The underperforming GP

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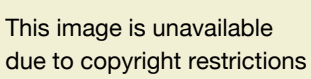
GPs are no less vulnerable to illness and stress than the patients they treat, and are likely to experience times when their standard of practice is difficult to maintain. GPs will, nevertheless, be held accountable to a range of performance criteria and need to develop ways of maintaining standards at times of increased stress.



Dr Steady has been a partner in your group general practice for the past 15 years. He has a busy practice and has always been popular with patients and staff. However, you receive several complaints about him in the period of a month, and a staff member resigns after an argument with him. At the weekly practice meeting, Dr Steady tells his partners that he has received notification of a complaint lodged with the medical board.

What has happened in Dr Steady's personal or professional life that has led to this cluster of events? Is it simply bad luck or coincidence, or has Dr Steady's performance slipped in some way?

What do we mean by 'underperformance', particularly in general practice? Is it the same as 'impairment', and is it remediable?

Underperformance v. impairment

'Performance' is a complex concept that defines the tasks involved in undertaking (and completing) a specified activity. Because performance of a task or activity can be described, it can also be measured. Assessed level of performance exists along a continuum. If performance is to be assessed as 'unsatisfactory' it is necessary to define the point along the continuum where the satisfactory can be determined from the unsatisfactory. For simple tasks, such as a spelling quiz, this is not difficult; however, for activities such as the provision of patient care, the definition of a point at which performance does not meet an acceptable standard is complex.[1] Underperformance doesn't generally relate to one or two poor decisions, but rather to the emergence of a pattern of failure to attain standards.

'Impairment' is that point along the continuum of performance where a doctor is not merely performing at a lower level than could normally be expected, but is performing in such a way that patient care and safety are significantly at risk.[2] However, not all doctors who are underperforming have reached the point of impairment.

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The debate about what constitutes underperformance has engaged many professional groups in recent years, yet there is no one definition. Each definition is based on a group's particular domain of interest. For the Royal Australian College of General Practitioners, underperformance relates to the failure to attain standards defined by the College as representing appropriate practice, including standards of communication and clinical competence.[3] For State medical boards, standards relate to protection of the public, and are focused primarily on the issue of impairment *v*. nonimpairment. Medical boards are only recently tackling the more complex task of defining 'competence'. For indemnity and other insurance providers, standards relate to avoiding negligence.

Each of these bodies may use a common set of standards as a template, but may interpret the standards according to their individual focus. For example, the GP who prescribes an antibiotic that is recognised as appropriate for a particular infection has performed adequately according to a College defined standard, based on an accepted set of antibiotic usage guidelines. From the perspective of the PBS, the GP may have performed very well by avoiding the use of a more expensive alternative medication. However, medicolegally, the GP may be judged as failing to meet an acceptable level of performance; he or she may have failed to warn the patient of a rare but

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recognised side effect of the medication, and failed to inform the patient of an alternative medication.

What determines performance?

Factors that determine performance include:

- **Knowledge** of appropriate and current methods of diagnosing and managing health problems
- **Skill** at an appropriate level in the activities and procedures undertaken in routine practice
- **Attitudes** towards issues such as informed patient consent
- **Appropriate behaviour,** as determined by the interaction of the doctor's belief and value systems with the environment in which the doctor exists; if the doctor has beliefs or values that are not shared by the general community, or is working in an environment that is causing high levels of personal stress, then the behaviour of the doctor may become compromised to the point of being unacceptable.

Inadequate communication, failure to recognise the boundaries of one's own skill level and perceived unacceptable behaviour are the most common causes for complaints against all doctors, including GPs.[4,5]

Psychiatric illness and the abuse of prescribed or illicit substances (including alcohol) are the most common reasons for impairment, with physical disability being much less common.[2]

How common is underperformance?

The prevalence of underperformance is difficult to assess, given the variable criteria applied by the different systems that may monitor GP performance. However, some statistics give a reasonable indication of the numbers of GPs that exist along different points of the performance continuum. It is likely that 0.5 to 1% of all doctors are 'impaired' at any one time. This figure comes from statistics kept by medical boards (including the Impaired Registrants Panel of the NSW Medical Board) with an acknowledgement that there are probably many impaired doctors practicing that are as yet undetected. Statistics kept by medical boards and other organisations, such as State doctors' health advisory services, indicate that GPs are somewhat overrepresented in these figures.[6] This may simply reflect that GPs are less able to avoid detection if impaired, or alternatively they may be more likely to self-identify and seek assistance.

