THE NATURE OF POOR PERFORMANCE

An analysis of cases referred to the General Medical Council following the introduction of the Performance Procedures

Charles Vincent and Maria Woloshynowych

Charles Vincent
Professor of Psychology

Maria Woloshynowych
Research Fellow

Clinical Risk Unit
Department of Psychology
(1-19 Torrington Place)
University College London
Gower Street
London WC1E 6BT
Introduction

In July 1997 the General Medical Council (GMC) introduced the Performance Procedures, to allow assessment of a doctor's clinical competence. Where there is evidence of very poor performance a doctor may be referred by the employer or authority responsible for their work, or by direct referral from a colleague or member of the public. The GMC has a responsibility to assess a doctor whose performance may be deficient and take action as necessary. However the GMC also wishes to achieve a greater understanding of the nature of poor performance, of the methods used to tackle poor performance locally and the reasons for the eventual decision to refer to the GMC. A greater understanding of these issues should enable earlier identification of these problems, which would be of benefit to doctors and patients alike. The study reported here examines the nature of poor performance in 50 doctors referred to the GMC between July 1997 and March 2001.

Background

The career of a doctor who is referred to the GMC Performance Procedures can be considered in three broad stages: (a) Local handling of poor performance prior to referral; (b) screening and assessment of performance, where appropriate, by the GMC; and (c) subsequent career following decisions taken by GMC. Few referrals were received in the first years of the Performance Procedures and as yet comparatively few doctors have completed an assessment.

The initial referral of a general practitioner is usually made by their Health Authority, while hospital doctors are most commonly referred by their employing NHS Trust. Typically a letter is received summarising the main problems, with some account also given of local attempts to resolve the various issues. Often, but not invariably, the letter is accompanied by reports of investigations carried out locally, complaints that may have been investigated and, on occasions, by the reports of independent experts from outside the health authority.

When a referral is received by the GMC it is initially assessed by a senior doctor (the screener) who makes a series of judgements about the nature of the evidence provided and decides whether there may be reason to formally assess the doctor. The screener records their assessment in a standard manner, relating the information they have reviewed to the GMC's core standards of good medical practice. The GMC may ask for clarification or further information from the referring agency at any stage. Ultimately a substantial dossier of information is available on most cases.
Methods used to examine the information

In this initial study we examined the first 50 cases available which had reached the screening stage and been judged as requiring assessment in the performance procedures. We examined the first 25 general practitioner cases and the first 25 hospital doctors. Doctors who had been referred but who had then decided to retire or who were subsequently referred into the conduct or health procedures were not included. We first extracted the core documents from the dossier of information on each case. These were (a) the letter of referral, (b) the report of the screener, (c) any reports of formal investigations carried out into the doctor's performance prior to the GMC and (d) any additional letter or document describing the local handling of poor performance. We did not re-examine core documents, such as patients' case notes, relying instead on the conclusions of formal reports and the judgements of the screeners. The GMC's own database provided information on the doctors' qualifications and career history.

Cases were examined for

- Events and circumstances that triggered referral to GMC
- Local methods of handling poor performance.
- Involvement of other organisations and bodies (e.g. Health Authorities, Royal Colleges)
Career, qualifications and referral

Most referrals were made by health authorities, in the case of general practitioners, or hospital trusts in the case of hospital doctors. Referrals also came from the general public, other doctors, local medical committees, newspaper reports and solicitors. A number of specialties were represented in the group of hospital doctors: surgery (8), obstetrics & gynaecology (6), anaesthetics (3), psychiatry (2), medicine (2) ophthalmology (2), paediatrics (1) and radiology (1). Thirteen of the doctors were consultants, six registrars, two senior house officers and the remainder staff grade appointments and other posts. At least 11 hospital doctors were locums, but this information is not always provided by the referrer, so this could be an underestimate. Only one general practitioner appeared to be acting as a locum.

There were some clear patterns in this early group of doctors referred to the GMC. However it is important to realise that the doctors referred first will be those with longstanding problems, and that that a different picture may emerge in the longer term. Table I summarises the most important patterns emerging.

