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Individual appraisal for senior medical staff

There is public concern about medical errors. In Britain, the Bristol Inquiry is the paradigmatic example that focuses professional and public attention on the safety of medical interventions. In the US the Institute of Medicine's recent report *To Err is Human: Building a Safer Health System* (1999) was widely seen on both sides of the Atlantic as confirming what most already feared, that medical interventions were accompanied by unacceptably high levels of preventable harms (Barach & Small, 2000). The response to these public concerns has been multifold. In the UK clinical governance was introduced in April 1999, principally to focus attention on continuously improving the quality of clinical care. At the same time, the arrangements for the registration of doctors by the General Medical Council (GMC) was under review and there was an expectation that NHS trusts would bring consultants, who hitherto had been regarded as independent practitioners outside any supervisory system or arrangement, within an appraisal system. It has become clear that this appraisal system will be a component part of the GMC's revalidation of doctors (GMC, 2000). What is clear is that these varying systems are designed to restore public trust by providing an open process, which has the confidence of the profession, management and public alike. In this paper we aim to discuss the historical development of appraisal as a system for reviewing the performance of individual practitioners, suggest a method for appraising senior medical staff and finally to discuss the limitations and problems inherent in the introduction of such a system.

Appraisal systems were introduced into large organisations in recognition of the need to assess the performance of individual members of staff, although the actual aims of the systems and the processes used have varied considerably. A survey conducted for what is now the Chartered Institute of Personnel and Development (CIPD) in 1986 found that the vast majority of employers operated performance appraisal schemes and that these were used to review the past performance of individuals and to set future objectives. In addition, the employers reported that the appraisals were intended to help improve performance through the identification of training and development needs and to assist with assessing future potential and with career planning decisions (Hogg, 1988). Although this may suggest that these employers, including both private and public institutions, were using appraisal schemes for developmental purposes, it is significant that 40% of the schemes in the survey were being used as part of performance-related pay arrangements. This is not surprising given that the word appraisal derives from old French, meaning 'to prize'. There are obvious problems with any appraisal system that links a review of performance with pay. It is likely that failures in performance will be underplayed in order to protect pay and so are unlikely to be addressed in such a way as to improve future performance. These same issues will apply when linking a review of performance with a punitive managerial system for managing poor performance.

Further investigation by the CIPD in 1991 and 1998, respectively, revealed that appraisal was a top-down process, involving the setting of objectives and the review of results against such goals, with a heavy reliance on weighting scales. By 1998 performance management had shifted to include an examination of how things were done with one-third of the organisations involved in the survey quoting assessment of competence as a component part of appraisal. Best practice organisations had adopted a comprehensive approach, providing comprehensive training in appraisal for managers and treating appraisal as a joint process between managers and the individuals undergoing appraisal (Armstrong & Baron, 1998).

The question is now how to apply techniques developed outside medicine to review the practice of senior and independent practitioners. It is recognised that there are increasing demands on senior medical staff both in terms of the volume of clinical work, as well as their responsibilities to trainees, and the running of their local health care organisations. These changes inevitably mean that there is a need for training and development. It could be argued that appraisal may have a role in establishing individual development needs. In the current climate it is likely that appraisal will be seen by the public as a mechanism for identifying poor performance with a natural expectation that the individuals so identified will be weeded out. Once we acknowledge that this approach is prominent in the public mind, it becomes clear that appraisal cannot be solely for providing positive support for the development needs of doctors. This point is implicitly acknowledged in the Department of Health's consultation paper *Supporting Doctors, Protecting*

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Patients (1999). The document found it necessary to reassure doctors by stating: "It is not the primary aim of appraisal to scrutinise doctors to see if they are performing poorly but rather to help them consolidate and improve on good performance aiming towards excellence." (Department of Health, 1999) Whatever the reassurance given in that document, it is indisputable that there is public expectation that appraisal will provide a formal system for identifying poor performance and action will be taken. The trick will be to ensure a positive focus while at the same time minimising the negative connotation of appraisal.

Appraisal in practice

It is important to be certain of what we mean by appraisal before putting it into practice. We wish to distinguish appraisal from assessment, peer review and mentoring. These are all related terms, but in our view are quite distinct from appraisal. Assessment usually involves making judgements about individuals against defined criteria. Peer review is a process by which people of equal standing consider the competence of one another. Mentoring is an arrangement whereby a voluntary, informal relationship is the basis for examining one's own personal development needs. The British Association of Medical Managers (BAMM, 1999) has defined appraisal as "the process of periodically reviewing one's performance against the various elements of one's job". This definition emphasises the fact that appraisal refers to a person's performance within a defined role that may comprise a multiplicity of tasks and responsibilities.