Recent reports from Australia and many other Western countries indicate that many doctors, including GPs, report disillusionment and dissatisfaction with their work. High levels of 'burnout' are reported with a significant incidence of each

Law update

The *Medical Practice Amendment Act 2000* (NSW), which was brought into effect on 1 October 2000, introduces new methods of assessing and reviewing doctors who are suspected of 'unsatisfactory professional performance'. It was introduced to consider patterns of behaviour (i.e. the law now recognises that the generally poor performing doctor may be as much a risk to the community as one who has committed one negligent or unprofessional act).

The new law in NSW widens the definition of unsatisfactory professional performance from being 'below the standard reasonably expected of a doctor with an equivalent level of training and expertise', to include receiving benefits for referrals or recommendations, and overservicing.

There can now be a three-step process to performance assessment: assessment, action by the NSW Medical Board and review by a Performance Review Panel.

Other new initiatives include: a longer initial suspension in some circumstances; a court's requirement to notify the Board of criminal findings, even those that do not proceed to conviction; and the requirement for a doctor to submit an annual return to the Board to specify details of any convictions, findings of sex or violence offences and any significant mental or physical illnesses.

To protect doctors, the Board cannot order a performance assessment on the basis of an anonymous tip-off. Further, the doctor under assessment can appeal to the NSW Medical Tribunal.

Editor's comment

Dr Willcock has written wisely and well about the problem of the underperforming GP. He did not choose the title. Reflecting upon it, I am troubled for there is no reason to believe that GPs underperform more than those in any other branch of our profession.

It seems that the Parliament of NSW has a similar view, for provisions of the new *Medical Practice Amendment Act 2000*[1] apply across the profession (see the box on page 129). Assessors of the newly created Performance Review Panel are empowered to assess any aspect of a practitioner's professional competence and report to the Medical Board. The Medical Board, in turn, may take steps to deal with any deficiencies or improprieties. Dr Willcock's article is therefore timely.

Assessment of clinical competence is more difficult than one might think. Some 40 years ago, I was privileged to receive an RACP scholarship that enabled me to discover what was going on around the world in training and assessment. Realising that wisdom was not confined to the UK and North America, I also visited New Delhi, Moscow, Singapore, Kuala Lumpur and a number of academic centres in mainland Europe. The result was very clear. Centres that depended substantially on examinations had little faith in them and those that used assessment of clinical performance had no faith in that process either. Both camps had compelling arguments to support their position and both were considering changing to the opposite technique, which I thought a triumph of hope over wisdom.

Assessment of the established practitioner raises complex questions. General practice covers an enormous field: some good doctors avoid certain areas and concentrate their attention on others. To survey their competence across the whole of general practice may well produce injustices.

The same selectivity can occur in other fields. I have the greatest respect for the efficiency of behavioural techniques in certain psychiatric disorders and send patients off to appropriate experts. I know enough to do this, but my detailed knowledge and clinical skills in the area would produce despair in any reasonable assessor.

There are many assessment techniques to be considered. Direct observation of the candidate at work and the use of simulated patients in the flesh and on videotapes can be illuminating. There is also the expectation, or hope, that ensuring that doctors have a sufficient quantity of CME experience will improve their competence. Perhaps it will for some, but certainly not for all. For example, a recent paper showed that after teams of doctors and nurses educated GPs at randomly chosen medical practices in the recognition and management of depression, GPs could no better recognise symptoms, or aid recovery than those in the control group – although those who had been educated believed that it would be helpful.[2]

Again, and importantly, there can be a significant difference between competence and performance. Eighty-seven GPs in Norway were invited to take part in a study in which standardised patients would present with symptoms of angina pectoris. Only 28 agreed without hesitation to participate, which raises the possibility that they were the ones more confident in their performance. Twenty-four practitioners were chosen; one recognised the pseudo-patient, which left 23 to be assessed. In fact, two patients presented to each doctor with symptoms of angina so it was possible to assess consistency in performance from one patient to the other. There was considerable intra-doctor variation, which raised questions about consistency in day-to-day practice that could not be answered by the data.[3]

This brings us back to the distinction between what doctors can do when they perform at their best and what they can do when they are tired, distracted, anxious or when something else stands in the way of consistent performance. There are, of course, the frankly incompetent and the impaired. Putting them aside, there is no guarantee that a practitioner who passes an assessment procedure will perform at this level all or even most of the time, particularly when no-one is looking. To be quite certain, one would need to have some way of sampling their practice indefinitely, which raises some very serious problems.

These few words are written to praise those who devote time and effort to the improvement of medical practice and to set out some of the difficulties that confront them.