Table I Characteristics of doctors referred to GMC

<table>
<thead>
<tr>
<th></th>
<th>General Practitioners</th>
<th>Hospital Doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Almost all male (24/25)</td>
<td>Majority male (21/25)</td>
</tr>
<tr>
<td>Date of qualification</td>
<td>Majority (64%) qualified before 1970</td>
<td>Varies widely - no clear pattern</td>
</tr>
<tr>
<td>Place of qualification</td>
<td>Majority (76%) qualified abroad</td>
<td>Majority (80%) qualified abroad</td>
</tr>
<tr>
<td>Referral</td>
<td>Most (64%) referred by health authorities</td>
<td>Most (64%) referred by hospital Trusts</td>
</tr>
<tr>
<td>Other comments</td>
<td>Over half in single handed practice</td>
<td>11 doctors were locums</td>
</tr>
</tbody>
</table>

The interpretation of this data is not entirely straightforward. For instance, the preponderance of single handed practices does not necessarily mean that this mode of practice is in itself problematic. Rather it may be that poorly performing doctors are more likely to opt to work single handed. Similarly the age of practitioners may simply mean that the early referrals are those doctors with longstanding problems, probably well known to their health authorities. The large number of doctors qualifying abroad might seem to indicate racial or cultural bias (either from patients or the referring agency). However many other factors might also be involved, such as differences in initial training, different responses to local attempts to resolve problems or other factors.
The most striking characteristic of these early referrals is that almost all (90%) are male. This may, certainly amongst older doctors, simply reflect the relative proportions of men and women in the profession. If the pattern proves consistent then it would warrant further investigation into, for instance, the attitudes of poorly performing male doctors towards accepting that they need assistance. With only a small sample of 50 doctors it would be premature to draw firm conclusions about the meaning of any of the patterns identified so far.

The nature of the poor performance

Although the letters from health authorities and others provide descriptions of a great variety of problems, the clearest formal assessments are made by the GMC screeners who identify one or more problems according to the core standards of good medical practice. Table II shows the most common problems identified.

Table II  Patterns of poor performance

<table>
<thead>
<tr>
<th>Problem</th>
<th>General Practitioners (n=25)</th>
<th>Hospital Doctors (n=25)</th>
<th>All doctors (n=50)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-standard treatment</td>
<td>19 (76%)</td>
<td>23 (92%)</td>
<td>42</td>
</tr>
<tr>
<td>Inappropriate/irresponsible prescribing</td>
<td>15 (60%)</td>
<td>3 (12%)</td>
<td>18</td>
</tr>
<tr>
<td>Practicing beyond skills or knowledge</td>
<td>7 (28%)</td>
<td>10 (40%)</td>
<td>17</td>
</tr>
<tr>
<td>Poor relationships with patients or relatives (26%)</td>
<td>6 (24%)</td>
<td>5 (20%)</td>
<td>11</td>
</tr>
<tr>
<td>Poor communication skills</td>
<td>6 (24%)</td>
<td>5 (25%)</td>
<td>11</td>
</tr>
<tr>
<td>Poor relationships with colleagues</td>
<td>4 (16%)</td>
<td>5 (25%)</td>
<td>9</td>
</tr>
<tr>
<td>Inadequate practice arrangements</td>
<td>12 (48%)</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Presenting an immediate risk to the public</td>
<td>9 (36%)</td>
<td>6 (24%)</td>
<td>15</td>
</tr>
<tr>
<td>Performance issues appeared very serious to screener, but not presenting an immediate risk</td>
<td>8 (34%)</td>
<td>3 (12%)</td>
<td>11</td>
</tr>
</tbody>
</table>

While sub-standard treatment is the overwhelming main deficiency identified in both general practitioners and hospital doctors, this is often accompanied by problems with communication and relationships with colleagues. Many doctors are rated as having problems in a number of areas of medical practice, and 15 were assessed by GMC screeners as presenting an immediate risk to the public.
Illustrative cases

The figures given above indicate the general nature of poor performance, but it can be difficult to appreciate what this means in practice. We have therefore included four case examples to illustrate the range of problems encountered and some of the responses of staff and health authorities involved. The examples are based on actual cases, but anonymised and altered in various respects to preserve the anonymity of those involved, both staff and patients.

