

Hospital medical directors have several duties, one of which is dealing with and offering advice on poor performance. A case study of a paediatric trainee is presented which highlights the dilemmas faced and gives an account of how these were dealt with together with more general advice on dealing with poorly performing doctors.

CASE STUDY

The medical director has received an email from a staff grade in the accident and emergency (A&E) department complaining that Dr AB, a specialist registrar (SpR) in paediatrics (a one year locum appointment–training (LAT)),¹ has upset one of the junior nursing sisters in the department and has been heard shouting at her and being rude to her. The email points out that this is the third time this has happened over a four month period. The medical director is requested to take action to stop this happening again.

The medical director asks the staff grade to put his concerns in writing but he declines as he says he was in another room at the time and could not hear all that was being said. The medical director then asks whether the nursing sister is prepared to provide a written statement outlining what has been happening. She declines as she says nothing ever happens when nurses complain about doctors, and in any case she has got to work with the doctor in the future. In view of this the medical director decides to take no further action.

Three weeks later the medical director is approached by one of his consultant colleagues who tells him that a senior house officer (SHO) in paediatrics, whom she is supervising, has complained that Dr AB has been making derogatory remarks about her. The SHO feels threatened and bullied. At about the same time the staff grade in the A&E department sends the medical director another email letting him know that another member of the nursing staff has spoken to him to ask his advice as she thought Dr AB smelt of alcohol when Dr AB came down to examine a child the previous evening. She commented that she had been concerned as her speech was slurred and Dr AB seemed rather brusque. She said this had happened on two or three occasions in the previous three weeks.

The medical director advises the consultant to consult the trust harassment and bullying policy that defines harassment and bullying, as it is important that what the SHO perceives as harassment and bullying concurs with the agreed trust definition of such behaviour. He also advises that if the behaviour falls within the agreed definition, the problem should be dealt with in accordance with the trust policy.

The medical director replies to the email and asks the staff grade to ask the nurse to put her concerns in writing. After two weeks the medical director has not received a statement. The medical director therefore decides to speak to the clinical director of paediatrics who tells him that he has no concerns about Dr AB who is a hard working trainee. He also tells him that he has not had any complaints from any of the staff in the paediatric department. The medical director decides to speak to the chief nurse and ask her to ask one of the senior nurses to talk to the nursing staff in the A&E department to find out whether there are any genuine concerns. She discovers that the nurse who raised the concerns used to live with the SpR but that she moved out of her flat about three months earlier.

COMMENT

► Bullying and harassment are unfortunately becoming an increasingly common problem^{2 3}. Most trusts and deaneries now have a policy for dealing with this behaviour and it is important for all staff to be familiar with their local policies for dealing with the issue. It is also important to agree what constitutes harassment and bullying: firm management is perceived to be good management by some staff and harassment and bullying by others. The National Health