Dr John Ellard
Editor

A list of references is available on request to the editorial office.

of the recognised burnout indicators: emotional exhaustion, depersonalisation and loss of a sense of accomplishment from work.[7,8] It is logical that GPs experiencing any or all these characteristics are likely to be performing at a lower level than they would be if they were feeling motivated and refreshed, and were finding their work rewarding.

All practitioners are 'at risk', but recognised high-risk categories include: geographically or professionally isolated doctors; those with inadequately managed psychiatric or substance abuse disorders; and those working in situations in which they are likely to experience a high emotional load (e.g. working with abused children or in very disadvantaged populations).

Impacts of poor performance

It is relatively easy to anticipate and document the consequences of impairment in terms of adverse or suboptimal performance

for the patient, the community or the doctor. The doctor whose clinical judgement is impaired by substance abuse or mental illness is likely to come to the attention of colleagues and/or regulatory bodies.

It is harder to assess the impact of underperformance; few statistics exist in general practice to document these outcomes and there have been few studies to estimate the community burden of underperformance.

Medical practice, even when undertaken at the highest standard, will sometimes result in a poor patient outcome. However, a recent incident monitoring study suggests that three-quarters of 'incidents' in general practice are preventable,[9] consistent with studies of adverse outcomes for hospital inpatients.[10] It seems reasonable to postulate that the underperforming GP can be more at risk of such incidents, although no-one has demonstrated a direct correlation. Many adverse outcomes relate to a range of issues that include poor communication, inadequate knowledge and patient dissatisfaction, all of which are potentially more likely if the doctor is not performing optimally. However, other described causes of adverse outcomes such as system failures may or may not be independent of the competence of the individual doctor.

Preventing unsatisfactory performance

As with managing any disease process, primary prevention is likely to be the most cost effective and least personally stressful method of managing underperformance. Attention to one's own emotional and physical health, and monitoring colleagues' health is logical, yet GPs often attach a low priority to their own health needs.

Paradoxically, GPs who allow themselves to become 'burnt out' attending to the needs of patients almost certainly perform at a lower level than if emotionally intact, thereby increasing the risks of subsequent complaints about their standard of health care.

Mental health resources have been developed to support GPs, largely on a State or Division basis. For example, the NSW Doctors' Mental Health Working Party has developed a Doctors' Mental Health Policy.[11] Strategies developed in response to this document have highlighted the need for GPs to adopt the same primary prevention methods that they routinely recommend to patients, including: regular exercise, a healthy diet, adequate rest and regular breaks from work. Most importantly, the strategies recognise the need for GPs to allow themselves to be 'patients' and to have their own GP.[12]

In situations where performance has already been adversely affected, appropriate resources are required to support the doctor to regain optimal performance. Even impaired doctors can, in the main, be supported back to safe practice through interventions such as impaired registrants panels, or their equivalents.[13] For the much larger group of practitioners whose performance is affected, but not impaired, standard diagnostic and management techniques for their problems are needed to achieve the best results.

Allowing distressed doctors to manage their own physical and emotional health problems denies them the opportunity to receive the maximum benefits available to other patients. Equally unfair is the prescription of *ad hoc* and minimal intervention from a well-meaning colleague during a 'corridor consultation'.

Discussion

Any GP's perceived underperformance increases the risk of complaints about their standard of practice, and also increases the risk that they may become impaired. Additionally, GPs are likely to find themselves held accountable to a range of performance criteria by a variety of organisations. Yet, it is not unreasonable for the community to expect that doctors who care for them can demonstrate ongoing competence.

Recent legislative changes in NSW will impact on how doctors who are suspected of 'unsatisfactory professional performance' will be assessed and reviewed (see the box on page 129). Other States may well follow suit. The implications of these changes are that medical boards are increasingly seeing their role as more than simply protecting the public from impaired or dishonest doctors. Demonstrating competency will over the next few years become a universal requirement.

It is therefore essential that GPs and the bodies that represent them ensure that the monitoring and maintenance of performance are core components of ongoing professional education and development programs. How best to assess or monitor underperforming doctors is the next question for the profession, and is outside the scope of this article (see the Editor's comment on page 130).

In instances where performance has already suffered, intensive and thorough interventions are required to support a return to appropriate levels of performance. GPs should ensure that they allow their colleagues to be true patients in a professional consultation environment, and should be aware of resources that they can access including State doctors' health advisory facilities, medical benevolent associations, and impaired registrants panels. MT

A list of references is available on request to the editorial office.

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Forum: The Underperforming GP

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