<table>
<thead>
<tr>
<th>General Practitioner</th>
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<tbody>
<tr>
<td><strong>Principal issues on referral</strong></td>
</tr>
<tr>
<td>• Unconventional referrals. E.g. Failure to visit patient with chest pain in nursing home. Recommended sending patient to Medical Assessment Unit, rather than A &amp; E as requested and expected.</td>
</tr>
<tr>
<td>• Complaints from practice nurses re professional standards. The practice nurses presented a 'Small sample of incidents of concern regarding Dr A' - 20 incidents are listed in a period of two months. These included patient complaints of inappropriate sexual comments, doctor telling nurse he was going to sue a local consultant, patient expressing concern over Dr A's mental state.</td>
</tr>
<tr>
<td>• Allegations of sexual harassment by practice receptionists. One receptionist appears to have resigned three months later. Formal letter of complaint submitted to practice complaints committee.</td>
</tr>
<tr>
<td>• Serious breakdown in professional relationship with partners.</td>
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<tr>
<td>• Dr A's refusal to co-operate with local initiatives.</td>
</tr>
<tr>
<td><strong>Steps taken locally</strong></td>
</tr>
<tr>
<td>• Practice partners and practice nurses tried to resolve issues. Partner suggested that Dr A's work be monitored for 6 months.</td>
</tr>
<tr>
<td>• Attempts to mediate between partners in practice by Local Medical Committee (LMC).</td>
</tr>
<tr>
<td>• Performance and assessment group of LMC recommended an educational assessment be carried out. Dr A declined. Renegotiation of terms. Dr A agreed to assessment - then questioned decision.</td>
</tr>
<tr>
<td>• Professional development plan drawn up. Dr A indicated that it was too demanding. No response to subsequent proposals.</td>
</tr>
</tbody>
</table>

The eventual referral letter commented that 'In view of all the circumstances it was felt that everything possible had been done to secure a resolution but little progress had been achieved'.

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General Practitioner

Principal issues on referral to GMC

- Management of specific patients. E.g. Prescribing of inappropriate and dangerous medication to a child for a facial wart near the mouth.

- Independent review panel re treatment of patient who suffered a stroke found that Dr B was; not proactive in management of hypertension; did not inform family about effects and reaction to stroke; failed to make necessary home visit.

- Clinical governance team reported that they were anxious about Dr B's health, that he was abusive and threatening during the team's visit, that there was no proactive clinical care and that had become isolated from supervision, educative and supportive local practices.

- Unavailability, lack of contact with other doctors, poor attendance at meetings, lack of continuing medical education. Multiple incidences of lack of contactability. Frequently in pub when on call or on duty.

- Reluctance to take advice regarding issues of performance or treatment issues.

Steps taken locally

- A variety of attempts to engage Dr B in Clinical Governance work and to address these issues but no formal action.

‘In summary therefore we have a practitioner about whom there have been many unofficial but widespread concerns from local practitioners and hospitals for many years but about which no official action has previously been taken as far as we are aware. Despite our best efforts Dr B has stated his unwillingness to engage further with the Clinical Governance team …… we feel that a more formal assessment should be made’ (referral letter).

Locum Consultant Psychiatrist

Principal issues on referral

- Management of long term patients.

  Patient admitted with severe depression and suicidal ideation; concealing tablets in home. In hospital she barricaded herself in her room and set fire to the bedding. Dr C. decided to withdraw all medication and made a diagnosis of severe personality problems. Two days later patient jumped from a footbridge over road sustaining serious injuries.

  Acutely psychotic, seriously deluded patient admitted under Section. Dr C removed Section order and discharged her home to her mother with patient’s 11 month old baby. Discharge carried out prematurely and without any consultation with other staff or family. At home patient was aggressive, paranoid, severely deluded and refusing medication.

- Changing diagnosis and treatment on basis of brief interview regardless of clinical history.

- Unable or unwilling to work with other members of multidisciplinary team.

- Unaware of the legislative framework for psychiatric practice.