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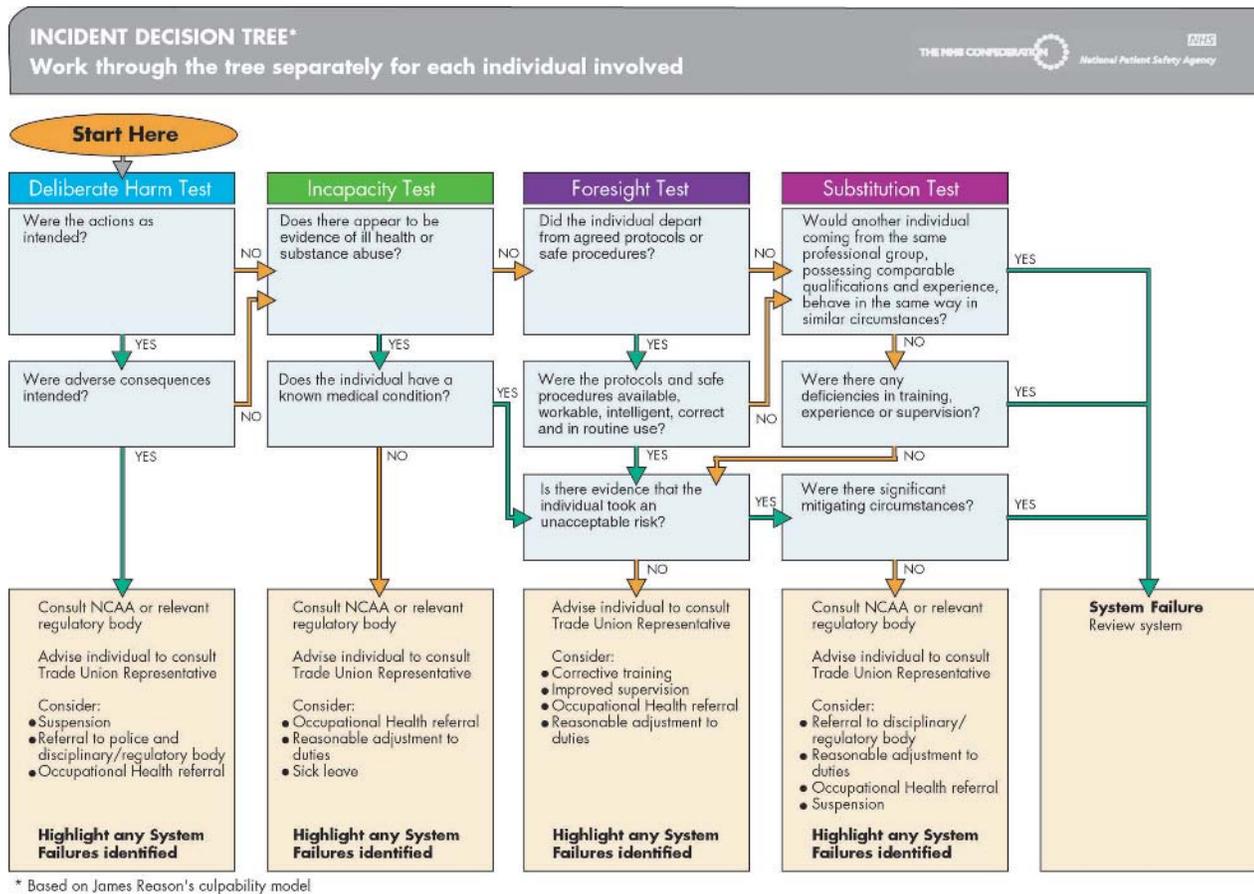


Figure 1 Incident decision tree. Reproduced courtesy of the National Patient Safety Agency & NHS Confederation.

Service West Midlands Deanery Bullying and Harassment Guidance gives useful advice and definitions of bullying and harassment.⁴

- ▶ When a problem presents it is extremely important to keep an open mind and not to make judgements until you have all the facts. The National Patient Safety Agency (NPSA) and NHS Confederation have recently published useful guidance⁵ on how to deal with an incident. The guidance includes an incident decision tree (IDT), which is based on work by Professor James Reason.⁶ This is reproduced in fig 1 and it is strongly recommended that the IDT be followed to guide the initial decision making and risk assessment. This should be followed by an analysis of the problem as outlined in table 1. Relevant questions to ask are suggested in table 2.
- ▶ It is almost impossible to take formal action unless you have written signed statements from those involved. A reluctance to put concerns in writing should alert you to

the fact that the concerns may be fabricated or embellished. Subsequent disciplinary action, if indicated, will require written statements from those involved. At this stage, in the absence of any written evidence, once you have established that there is no risk to patients, you should deal with the matter informally. It is, however, essential that you document fully the action you have taken and why. Bear in mind what you write is likely to have to be made available to all parties and that this includes email correspondence. In difficult cases take advice from colleagues, if necessary anonymising the case (table 3). Clinical and medical directors often find it helpful discussing cases in confidence with other medical managers either from the same or another NHS trust.

The parents of a 3 year old child write in to complain about the attitude and behaviour of an SpR in paediatrics. They complain that they bought Andrew,

Table 1 Analysis and quantification of the problem

- ▶ Has the problem crossed a threshold requiring action?
- ▶ Is there a risk to patients?
- ▶ Do I need to do a risk assessment?
- ▶ Is it personal or professional?
- ▶ Is it a personality problem or conflict?
- ▶ Is it lack of competence or confidence?
- ▶ Is there a role for increased supervision?