The expectation is that appraisals will be held annually between the medical or clinical director and consultants. There will be some form of paperwork to provide both parties with an opportunity to identify and consider relevant issues beforehand. Typically, consultants might wish to have their clinical resources and responsibilities considered, together with their contribution to teaching, research, professional activities and trust management. It may be necessary to have data in certain areas that would provide some objective measure of consultant workload (Fig. 1). Some trusts have gone further and have identified workload norms or standards in particular areas of responsibility so that the consultant's standard can be reviewed in the light of his/her peers' activity or predetermined targets. The framework will usually require review of the role, performance over the past year and plans for the forthcoming year. A private meeting between the medical or clinical director and the consultant will be convened and the outcome recorded in writing and signed by both parties. This document will form the personal development plan.

In addition to the areas that are covered in Fig. 1, there is a suggestion that other competencies may also be of interest. These include consideration of the breadth of the awareness of the structures, processes, policies and politics across services; decisiveness and judgement, including the ability to review information objectively; drive and direction; integrity, insight and team-working; and the ability to cooperate with others (Goodson-Moore *et al*, 2000). The suggestion is that clinical performance and these other competencies may be evaluated by questionnaires completed by other people with whom the consultant works in the so-called 360-degree appraisal. This approach has the attraction that a comprehensive view of the consultant's skill and style is gained. This is similar to the BAMM approach. BAMM suggest that appraisal should be 'three-angled', incorporating information from the individual doctor, his or her peers or team members and his or her patients. There is an expectation in the BAMM approach that the domains of performance, which should be the focus of appraisal, should be: clinical performance, attitude and effectiveness, personal development, continuing development and teaching/research effectiveness. The approach of utilising information from a wide array of sources is sanctioned in the GMC's consultation document *Revalidating Doctors: Ensuring Standards, Securing the Future* (GMC, 2000).

Problems and limitations

In order for appraisal to work, consultants must feel that the content of their discussion with medical or clinical directors is confidential. We recognise that the public expects a process that is open to scrutiny, but we believe that a confidential discussion is more likely, in the long run, to lead to improvements in clinical care. In our view, this means that even if a system of appraisal forms part of the revalidation process demanded by the GMC, it should only be a requirement that a consultant participates in an appraisal system rather than the content of the discussions being open to the GMC. This may mean that an independent scrutiny of the rigour of the process may need to be conducted on a regular basis in order to assure the public that the process is safe.

We believe that appraisal is time and labour intensive. Thus, there are significant resource implications. medical and clinical directors will need to be properly trained to conduct appraisals thoroughly, fairly and consistently. Furthermore, in a trust that employs 40 consultants, and with an estimated 1 hour to prepare for an appraisal and 1 hour to meet with the medical or clinical director, this would mean that 160 working hours would be required to fulfil the most basic expectations. This does not include the administrative time required to produce data and facilitate the process. Of course, all of this activity is occurring at the same time as the demands on clinical time are increasing. Appraisals would be worthless if the identified training and development needs do not naturally lead on to action plans. Even using a conservative estimate that in a trust employing 40 consultants half of these consultants are required to attend a refresher course on suicide and homicide risk assessment, which is arranged in-house for half a day, the immense time and financial implications are all too clear to see. As far as we know, there is very little discussion of these matters within government circles, nor is there any recognition of the financial implications.

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In view of our concerns about the resource implications of appraisals, a fundamental question is whether it works or not and indeed whether it is cost-effective. There is little empirical work examining the benefits of appraisal systems. Generally speaking, appraisal is usually introduced as an unarguable good. The survey of private and public institutions by the CIPD attempted to see whether performance management was well correlated with organisational effectiveness, including financial results, skill development, customer care and quality. Although over 90% of managers rated performance management as moderately or highly effective in a qualitative way against these criteria, no statistical correlation was found. This is not to argue that there should be no formal mechanisms for evaluating performance but, rather, it should be viewed as only one of a number of mechanisms for improving the quality of clinical care (Armstrong & Baron, 1998).

Traditionally it has been understood that consultants are wholly independent practitioners and they have not been in a supervisory relationship with respect to their clinical practice within their employing organisations. With the introduction of clinical governance it has become clearer that the consultant within the NHS is more firmly wedded to the organisational goals of his or her employing organisations. An appraisal system may, by implication, and without much discussion, suggest that consultants are now not just accountable for their clinical decisions and actions but are also in a hierarchical clinical supervisory relationship with medical or clinical directors. We believe that it would be inappropriate for there to be such a supervisory relationship between consultants and medical or clinical directors. It is inevitable that such an arrangement would infantilise senior and competent individuals and would ultimately harm the self-respect, self-esteem and professionalism of highly trained people. It would do no good for patient care. It is also patent that given the complexity and highly specialised nature of modern medicine, there could not possibly be enough medical or clinical directors who would be sufficiently clinically competent to supervise the work for all other consultants. In any case, it would be imprudent for any individual who is distant and detached from a live patient and who does not have clinical responsibility, nor is accountable for that patient, to be providing supervision for someone actively taking clinical decisions. It would be a case of authority without responsibility.