- Dismissive of views of others, whether patients or staff. Unable to accept advice from colleagues.

Steps taken locally

Dismissed from post and referred immediately to the GMC. Hospital felt that this was 'the only safe option'. Asked that re-training should be considered.
Orthopaedic surgeon

Principal issues on referral to GMC

- Initial general concerns of about attitude and lack of knowledge.
- Continuing concerns about clinical performance and attitude raised by medical and nursing colleagues.
- Laid back and casual, insufficient attention to detail.
- Specific incident when Dr D was reported as having instructed an SHO to administer a potentially lethal dose of drug. This was queried by nurses and the SHO, who checked with pharmacist. Later Dr D denied recommending the high dose, but several staff statements contradict this.

Steps taken locally

Informal meetings at which Dr D was questioned about his casual attitude and its effect on other junior doctors. He took no action to remedy the various problems pointed out to him. A further formal meeting, involving the Personnel manager, considered specific problems: his operating skills were not fully developed, he drifted between areas of work; he had insufficient general experience, which he did not seek to remedy; he was demotivated and unwilling to accept responsibility.

Following the incident and further discussion Dr D agreed to undergo assessment of his clinical skills. A one hour assessment was carried out by senior consultant surgeons in three subject areas.

Professor A would have ‘failed him in two areas at FRCS level’ and there was ‘a worrying uncertainty as to the depth of his knowledge’. The reviewers comment that:

- All three subjects had been repeatedly covered in regular teaching sessions
- His manner of dealing with the subjects was disorganised and did not inspire confidence that he would deal effectively with these common situations
- Surprising lack of factual knowledge given that these were common conditions

The report also states however that ‘we have not assessed his competence as a general orthopaedic or trauma surgeon and hence his suitability for a consultant appointment restricted to matters other than the spine and back pain’.

Dr D left the Trust but was apparently continuing to work in the area and eligible to apply for consultant appointments. He left no forwarding address. The Trust had ‘serious misgivings about his work and hence about his suitability for consultant status'.
The four cases shown here are fairly typical in the range of issues identified and the seriousness of the problems identified. They are typical in that they indicate that a doctor is seldom referred on the basis of a single case, or even simply a pattern of poor performance. There are often formal investigations, warnings to improve standards and complaints from both patients and staff. Frequently it appears that other staff are having to compensate and be on the alert for potential problems in patient care. Clinical issues on their own are seldom enough to lead to a referral, at least in this group. Almost always there are references to complicating factors, such as poor communication, a difficult personality, or health problems. However there were also a small number of doctors who, while clinically inept, appeared to be popular with staff and patients and who had been 'carried' by their colleagues for some years. Finally, an extremely common theme was the doctors unwillingness or inability to respond to attempts to help them. This often appeared to be a deciding factor in the eventual decision to refer to the GMC.

Methods of handling poor performance locally

From the documents available it was not always possible to be sure of the full range of attempts to investigate and resolve problems locally. The information available is also restricted as events prior to July 1997 are excluded under the terms of the relevant act of parliament. Nevertheless it was clear that in the great majority of cases substantial attempts had been made to resolve problems, often over many years. In most cases there were many offers of support and retraining, commitments by the doctors to reform or reorganise which usually came to nothing. The tone of frustration in many of the letters was marked. It should of course be borne in mind that the doctors discussed here are by definition the ones who were unable to use the help offered. Doctors' whose problems were resolved with retraining or additional support would not be referred to the GMC.

Some of the principal actions taken locally were:

General practitioners

- Independent reviews (5)
- Local performance procedures (4)
- Independent reviews & Local performance procedures (1)
- Local medical committee and/or health authority involvement (including educational assessment), but doctor refused to comply or there was no significant change (6)
- Health authority commissioned own report (2)
- Discussions with Primary Care Trust or Health Authority (3)
- PCG involvement - but doctor refused to comply (2)
- No direct local action (2)

Overall 16 (64%) of general practitioners appeared to have co-operated with some review or action at a local level before being referred to the GMC. Two doctors had no local level input, one due to being referred to the GMC by a member of the public and one because the doctor had left the area. The remainder of doctors either refused to comply immediately or expressed agreement with local handling and then failed to co-operate.
Hospital doctors

