

Health and probity in appraisal: what do you ask?

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Introduction

During my time as an appraiser in North Lambeth for the last two and a half years, I have grown increasingly uncertain about addressing the “Health” and “Probity” sections. This is because I believe that as appraisers we do not have a uniform approach, and I have heard that these “tail-end” areas can be treated with scant respect. “Are you in good health?”, “Yes”, seems a common appraisal conversation, with “No issues of concern; no action required” a standard appraisal summary record. I felt that we were missing an opportunity. Probity seemed similarly unclear. I discussed my thoughts with Dr Clare Gerada, who at that time was a Director at the NHS Clinical Governance Support Team (CGST). She agreed to act as a my sponsor for my Study Leave project. The CGST had already produced their own document about evidence for revalidation (*Defining the evidence for revalidation*) and agreed that “Health” and “Probity” were worth addressing in greater detail. I undertook the project over a 12 week period in the summer of 2005 (full-time out of surgery) My funding came partially from PSL funds, the rest of my locum replacement costs being personally met by me.

Aim of project: to address the two GMC *Good Medical Practice* areas of “Health” and “Probity”, and develop some ideas as to how these issues could be approached within the Appraisal process.

My initial intention was to give structure to facilitate the appraisal process, but it became clear as I began that many doctors actually thought that their health should not be discussed within appraisal. I therefore also addressed the issue of whether it was appropriate to discuss health in a process that had a potential link with revalidation.

Methods:

Literature Search.

I rejoined the RCGP at the start of this project, and made use of their library and staff. This was very helpful, and I will now continue to be an active member!

The librarians kindly performed a literature search for me, which I can forward to anyone who is interested, but basically there was not much on this topic other than the documents listed below, which had already been recommended to me by Dr Maurice Conlon, the appraisal lead for the NCGST.

I read the following documents/literature

GMC Good Medical Practice

RCGP Good Medical Practice for GPs

RCGP Draft Revalidation Portfolio

CGST Defining the Evidence for Revalidation

The Shipman Report (particularly Ch 26, but other bits aswell)

Professor Mike Pringle's John Fry lecture on Revalidation.

NCAA Factors that can affect performance

The Picker Institute's Ideas for the CMO's Review of Medical regulation.

NMC Guidance: requirements for evidence of good health and good character

Medical Council of New Zealand : Doctors' Health.

Doctors as Patients (Petre Jones)

Appraisal for the Apprehensive (Ruth Chambers)

What Stress in Primary Care ? (Ruth Chambers)

Questionnaires related to health factors eg HADS, AUDIT, GHQ

Gathering views: Interviewing the experts

I met with or had e-mail discussions with the following people:

The NCGST (with lots of ongoing support from Drs Martin Shelly, Nick Lyons, and Maurice Conlon).

Professor Mike Pringle (Professor of General Practice, Nottingham)

Professor Roger Jones (Wolfson Professor of Primary Care, Kings, Guys, St Thomas')

Dr Tina Ambury (ex Appraisal Steering Group and non-principle)

Jock Lowe (ex Concorde pilot and member of the CMO's Call for Ideas

Revalidation/Shipman enquiry.

Patricia Moberly (Chair of Guys and St Thomas' Trust and GMC member)

Amanda Watson (GMC)

Dr Michael Wilks (Chair of BMA Ethics Committee)

Dr Dianne Aitken (Medical Director and Clinical Governance Lead, Lambeth PCT)

Dr Mayur Lakhani, (RCGP Chair)

Fiona Ross,(director of Nightingale School of Nursing)

Professor Pauline McAvoy (NCAA)

Dr Kishor Vasant (Southwark GP who has completed some research into appraisal)

My local appraisers group

Edgecombe Training

Doctors' Support Network (Dr Lizzie Miller)

Dr Jane Marshall, consultant Psychiatrist, The Maudsley Hospital, with particular expertise in caring for sick health professionals.

Professor Woody Caan (Prof Public Health APU, Chelmsford...he is planning a health needs analysis of GPs)

Dr Julia Whiteman (London Deanery)

Phil Johnson (Editor of Pulse)

The Appraisal Toolkit Website administrators (Newcastle)

Sir Liam Donaldson (CMO) (not a discussion, but to tell him what I was doing, ask him if he wanted any input, and feed back of conclusions)

Dr Mike Peters (Doctors for doctors, BMA)

Gathering views: Interviewing local colleagues.