A high quality of clinical care and the safe practise of medicine are self-evidently desirable and an appraisal system, in conjunction with a number of other measures, may help to ensure a culture in which competent and reflective practice is the norm. The danger is that too much will be expected of appraisal of senior medical staff. Many clinical mishaps are undeniably tragic but it is equally true that clinical error, as a class of events, is undeniably inevitable. One can already predict that in the future a doctor who has been successfully appraised over a 5-year period and subsequently revalidated by the GMC will be involved in some clinical mishap. It is important that the public and politicians alike be forewarned of the danger of having unrealistic expectations of the health

(a) Clinical responsibilities
- Up-to-date job description
- Up-to-date job plan
- Medical, ward and community resources
- Clinical statistics for previous year:
  - Domiciliary visits
  - Out-patient attendances
  - In-patient admissions and discharges
  - Detentions under the Mental Health Act 1983
  - Patients on standard and enhanced levels of the Care Programme Approach
  - Medical complaints
  - Clinical litigation
  - Suicides
  - Homicides

(b) Clinical audit
- Details of participation in clinical audit and results

(c) Teaching
- Details of teaching

(d) Research
- Title of current research projects and progress
- Titles of publications including conference posters, length, publishing journal/conference
- Grants etc. applied for, including title of project, value of application, length of project, funding body, outcome of application

(e) Trust administration/management
- Committees

(f) Other professional activities
- Course organisation
- Committees
- College/General Medical Council
- Others, including editorial boards

(g) Continuing professional development (CPD)
- Details of CPD for previous year (CPD letter from Royal College of Psychiatrists)

Fig. 1. Framework for individual appraisal and personal development plan for medical staff

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care process, as well as of administrative processes such as appraisal of consultants.

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Approaching employment

Mental health, work projects and the Care Programme Approach

Most people with severe mental illness (SMI) may now live in the community, but few have jobs and many are socially isolated. Unemployment rates for people with serious mental health problems range from 60% to nearly 100%, and are particularly high if people have additional disadvantages in the labour market – being a member of an ethnic minority, having poor educational and employment history or possessing a criminal record. Unemployment is a cause of poverty, physical and mental ill health and is a cost to the community. Paid employment is central to human health and offers financial, psychological and social benefits to people with mental health problems: an income not derived from benefits, social contacts, a social role other than that of psychiatric patient, psychological recovery and possibly symptom reduction. These psychosocial and health gains may follow from any work – paid employment, low paid or unpaid work, training or education. Many mental health service users want jobs and alternatives to welfare dependency and traditional day centres. The Government wants to improve health and to reduce welfare spending and social exclusion. For deinstitutionalisation to achieve social integration and employment as well as relocation there is a need for a range of actions; public psychoeducation, political reform and development and research of modern alternatives to sheltered work and industrial therapy.

This high unemployment is as much a product of social factors – discrimination and stigma, organisational policies and practices, the regulations of the benefits system and the economy – as of the personal consequences of mental health problems. Most employers and employees are not yet ready to work alongside people with mental health problems and modern organisations may be technologically demanding and stressful, themselves a cause of ill health. Mental health professionals may discourage or ignore employment needs. The social security system, while central to the well-being of unemployed people with disabilities, traps them with 'penal levels of means testing', making it difficult to return to anything but well-paid jobs, and precluding part-time earnings above a token allowance (Bray *et al*, 1997). The local and national labour markets, economic cycles and cultural factors all have powerful effects (Warner, 1994).

The Government is using a combination of anti-discrimination legislation and reform to the welfare, tax, employment and health systems – in a context of (and probably dependant on) economic growth with relatively low unemployment and high job availability. The Disability Discrimination Act 1995 requires employers to make 'reasonable adjustments' to jobs and work places and has recently been reinforced by the Disability Rights Commission. This is combined with wider anti-stigma campaigns – as in the Department of Health's *Impact* (1999). There is an evolving process of change to the tax–benefit system and to employment services, with a number of pilot – and as yet, unevaluated – schemes including the New Deal for Disabled People, the Disabled Persons Tax Credit and the ONE service, which provides a "single gateway to benefits . . . a personal adviser . . . (and) a work focused interview" (Department of Social Security, 2000). The National Service Framework (NSF) for Mental Health (Department of Health, 1999) states that:

> "An appreciable number of (mental health) service users may . . . need help to access employment, education and training, and some at least will be able to obtain and sustain work."

The NSF notes the importance of work to the wider community of people with mental illness, including those using primary services, and requires action within the

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