Assessing the performance of doctors in practice

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Sometimes there are questions about a doctor's practice, and so a medical reviewer is asked to comment on some documents. This is what one reviewer does.

Doctors share the attributes of the general population. That is, most of them are honourable people doing their best all the time, but a few are not. There are many reasons for this, and sometimes patient care can be compromised. Not only does this harm some patients but it reflects adversely on the status and reputation of our profession. The 2000 Readers' Digest survey of 3500 Australians showed that in terms of trust doctors were ranked sixth after pilots, nurses, pharmacists, members of the Armed Services and the police, in that order. There is no sign of improvement.

There are regulatory bodies that have the duty of protecting the public. They take their responsibility seriously and, *inter alia*, turn to the profession for advice about satisfactory standards of care. Generally this comes from individual reviewers. Since I am one of them I believe that I should write about what I do, for it is important that the process should be as public as possible. I should think that other reviewers do much the same, but I shall write in the first person to make it clear that I am speaking only for myself.

You may wonder why a psychiatrist should be chosen to perform such a task. I suspect that there are two reasons. The first is that some of those who need assessment are psychiatrists; psychiatric assessors will need to be involved. The second is that irrespective of the categorisation of the doctor under scrutiny – general practitioner, specialist or what you will – failure to achieve an acceptable standard often arises from psychological problems and disorders of various kinds, and it is an advantage if the assessor has a psychiatric background. There is a possible third reason for using me. I have been in the practice of medicine for almost half a century and in one way or another have personal knowledge of some of its difficulties and imperfections.

Even when it is appropriate, it is unpleasant to make critical judgements about a colleague's behaviour and competence, but patients and the reputation of our profession must be protected and some form of supervision must exist. Below, I set out some of the steps involved in providing an assessment of a doctor's practice.

What may be wrong?

It is useful to consider substandard practice under a number of headings. They are not rigid, precisely circumscribed categories, but they help to direct one's inquiry. There is often some overlapping.

- **Incompetence.** To put it shortly, doctors are required to have a sufficient understanding of what they are doing and to apply that knowledge efficiently. I shall refer to the appropriate standards below.
- **Negligence.** Doctor A botches the amputation of a leg because of insufficient skill; this is incompetence. Doctor B performs a perfect amputation but removes the wrong leg; this is negligence.
- **Improper conduct.** This usually means breaching the professional boundaries – exploiting patients sexually or financially, and the like. Overservicing, accepting a kickback for a referral or recommending a health product for financial gain: all these things qualify.
- **Impairment.** Here the practitioner performs at an unacceptable level because of a personal problem such as depression, misuse of alcohol or drugs, and dementia.
- **Bad character.** The practitioner has obtained a position by inventing a false CV, or has obtained advancement by falsifying research results. The possibilities are numerous.

Human ingenuity being what it is, occasionally there will be aberrant behaviour outside these headings which attracts adverse attention. There are also those who engage in criminal activity, such as defrauding Medicare. They are dealt with in the criminal courts; the issues are usually very clear there.

Some preliminary considerations

Each State has different rules and regulations in disciplinary matters. For that reason I shall not refer to the particular procedures existing in particular places, confining myself to the central issues of assessment.

The assessor must consider whether he or she has an existing relationship with the doctor who is the subject of the complaint. It may be a financial or professional association or a friendship. Again, there may be bias. If I have a firm view that the doctor under inquiry is either a good doctor or a bad doctor then I disqualify myself. One must start from a neutral position.

Next, the assessor must keep his or her role in mind. I find it helpful to believe that my report in due course may be placed before a court or a tribunal that is required to try the issue. It is not my duty to make out a case to achieve a particular

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result; lawyers are trained and paid to do that. My role is to report on the medical issues and let others persuade the tribunal one way or another. In short, my duty is to the tribunal and I am not an advocate.

What are the facts?

It is not my duty to determine the facts. Very often, the complainant will say one thing and the doctor another. There is a great deal of lying in forensic matters. For example, it has been reported that more than 500,000 video surveillance operations are performed each year in Australia. On such videos, I have seen flail arms light cigarettes and people reported to be paralysed running down roads. Doctors have no special skill in discovering the truth; I leave it to others.