Table 2 Relevant questions to ask of a difficult colleague

- | | |
|---------------------------------------|-----------------------------------|
| Is he/she an alcoholic? | Is he/she ill? |
| Is he/she manipulative? | Does he/she have family problems? |
| Does he/she have any insight? | Is he/she 'nice but useless'? |
| Is he/she controlling? | Is he/she rigid? |
| Is he/she rude and dismissive? | Is he/she inattentive and bored? |
| Does he/she have an attitude problem? | Is he/she in the/she wrong job? |
| Is he/she a bully? | Is he/she nasty? |
| Is he/she disruptive? | Is he/she impossible? |

their son, up to the A&E department with a cough, shortness of breath, and high fever. They are seen in the department within 30 minutes and told that their son needs a chest x ray. Because of pressures in the department he is sent to the paediatric ambulatory care unit before the x ray is done and an SHO in paediatrics sees him there. When seen he is apyrexial, has a respiratory rate of 30 per minute, and has no obvious respiratory distress. The SHO does not think the child needs a chest x ray but his parents are insistent that one should be done. The SpR is called. She does not think an x ray is necessary and advises the parents to take their son home. She does not examine the child. The child's parents reluctantly take him home and write in to complain that the SpR was abrupt and dismissive, failed to examine their child, and failed to listen to their concerns. They also complain that the SpR's speech was slurred and that she smelt of alcohol.

The medical director arranges for the complaint to be investigated in accordance with the NHS trust's complaints procedure. This involves obtaining a statement from Dr AB and witness statements from other staff involved.

COMMENT

- ▶ It is important that statements are based on the facts and are not based on hearsay evidence or opinion. Issues to consider are given in table 4. A response is then sent to the complaint with a suitable apology, if indicated. The aim is to send out a final response within 20 working days. Having responded to the complaint, it is then important to review the incident to see if there are lessons to be learned and whether any action is required to prevent a recurrence. All that most complainants want is an apology and reassurance that lessons have been learned and measures put in place to prevent a recurrence.⁷
- ▶ It is always difficult to judge at what stage you should share information with the doctor concerned, but, as a general principle, any concerns should be discussed openly at an early stage. Such informal discussions may in themselves bring about a change in behaviour, if the doctor concerned has insight.
- ▶ It is important to realise that staff may not put information down in writing, but where there are multiple sources of information—"triangulation"—it would be very difficult for a medical manager not to take action. At this stage it would be appropriate for the medical manager to see the doctor to inform him/her that certain concerns had arisen and that preliminary enquiries were being undertaken to establish the nature of those concerns

Table 3 Sources of advice

Internal	External
Consultant	Specialist registrar (SpR) programme director
Educational supervisor	Postgraduate dean
Paediatric tutor	Overseas Doctors Association (ODA)
Clinical tutor	Royal College of Paediatrics and Child Health (RCPCH)
Clinical director	British Medical Association (BMA)
Director of human resources	Hospital Consultants & Specialist Association (HCSA)
Medical director	National Clinical Assessment Authority (NCAA)
Chief executive	General Medical Council (GMC)

The National Clinical Assessment Authority (NCAA) has been renamed the National Clinical Assessment Service (NCAS) from 1 April 2005.

Table 4 The evidence

Is it:	Proven or suspected?
	Fact or opinion?
	Written or verbal?
	Team or individual?
	External or internal?
	Strong or weak?
	A trend or isolated?
	Triangulated or not?

and whether they were justified. Any inquiry should require those who had previously made verbal comments to provide formal written signed statements. If nobody is prepared to give a statement then it is appropriate for no further action to be taken unless additional information is forthcoming.

- ▶ If you feel that formal action is justified, you must take this in accordance with the agreed NHS trust performance and disciplinary procedures. From June 2005 these will be based on the new guidance that has recently been issued by the Department of Health.^{8,9} The new framework for handling concerns about the safety of patients posed by the performance of doctors and dentists, which come to the attention of an NHS trust, is a coordinated process which aims to ensure that rapid action is taken to remove the source of the risk and that action is put in place to tackle any underlying problem. The new guidance replaces Department of Health Health Circular HC(90),¹⁰ that was used by most NHS trusts to formulate their performance and disciplinary procedures. Concerns about the capability of doctors in training should be considered initially as training issues and the postgraduate dean should be involved from the outset.
- ▶ Following any incident, an individual will need time to reflect on what has happened and may be distressed and unfit for work. The individual may also require time to prepare and write a statement, so a period of leave is frequently required. Under the new procedures, exclusion from work is seen as only being necessary in the most exceptional circumstances and voluntary restrictions on practice are the normal method by which concerns are handled.
- ▶ There is a requirement for any exclusion to be kept under active review. National Clinical Assessment Authority (NCAA) advice is best sought at an early stage and should be sought in all cases where exclusion is being considered, unless there is an immediate threat to patient safety or there is a police investigation in progress. Such cases are rare and discussion with the police will normally precede the decision to exclude a doctor.
- ▶ All referrals to the NCAA require the consent of the doctor concerned. Should this not be forthcoming, particularly in cases where considerable concerns have been raised about a doctor's performance, it would be deemed a "reasonable management request" for a doctor to undergo an NCAA assessment. If the doctor refused such a request, this would lead to disciplinary action that would test the reasonableness of that management request.
- ▶ The new guidance sets out the action to be taken when a concern arises, the arrangements for restriction of practice and the exclusion of practitioners from work.⁸ The new disciplinary framework covers conduct hearings and dismissal, procedures for dealing with issues of capability, and procedures for handling concerns about a practitioner's health.⁹
- ▶ If there are concerns about patient safety and that the doctor works for another employer, that employer must also be informed of the concerns. If the doctor is likely to

