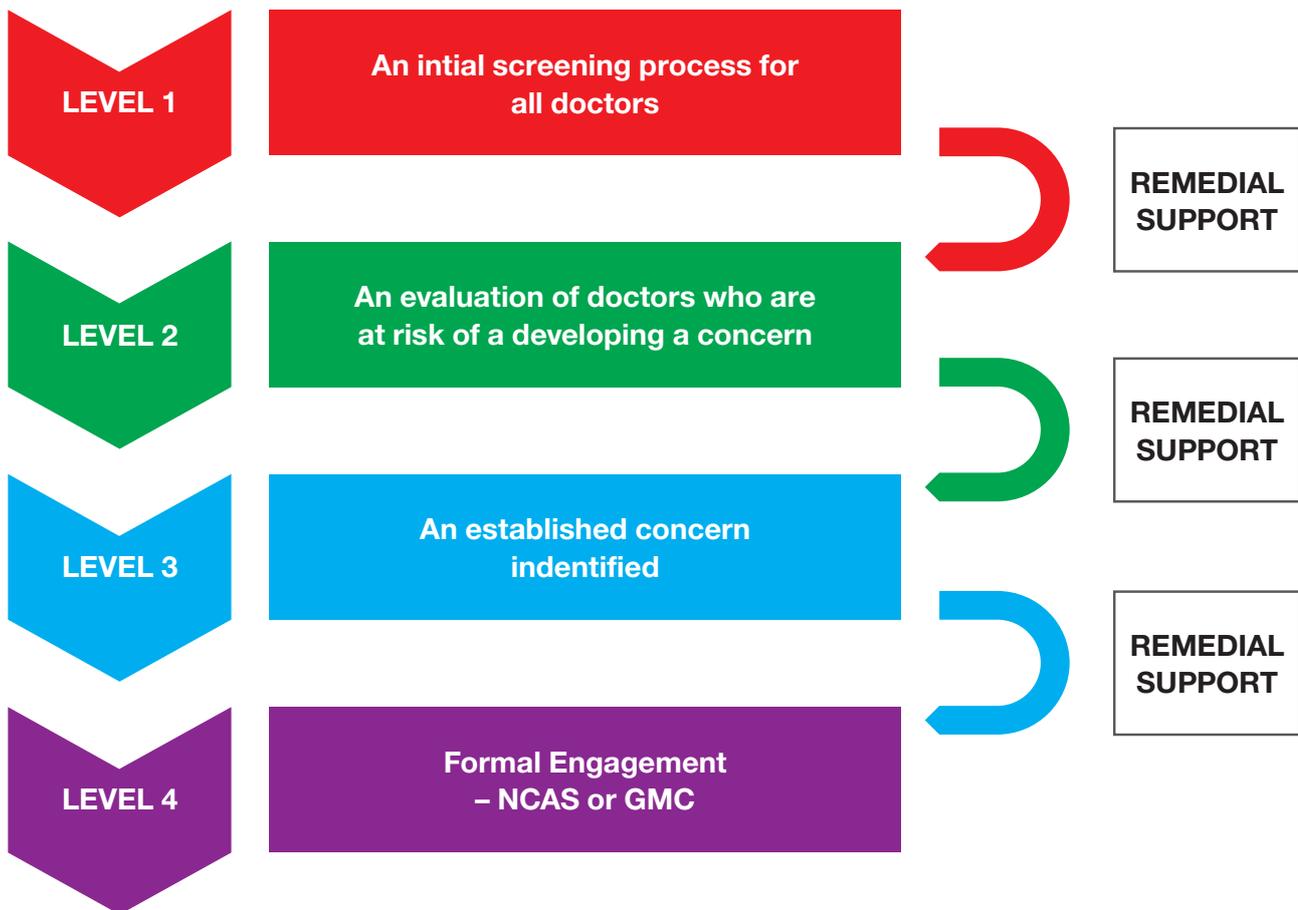


Model 2. Reflection and Self-regulation



In this model self assessment and reflection have revealed a need for help. The appraiser would ideally need to be informed, he/she may know of those who may be able to help. We would strongly recommend an independent skilled diagnostic interview. Unless the doctor concerned is crystal clear in his self diagnosis then this is not the issue for 'over the counter self medication'. The diagnostic interviewer should not be the appraiser. The process is explicitly confidential and conducted outside of Trust governance processes.