I began with a brief questionnaire to a sample of 10 GP appraisers, 3 from my local appraiser group, and 3 from neighbouring areas. I asked them if they currently had a clear structured approach to the health and probity sections, whether they had an almost 100% understanding of how to appraise health/probity, and whether they would like more guidance in these areas. I also tacked on a question about whether they would be happy to continue as appraisers if the whole process changed from summative to formative (just out of curiosity!)

It transpired that half of us did have a structured approach (half did not). Most felt that they did not have a 100% understanding of how to appraise health and probity. 90% said they would welcome more guidance in these areas. Most appraisers would continue in their roles, even if there was a switch to a summative process.

I then interviewed 13 GPs. These were mostly LSL GPs, all of whom had been appraised at least twice. Some were appraisers themselves, most were not. I believe them to be representative of my colleagues. One is single-handed, one a non-principle, and there was a racial and sexual mix.

I asked the following questions:

1. Is the current approach to health (in appraisal) satisfactory?

- I asked them to consider their own experiences, and any comments they had heard from colleagues, or any concerns they had about colleagues.

Answer: Most people felt that the current approach to health in appraisal was not satisfactory. The general feeling was that at present the lack of structure makes the section meaningless. It is a wasted opportunity.

2. Can we trust doctors to self-declare their health ?

- The RCGP has asked for a self declaration for "evidence"

Answer: There were mixed feelings as to whether doctors could be trusted to self-declare. The overview was that doctors who had a drug or alcohol problem would

not self-declare this, but that as we are professionals we understand and must accept the consequences of lying in this situation.

3. Is it appropriate for an appraiser to be asking health questions, other than asking for a self-declaration?

1. Answer: It is appropriate for an appraiser to ask about stress at work and work-life balance, but not appropriate for them to perform a “policing” health assessment.

4. If not an appraiser, then who should do a health assessment ?

Answer: Only an Occupational Health Physician or possibly the appraisee’s own GP is in a position to perform a formal health assessment.

5. What is an appropriate health assessment for fitness to practise for someone who is not already a “cause for concern”?

Answer: It would be a waste of resources to perform regular Occupational Health checks on all doctors. A self-declaration should be enough. Many doctors would be happy to subject themselves to drug/alcohol screening if required, and perhaps a 360-degree assessment by colleagues could be helpful.

6. Would you like more guidelines about probity issues?

2. Answer: Most people wanted more guidelines about probity issues. It was felt that the GMC should offer more detail and tailor this for different disciplines.

Gathering views: The power of the press: *PULSE* Questionnaire

It became increasingly apparent that health was an emotive issue. After reading *Doctors as Patients*, I became aware of the Doctors Support Network, and had some detailed e-mail correspondence with one of their members. It is clear that most doctors who have had health problems feel strongly that their health is nothing to do with appraisal. They state that: health does not have to be a performance issue; doctors as patients get a raw deal; appraisers are not trained in occupational health; there are confidentiality issues.

My interview group was small (qualitative not quantitative evidence) and my study time was brief, so I hijacked the press and asked the editor of Pulse (Phil Johnson) if he would help me. He kindly agreed to do a questionnaire about appraisal, and to include a question as to whether GPs felt it was an appropriate subject for appraisal. His questionnaire covered other aspects as well, and I can give the full results to anyone who is interested, but for the purposes of my study the interesting result is that (out of 200 responses) *54% of GPs felt that appraisal was not an appropriate environment to discuss their health, and 16% felt strongly about this.*

Discussion and suggestions

“Evidence” versus “non-evidence”

The NCGST (my sponsors) believed strongly that there are 2 components to Health and Probity. There is “*evidence*”, which is documented, evidence based information that can/will be required for revalidation, and there is a private, softer, grey area appropriate for exploration in an appraisal interview, but not to be documented for revalidation. I refer to this as “*non-evidence*”.

Both the NCGST and the RCGP have produced their own ideas for “*evidence*”, which is essentially to wait for a decision from the GMC on what form of self-declaration might be acceptable. I therefore decided to concentrate mainly on the appraisal interview (the “*non-evidence*” area) and explore what subjects for discussion around health and probity might be helpful.

I need to state at this point that it is my strong impression from my interviews with practising clinicians that an appraiser or an appraisal interview can not be used to produce evidence of good health (with regard to fitness to practise). Apart from the confidentiality issues, appraisers are not trained in Occupational Health. Doctors seem likely to resist an assessment of their health (if it is to be used as evidence of fitness to practise) from anyone other than their own GP or an Occupational Health Doctor.

Health in Appraisal

General points:

Doctors are at risk of certain health problems (stress, anxiety, depression, dependency).

We work in an NHS environment of constant change. This is at best challenging and potentially stressful and unsupportive.