Table 5 Alternatives to exclusion (suspension)

- ▶ Restricted duties
- ▶ Alternative duties
- ▶ Increased supervision
- ▶ Special leave
- ▶ "Gardening" leave
- ▶ "Sick" leave

seek work elsewhere, the General Medical Council (GMC) should be informed. Otherwise it is usually best to await the outcome of any investigation before informing the GMC. The threshold for informing the GMC is if there is concern that the doctor's actions are such that they are likely to, or could affect, the doctor's registration. The alternatives to exclusion are listed in table 5.

In this case witnesses confirmed that Dr AB did not smell of alcohol on the night in question and the paediatric nursing staff were of the opinion that Dr AB behaved appropriately with the child's parents.

Approximately a week later the medical director received a telephone call from a consultant at another hospital. He had concerns about Dr AB who had been attending a course at the hospital. He was concerned that during the two day course Dr AB appeared disinterested and at times made comments which were not in context and were inappropriate. Dr AB had been critical of his work colleagues and had not performed to the standard expected of an SpR. She had failed all her assessments on the course and had achieved very low marks in the final written assessment. She was thought by the course staff to have displayed such a seriously deficient performance that they had sought independent advice from the NCAA. The NCAA had advised the consultant to discuss his concerns with Dr AB's employer—hence the telephone call. In addition the consultant had observed Dr AB's speech to be slurred.

Informal enquiries revealed that Dr AB, who was unmarried, had few close friends and that she was considered by her colleagues to be a young female doctor who drank more heavily than average. She had had difficulty passing her Membership of the Royal College of Paediatrics and Child Health (MRCPCH) examination and had eventually done so after three attempts.

COMMENT

- ▶ The concerns disclosed to date are strongly suggestive of a trainee in serious difficulty and it is important to put the latest findings in context and consider the causes of poor performance (table 6) and reasons for it (table 7). To this end a discussion with the trainee's educational supervisor

Table 6 Causes of poor performance

Ignorance	Lack of knowledge
Knowing but not understanding	Lack of comprehension
Poor ability	Lack of competence
Failing to deliver	Lack of performance
No motivation	Lack of motivation
Being prevented from performing	Lack of resources

is required and also with the Royal College of Paediatrics and Child Health (RCPCH) tutor and SpR programme director. In view of the concerns, it is essential that a risk assessment be undertaken to determine whether Dr AB is safe to work and in particular that she is safe to care for patients. To this end confidential discussions are required with consultant colleagues.

- ▶ It is always difficult to gauge at what stage the doctor should know about the concerns that have been raised. One view is that the doctor should be made aware of all concerns regardless of whether they are vexatious or genuine. Another is that the doctor should only be made aware of concerns that have been substantiated and are to be investigated formally. In this case it is important that the doctor is aware of the concerns that have been raised and is also aware of the background to those concerns.
- ▶ If concerns have been raised confidentially, it is important that those raising the concerns agree to their concerns being raised with the doctor and to the source of the concerns being disclosed. Each case needs to be assessed individually and judgements will have to be made as to whether concerns raised in confidence and the source of the concern are disclosed to the doctor. One tactic before hearing concerns is to warn the person who wishes to raise the concern that both the concern and the name of the person raising it may have to be disclosed to the doctor if formal proceedings are instigated. It is also important to ensure that complainants are aware that they will be properly represented and supported should they wish to raise a concern, and that they are informed of this beforehand.
- ▶ Following an analysis of the problem and a discussion of the possible solutions, a practical way forward should be agreed. This must have the agreement of all those involved, including the trainee.