Usually I am asked to assume that certain facts are true. I do that, making it explicit in my report that I am accepting that assumption. If later the facts are proved to be otherwise, that in no way demeans me or my report – I did what I was asked to do. If presented with a different set of facts, it is possible to reach quite a different opinion.

In most cases, one has detailed notes from the doctor, the patient and other relevant sources. If a detailed reading of the notes makes the facts that I have been asked to assume untenable then I say so. For example, the doctor's notes may record him or her being in two places at once, or that he or she performed some absolutely impossible task. It will then be the duty of others to sort all that out. Meanwhile, I state clearly the facts that I have assumed to be correct.

If I am not asked to assume a particular set of facts, I decide what my assumption will be and make it explicit.

The documents

To make an assessment, one must have something to assess. Almost invariably this will be documents, often in a substantial amount. In my report, I list the documents I have received so that the basis of my opinion will be clear.

Reading a large volume of material can be a task – there may be hundreds of pages of clinical notes, hospital records, pathology reports and the like. I have to read every word, because occasionally a significant fact emerges in a brief nursing note, a pathology report or a letter of referral. When I have finished with the documents they usually bristle with coloured sticky notes because I cannot keep it all in my head and I need to go back to many points from time to time.

Clinical notes range from the meticulous and thorough through the skimpy and confusing to the nonexistent. There are judgements to be made there.

The limits of my knowledge

I recognise the limits of my knowledge and experience. I have an up-to-date library and I use internet sites such as the Cochrane Library and the US National Library of Medicine. I find it helpful to support my opinion by providing photocopies of articles or pages of books that are relevant to the issue.

Almost invariably I confine myself to my specialty. However, if I find, for example, someone treating acute appendicitis

with aromatherapy I shall report it with an appropriate comment.

Some standards

The standard to be applied is not what I would have done in a particular case, but whether or not the doctor pursued a course that most of his or her competent peers would find acceptable.

Again, my personal views are not a criterion. For example, in a particular case the status of the chronic fatigue syndrome became an issue. I have my own views on that topic, but they were irrelevant. I gave a history of the syndrome, beginning with the definition of neurasthenia in the last third of the 19th century in New York and Boston, its graduation eventually to myalgic encephalomyelitis, and then the statements of the Royal Colleges of Physicians of London and of Australasia that there being no discoverable pathology the term ME was not tenable and that the words 'chronic fatigue syndrome' should be used. I pointed out that the majority opinion was that it was a blanket term covering fatigue from many causes, but that there was a minority opinion, held by some respectable academics, that there is also a specific disorder, which they hope one day will have a specific remedy. The answer required of me was not just what I thought, but what a reasonable survey of the literature would have indicated.

The outcome of the treatment is not an issue. What matters is whether or not the treating doctor performed at a satisfactory level. The patient may have survived unscathed from manifestly substandard care, or may have died in spite of attention of the highest standard.

One must bear in mind the time at which the treatment occurred. Some complaints go back a long way. I have a selection of texts and medication guides that go back over decades. Knowledge of side effects is gained over time. One cannot criticise doctors on the basis of present knowledge and experience if they were treating a patient a decade ago.

The standard of care does not have to be ideal. If it were, there would be few of us left in practice. Again, as I have indicated, it is not my standard, it has to be a standard that would be acceptable to peers and colleagues of good standing. In particular, it is not the standard of the most expert practitioner in that field; but also, the fact that a doctor's care was not at the bottom of the barrel does not make it acceptable.

Writing the report

I am well aware that most of the people who read my report will not be doctors. It is my duty to say what I have to say in plain language and to avoid technical terms and acronyms when it is possible to do so. If some must be used then they must be explained.

I find that it aids my thinking and helps my readers if I use subheadings.

I remember that anything I write is likely to be the subject of cross-examination and may appear on the front page of a large newspaper. I see reports at the bottom of which the authors have written that the report is not to be communicated to a third party, or something of this sort. The regulatory bodies will do everything they can to protect one's confidentiality, but the law must pursue its course and the report is very likely to be made available to all parties if there is a dispute and to appear in the press if the dispute reaches court. It is better to write on the assumption that one's report will become public in due course than to be troubled when it does.

At the end of it all, I proofread the report very carefully because mistakes happen and can be misleading. Then I sign it, to accept full responsibility for what I have written.

Conclusion

To report upon a colleague is a very serious matter. It requires time, thought and a constant examination of one's own processes of judgement. MT