Doctors are notoriously bad patients and traditionally self-medicate (a path to dependence) and self-refer (a path to inappropriate and sometimes inadequate treatment).

Many doctors do not have access to a good occupational health service. Many doctors would like such access.

“*Non-evidence*” for health

Actual evidence of good health cannot be obtained from an appraisal interview (other than the receipt of a self-declaration). However, looking at it positively, the appraisal interview is an opportunity for a trained supportive appraiser to explore health issues with appraisees, and maybe help prevent health problems. It is an opportunity to flag up risk factors and offer signposts to resources (e.g. support groups, mentors, etc.).

The preparation for appraisal is an opportunity for doctors to reflect on their health and stress factors, and perhaps a good time to perform self assessment (e.g. Hospital Anxiety and Depression Score, General Health Questionnaire, AUDIT (alcohol questionnaire)). Perhaps these could be attached to the Appraisal Toolkit website, with attached pathways to help if needed)

It is important that health discussion within appraisal is seen as supportive, not punitive. Appraisers need great sensitivity. The appraisee needs to feel safe, and to trust in confidentiality.

I have drawn up a list of areas that I believe to be relevant to health and performance, suitable for discussion in appraisal (See Box 1). I have used evidence from various sources, particularly *Factors that Affect Performance* from the NCAA, and other publications about doctors' health. I think it could help if appraisers used these as guidelines.

I have met with team members of the Appraisal Toolkit (www.appraisals.nhs.uk), to suggest that they incorporate some self-assessment questionnaires in the site, and guidance on suitable areas for discussion in the appraisal. They are supportive and the ideas will be piloted.

Box 1 “*Non-evidence*” topics suitable for discussion under “Health” in appraisal.

1. Are you registered with a GP?
2. Have you attended your GP in the past year?
3. Have you self-prescribed in the past year, or asked a colleague to prescribe?
4. Have you bypassed the normal NHS referral process in the past year?
5. Do you have a chronic illness?
6. Are you in pain?
7. Have you had a recent bereavement?
8. Are you experiencing stress at work or elsewhere? (include an enquiry about excessive workload).
9. What are your coping strategies for stress?
 - a. Do you actively self-care and consider work-life balance?
 - b. Do you have adequate holiday and study leave (and do you actually take this entitlement?)
 - c. What is your network of support at work and outside work?
(Consider friends, colleagues, mentors, support groups)
10. Are you involved in a complaint?
11. Are you sleep-deprived?

“*Evidence*” for health

As stated above, this cannot come from the appraisal process.

Either it has to be a self-declaration (as suggested by the RCGP and NCGST) or it has to be an *assessment*, by an Occupational Health doctor or the appraisee's own GP.

There is some doubt as to whether doctors can be trusted to self-declare, but as professionals we understand the consequences of a false self declaration.

Documentation about Hepatitis B status can be produced to supplement health evidence. A 360-degree colleague review may add evidence to a self declaration, provided it includes validated questions relating to health.

Probity in appraisal.

Again, this is an area where doctors stated they would like more guidance, but the feeling is that an appraisal is unlikely to uncover a lack of probity if a doctor is already knowingly practising in a dishonest way.

“Non-evidence” for Probity

Some potential “grey areas” appropriate for discussion in appraisal are:

- Ethics of working with drug reps (All doctors)
- Ethics of referring to alternative practitioners (All doctors).
- How/whether to tell patients which local pharmacy to visit (Primary Care clinicians).
- Doctors receiving gifts from patients (All doctors).
- Teaching issues e.g. having school children doing work experience, how much responsibility to give medical students (All doctors).
- Conflicts when interests of the PCT/Trust (or wider NHS) conflict with what is best for individual patient care (All doctors).
- Partnership issues e.g. cheque signing, salaried versus profit sharing (Primary Care clinicians).
- Sickness certification.

“Evidence” for probity

This is similarly problematic for probity as for health. The GMC is expected to produce a self-certification template. It remains to be seen how this will overcome the obvious concern that a doctor acting in breach of probity is perhaps more likely to make a false self-declaration.

Conclusion

The many communications and conversations I had during this brief sabbatical project confirmed the complexity and delicacy of the subjects of health and probity as these relate to doctors. Negotiating them at all is an anxious enough business for most , more so with the added concern that the findings could contribute to a decision on fitness to practise, through revalidation.

Nevertheless, I believe there is value in exploring health and probity matters in private, protected appraisal, and hope my “prompt lists” will be of help to appraisers and appraisees who are prepared to embark on such themes. I know my project was undertaken in the context of Primary Care. I hope nevertheless that it will have resonance and relevance for doctors in other sectors too.

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