Model 3. Remediation and phased approach



This model shows the potential gradation from almost no concern at all to very serious issues, which we have labelled 1–4. These labels do not have any discriminatory meaning and are not defined. They simply show the progress from one to another. Within a trust or college it might be envisaged that over time some analysis using this approach would be useful. Ideally doctors with problems are identified in stage 1 and 2 and not at level 4.

Model 4. The remediation Spectrum



This model reflects the increasing gradation of concerns from low to high level and eventually attention of the GMC, the regulator. The ideal is to nip issues in the bud at the stage of self help, however some problems may not arise until the R, high level is reached. Awareness and attention to all aspects of revalidation may initially highlight more high level issues, but as these are studied and evidence collected about the total process it may be possible to more reliably identify problems at an early stage.

APPENDIX 3: REMEDIAL SERVICE PROVIDERS FROM NCAS WEBSITE

ORGANISATION	RESOURCE TYPE
Association of Medical Professionals	Learning support and personal development
A.S.K. Europe plc	Learning support and personal development, Management skills
British Dental Association	Clinical skills, Learning support and personal development, Management...
Brenda Beecham	Learning support and personal development, Management skills, Team...
BMJ Learning	Clinical skills, Learning support and personal development, Management...
Chambers for Organisational Research and Development	Clinical skills, Learning support and personal development, Management...
Centre for Health Planning and Management, Keele University	Learning support and personal development, Management skills, Team...
Cygnus Mentoring and Professional Development	Learning support and personal development, Management skills, Team...
Communication Team in the Medical Education Unit of the University of...	Clinical skills, Learning support and personal development, Management...
Coaching and Mentoring Research Unit	Learning support and personal development, Management skills
Clinical Effectiveness Group	Learning support and personal development, Management skills, Team...
Chambers for Organisational Research and Development	Learning support and personal development, Management skills, Team...
Dental Practitioners Association	Clinical skills, Learning support and personal development, Management...
David Megginson	Learning support and personal development, Management skills, Team...
Doctors' Support Network	Clinical skills, Learning support and personal development, Management...
Doctors' Support Line	Learning support and personal development
Doctors Plus	Learning support and personal development
Doctors for Doctors and BMA Counselling Service, British Medical...	Learning support and personal development
Dentists' Health Support Programme; The service is confidential and...	Management skills, Team development

ORGANISATION	RESOURCE TYPE
Dr Valerie Harley-Brewer	Management skills
Dr Nick Maguire	Learning support and personal development
Dr John Boddy Chartered Occupational Psychologist	Clinical skills, Learning support and personal development
Dr Dow Smith	Clinical skills, Learning support and personal development, Management...
Dr David Parker	Clinical skills, Learning support and personal development
Dr Brian Millar	Learning support and personal development, Management skills, Team...
Dovedale Counselling LTD	Learning support and personal development
Doctors' Support Network	Learning support and personal development, Management skills
East of England Multiprofessional Deanery	Clinical skills, Learning support and personal development, Management...
Effective Professional Interactions Ltd	Clinical skills, Learning support and personal development, Management skills, Team...
Education Department, Postgraduate Deanery for Kent, Surrey and Sussex	Clinical skills, Learning support and personal development, Management...
Edgecumbe Health	Learning support and personal development, Management skills, Team...
East of England Multiprofessional Deanery	Clinical skills, Learning support and personal development, Management...
Faculty of General Dental Practice (UK)	Clinical skills, Learning support and personal development, Management...
Guys', King's and St Thomas' School of Medicine, Department of General...	Learning support and personal development
Learning support and personal development	Clinical skills, Learning support and personal development, Management...
Gay and Lesbian Association of Doctors and Dentists	Gay and Lesbian Association of Doctors and Dentists
Hull and East Yorkshire General Practitioner Mentoring Scheme	Learning support and personal development, Management skills, Team...
Healthcare Performance Ltd	Clinical skills, Learning support and personal development, Management...
Health Services Management Centre, University of Birmingham	Health Services Management Centre, University of Birmingham

