Doctors' behaviour and performance

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Adverse events have always occurred in healthcare but some high-profile cases over the last few years have led to greater public scrutiny than ever before. Such events may result from problems in clinical practice, products, procedures or systems; attention, however, has focused largely on healthcare workers, and especially on doctors – perhaps in tacit recognition of their leadership role within the field. The performance of doctors – their knowledge, skills, health and behaviour – is firmly in the public eye and therefore on the agenda of their professional organisations and the relevant regulatory bodies.

Patient safety is, and always has been, a fundamental principle of patient care but is now seen as the highest priority. Indeed, it is now acknowledged that health services have the right to know if there have previously been problems or concerns related to an individual doctor's performance or behaviour that could affect patient care. This is a major shift in attitude from the time when doctors' practice and behaviour were rarely challenged, if ever, and has led to new responses from the medical profession and the health service in many countries, including a much more frank discussion and appraisal of the causes of poor performance.

It seems obvious that doctors' health may affect their performance and this subject was discussed in the July 2005 issue of *International Psychiatry* (number 9). However, poor performance can also result from other factors, including the personal characteristics of doctors and the context in which they are working. These factors are often interrelated (National Clinical Assessment Authority, 2004).

As in many other areas, stress is often cited as a major underlying cause of poor performance and studies have shown that stress levels among doctors and other healthcare workers are higher than in the general population, with about 30% of doctors suffering from stress at any one time (Firth-Cozens, 1995; Paice, 2000). This is probably related to the fact that, from undergraduate days onwards, doctors are encouraged and trained to perform a multitude of tasks to a consistently high standard. Admission of tiredness or difficulty in coping can be perceived as failure, which discourages them from disclosing problems; this in turn contributes to an increasing sense of isolation. Long hours of high-intensity work combined with decreased time to sleep also increase stress. Other factors perceived to be responsible for stress are difficulties in maintaining a balance between career and personal life, fear of making mistakes, fear of litigation, difficulties in hierarchical professional relationships and difficulties in dealing with patients (Firth-Cozens, 1995). Although some groups are considered to be more vulnerable than others, stress among doctors is not restricted to specific specialties or career levels. For instance, doctors within their first year of practice and female doctors tend to exhibit high levels of psychological morbidity (Paice, 2000; Graske, 2003).

Most of the stressful factors which doctors have to handle are common and frequent and, although they may have a significant impact on performance, it is important to consider also the personality characteristics that may affect performance and that may interact adversely with stress. For example, doctors' work culture promotes perfectionism and self-criticism, which are in turn predictors of stress and depression. Together, such factors may affect performance.

A survey of UK postgraduate deans demonstrated that, out of 80 trainee doctors in difficulty who had come to their attention, 34 had presented with 'poor performance'. Of these, substance misuse was the triggering problem in 11 cases and four doctors were described as having personality disorders that led to unacceptable interpersonal conflict (Paice, 2000). Similarly, in a study of doctors referred to the UK's General Medical Council Health Committee from 1980 to 1996, it was found that 12% had personality disorders (Morgan *et al*, 1999): they had deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations. Typically, those with personality problems are significantly different from the average individual in a given culture in the way they perceive, think, feel and relate to others.

If it is acknowledged that personality difficulties can contribute to poor performance, it makes sense to consider an individual's personality at the point of entry to training for the profession. Clearly, medical schools have to be careful to maintain equality of opportunity and not to breach applicants' rights, but at the same time many of the problems exhibited by poorly performing doctors have been apparent since medical school days. Firstly, it is worth noting that early childhood experiences are thought to contribute to the choice of becoming a healthcare professional, with emotional neglect in childhood being a notable example. Similarly, there is some evidence to suggest that traumatic childhood experiences such as parental divorce and maternal death are associated with higher stress levels and even increased misuse of substances among doctors (Vaillant *et al*, 1970; Firth-Cozens, 1992).

Developmental conditions such as conduct disorders, personality disorders and Asperger syndrome may

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be present when students are selected for medical school but only later manifested as sustained abnormalities of social behaviour – unmasked perhaps by the absence of structure in comparison with life at school or in the parental home, rather than by any direct stress of university life. It is true that prospective medical students are subjected to a variety of selection procedures but most medical schools around the world offer little in the way of screening for significant personality and behavioural problems. It is therefore possible, and indeed probable, that vocational medical courses accept young students who may not have developed sufficient personal maturity or strength to deal with the rigours of medical training. It is also true that trainee doctors may have to take on considerable responsibility at a comparatively young age and that many find this difficult.

In recent years there has been a growing emphasis on the importance of doctors having good communication skills and this is now addressed within the medical school curriculum. This is important in terms of communicating not only with patients but also with colleagues. A stressful working environment combined with a communication style that others find difficult frequently leads to problematic working relationships that contribute to impaired performance. Often the individual concerned lacks insight and while colleagues may recognise that someone is difficult to work with they may not be able to pinpoint the specific underlying problem. It is only when an adverse event occurs that everyone acknowledges that damaging interpersonal behaviours may have played a major role. However, for the sake of patient safety, such issues should not be allowed to smoulder indefinitely.

Early recognition of patterns of behaviour which may indicate that a doctor is struggling in work is of paramount importance.

The General Medical Council's guidance *Good Medical Practice* (2001) states that 'all patients are entitled to good standards of practice and care from their doctors. Essential elements of this care are professional competence; good relationships with patients and colleagues; and observance of professional ethical obligations'. In *Good Psychiatric Practice*, the Royal College of Psychiatrists (2004) identified a number of core attributes for practitioners, including 'a critical self-awareness of emotional responses to clinical situations' and 'being aware of the power inherent in the role of doctors and its potentially destructive influence on relationships with colleagues in other disciplines, with patients and with carers, and respecting boundaries'.

It follows that, if there are serious concerns about a doctor's competence and behaviour, there need to be clear routes for assessment. Early recognition of patterns of behaviour which may indicate that a doctor is struggling in work is of paramount importance. However, a strategic approach to prevention will also be important. In a study of over 50 cases referred for poor performance, the National Clinical Assessment Authority (2004) in the UK identified wider, systems issues. These included undergraduate and postgraduate training, workload, team function and handling stress. Studies of this type are invaluable in identifying what contributes to a competent and well performing doctor being derailed from good practice and good delivery of care.

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THEMATIC PAPERS – INTRODUCTION

Recruitment into psychiatry: a medical student perspective

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To ensure a successful future for our profession, we have to attract young enthusiastic doctors to take up residencies in psychiatry, but there have been murmurings of disquiet in recent years that we are not being as successful as we might, or as we should. We have taken soundings for the theme of this issue: why do too many medical students not consider psychiatry as a career choice? We bring

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