In all 12 (48%) doctors underwent assessment or investigation at a local level and a further 3 hospitals involved the Royal Colleges before referral to the GMC. The contracts of six locum doctors were simply terminated prior to referral to the GMC. Four doctors had little or no local level input due to being referred to the GMC by a member of public or because an immediate referral was made for advice from the GMC. In other cases advice may have been sought locally but no formal assessment was carried out prior to referral. The principal formal actions taken locally were as follows:

- Investigation or internal enquiry (6)
- Investigation panel + external professional review/independent expert advice (2)
- Assessment by Professional Standards committee (2)
- Clinical skills assessment (1)
- Referral to the post graduate Dean
- Involvement of Royal Colleges (3)
- Termination of locum contracts (6)

Following local investigations three doctors (12%) were suspended, and 7 (28%) were restricted to certain kinds of clinical work. Two doctor then broke agreements to restrict their activities and subsequently were suspended or resigned. Two locums were restricted to routine clinical care, and other doctors had admitting rights removed, were taken off surgical duties or were withdrawn from all clinical duties, but not suspended. A further two doctors were suspended pending the outcome of investigations, and one doctor resigned at the time of referral to the GMC.
Conclusions

Some obvious, but important, points need to be made before commenting on these findings. The first is that this is an extremely unusual group of doctors. They represent only a tiny proportion of the doctors practicing in Britain and, being among the first of the GMC referrals, may not even be representative of problems of poor performance in the NHS. Second, they are marked out not simply by poor performance, but by their attitudes and responses to attempts to help them. In many instances substantial efforts had been made to retrain, counsel, exhort and encourage to little avail. While it is difficult to prove categorically, it would appear that one of the principal characteristics of doctors referred to the GMC under the Performance Procedures is their lack of insight into their own problems and an unwillingness to accept the advice or help of their colleagues.

With these provisos in mind, some general points can be made. The problems referred to the GMC and subsequently screened as being appropriate for the Performance Procedures are, in the main, extremely serious in nature underlining the importance of the work carried out both by the GMC and by all those involved in the local handling of poor performance. Almost a third of those referred were judged to present an immediate risk to the public with most of the remainder presented prima facie evidence of seriously deficient performance. Clinical issues on their own are seldom enough to lead to a referral. Almost always there are references to complicating factors, such as poor communication, a difficult personality, health or drug problems.

In the great majority of cases substantial attempts had been made to resolve problems, often over many years. In most cases there were many offers of support and retraining, commitments by the doctors to reform or reorganise which usually came to nothing. The tone of frustration in many of the letters was marked. It was often clear that referral to the GMC was seen as a last resort, when all other avenues had failed, although a small number of referrers sought advice or looked to the GMC procedures as a way of conducting a formal assessment.

The protracted nature of many local attempts to deal with the problem was due in part to the complexity of the issues and the difficulty of identifying unequivocal instances of deficient care. There was also usually a strong commitment to trying to help even the most recalcitrant of colleagues, although there seemed to be less compunction about referring locum staff. The efforts made to help colleagues are of course understandable, but at times it seemed that supporting colleagues was achieved at the expense of protecting patients. This is particularly apparent in cases were doctors were 'carried' by their colleagues, informally watched and guided even though no formal action may have been taken. In the short term there is of course no difficulty with this, but there were suggestions in some cases that problems had been apparent for many years without decisive action being taken. This conclusion can only be tentative, particularly as events pre-1997 cannot be considered by the GMC.

Finally, this study has demonstrated the value of summarising and describing the performance problems referred to the GMC. Early findings are necessarily tentative as the information supplied to the GMC by referrers varies considerably. However, now the basic patterns have been identified it will be possible to move to a more proactive and routine method of data collection with a corresponding increase in accuracy and comprehensiveness of the information collected. In the longer term an understanding of the nature of poor performance and the difficulties encountered locally should provide a solid foundation for helping earlier identification of problems, enabling prompt but supportive local action and so protecting both doctors and their patients.