ORGANISATION	RESOURCE TYPE
Health Partnerships	Learning support and personal development
Haymarket Medical	Clinical skills, Learning support and personal development
Inspire Change Limited	Learning support and personal development, Management skills, Team...
Individual Support Programme	Clinical skills, Learning support and personal development, Management...
Kate Harmond Consultancy	Learning support and personal development, Management skills
Life By Design	Learning support and personal development
Landmark Health Consulting	Learning support and personal development, Management skills, Team...
Luminessence Coach Ltd	Learning support and personal and team development, Management skills, Team...
London Deanery	Clinical skills, Learning support and personal development, Management...
Lincolnshire Partnership NHS Trust	Clinical skills, Learning support and personal development, Management...
Life Coaching for Doctors	Learning support and personal development, Management skills, Team...
Medic Support	Learning support and personal development, Management skills
MPS Risk Consulting	Clinical skills, Learning support and personal development
MiAD (UK) Ltd	Clinical skills, Learning support and personal development, Management...
Medical Womens Federation	Learning support and personal development, Management skills, Team...
Medical Forum	Learning support and personal development, Management skills, Team...
Northern Deanery	Learning support and personal development
Nina Murphy Associates LLP	Clinical skills, Learning support and personal development, Management...
NHS Partners	Clinical skills, Learning support and personal development, Management...
NHS North West Mentoring Scheme	Clinical skills, Learning support and personal development, Management...

ORGANISATION	RESOURCE TYPE
NHS Exposed	Clinical skills, Learning support and personal development, Management...
National Patient Safety Agency	Clinical skills, Learning support and personal development, Management...
OPS Ltd	Learning support and personal and team development, management skills
Occupational Psychology Services	Learning support and personal development, Management skills
Panorama Training Consultancy	Management skills, Learning support and personal development
Primary Care Choices	Learning support and personal development, Management skills, Team...
Postgraduate Deanery for Wales	Clinical skills, Learning support and personal development, Management...
Philippa Hain Associates	Learning support and personal development, Team development
QCMC	Team development, Management skills
Revolve Staff Support Service	Learning support and personal development, Management skills, Team...
Rebecca Myers	Learning support and personal development, Management skills, Team...
Raven-Vause Consultants Ltd	Learning support and personal development, Management skills, Team...
Royal College of Surgeons of Edinburgh	Clinical skills, Learning support and personal development, Management...
Royal College of Surgeons - Professional Standards	Clinical skills, Learning support and personal development, Management...
Royal College of Radiologists	Clinical skills, Learning support and personal development, Management...
Royal College of Psychiatrists	Learning support and personal development
Royal College of Physicians	Clinical skills, Learning support and personal development, Management skills
Royal College of Obstetricians and Gynaecologists	Team development
Royal College of General Practitioners	Learning support and personal development, Management skills, Team...
STRAD Consulting	Learning support and personal development, Team development

ORGANISATION	RESOURCE TYPE
South of Tyne Mentoring Scheme for General Practitioners	Learning support and personal development, Team development
Skill: National Bureau for Students with Disabilities	Learning support and personal development
SI Group	Learning support and personal development, Management skills, Team...
Sherwood Forest Hospitals NHS Foundation Trust	Clinical skills
Section of Postgraduate Education for General Practice, Wales Deanery	Learning support and personal development
Salomons, Centre for Leadership and Management Development	Learning support and personal and team development
Salomons, Centre for Leadership and Management Development	Learning support and personal development, Management skills, Team...
The Venworks	Clinical skills, Learning support and personal development, Management...
The College of Executive Coaching	Learning support and personal development, Management skills, Team...
Terema	Clinical skills, Learning support and personal development, Management...
Track Surveys Ltd	Learning support and personal development, Management skills, Team...
Tony Winkless Associates	Learning support and personal development, Management skills, Team...
Tim Norfolk & Associates	Clinical skills, Learning support and personal development, Management...
The Working Lives Partnership	Learning support and personal development, Management skills, Team...
University of Southampton	Learning support and personal development, Management skills, Team...
UCL, Eastman Dental Institute	Clinical skills, Learning support and personal development
Working Lives Partnership Coaching and Career Councillng Services	Learning support and personal development
West Midlands Deanery	Clinical skills, Learning support and personal development, Management...
Wessex Institute NHS South Central	Clinical skills, Learning support and personal development

- 1 Department of Health. *Supporting Doctors, Protecting Patients*. London: Department of Health, 1999.
- 2 NHS Revalidation Support Team. *Strengthening NHS Medical Appraisal to Support Revalidation in England – a proposal paper*. London: RST, July 2009.
- 3 National Patient Safety Agency. *Back on track - Restoring doctors and dentists to safe professional practice*. London: NPSA, 2006. <http://www.ncas.npsa.nhs.uk/resources/publications/key-publications>
- 4 Department of Health. *Tackling Concerns Locally – report of the Working Group*. London: Department of Health, March 2009, Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_096492
- 5 Department of Health. *The framework for responsible officers and their duties relating to the medical profession*. A consultation on responsible officer regulations and guidance DH 2009

35-43 Lincoln's Inn Fields
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WC2A 3PE

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