The discussions highlight the real possibility of alcohol or substance abuse. This requires a more detailed assessment and the medical director recommends to Dr AB's educational supervisor that she discuss the situation with Dr AB and with her agreement refers Dr AB for an occupational health assessment, which Dr AB agrees to. The assessment uncovers no evidence of alcohol or substance abuse. During the assessment Dr AB discloses that she has been suffering from headaches. These have not been particularly severe and are attributed to stress. It is decided that Dr AB is fit to continue at work. The medical director recommends closer supervision from the paediatric consultants who agree to do this.

During the next six weeks Dr AB performs her duties satisfactorily and there are no major concerns. On one occasion Dr AB is abrupt with one of her colleagues

Table 7 Reasons for poor performance

- ▶ Isolation
- ▶ Poor training
- ▶ Lack of involvement in meaningful continuing education
- ▶ Stress
- ▶ Poor organisation
- ▶ Low morale
- ▶ Poor infrastructure
- ▶ Lack of resources
- ▶ Poor support
- ▶ Physical and/or mental illness

and is perceived as being difficult over a proposed on-call rota change. She is known to favour going off for long weekends by herself and on this occasion had planned a walking holiday that she did not wish to cancel. During the six week period she is felt by all the staff to be rather more rigid than usual with her behaviour gradually becoming more difficult. This type of behaviour is felt to be in character. By the end of the six week period the majority of Dr AB's close colleagues are openly saying that she has become very difficult to work with, is unhelpful, and is not handing over properly when she goes off duty. They say she always seems to be in a rush to leave the department and on several occasions has been late for work. When questioned she puts this down to problems with the traffic.

COMMENT

► It is important at this stage to try and quantify the problem and determine whether the situation has reached a threshold requiring more definitive action. The apparent breakdown in communication is worrying and a definite indication that patient safety is being compromised. Handover is now seen as an extremely important part of a junior doctor's daily routine.¹¹ The question is whether the situation can be contained and dealt with informally or whether more formal action is required. As the SpR will have to work out of hours with no direct supervision, a view will have to be taken on whether she is fit to be on call. To some extent this will depend on the degree of supervision the nursing staff and consultant staff are prepared to undertake and whether the trainee has insight into her problem. It is always difficult to know how much information to share with more junior trainees. It is of the utmost importance that confidentiality is not breached and that trust is maintained. If it is decided that the trainee should not be working, this is a situation that must be handled sensitively. If the trainee is told not to work, the decision must be on the grounds of the risk to patient safety.

There has been a gradual escalation of the problem during the past three months and following discussion it has been agreed that Dr AB merits closer supervision and should not undertake unsupervised on call. She is therefore taken off the on call rota and a further referral to the occupational health department is deemed necessary. It is suspected that she is suffering from stress.

Dr AB is seen in the occupational health department, this time with the additional information that has become available since her last assessment. She is assessed as being under stress due to a combination of factors and it is decided that she needs two weeks sick leave. She is reassessed at the end of that time and deemed to need another two weeks off. At the end of this time she is reviewed again and as she appears to have improved it is decided that she should have a phased return to work. It is agreed that she will initially only work two days a week and that she will do no on call. The plan is for her to gradually return to full time work over the next six weeks. During the period that she is working part time she is seen by an occupational psychologist and has regular meetings with her educational supervisor. At the end of the six week period she resumes full time work. Towards the

Key points

- All allegations or concerns must be properly investigated to verify the facts so that allegations can be shown to be true or false.
- Always use the agreed process for investigating any concern
- Use *Good medical practice* as a benchmark for expected standards
- Consider health issues as a cause of poor performance
- Postgraduate deans must be made aware of trainees in difficulty.

end of that week, she has a major seizure while she is seeing a child on the ward. She is admitted to hospital as an emergency and a magnetic resonance imaging brain scan reveals a large frontal lobe tumour. This is subsequently removed surgically and she makes a full recovery.

In Dr AB's case her behaviour problems were caused by a combination of lack of sleep, intermittent headaches, subclinical seizure activity, and stress. She was acutely aware of her underperformance but found her colleagues unsympathetic and unsupportive to the extent that she was unable to confide in them.

COMMENT

- The importance of considering health problems in someone who appears to have personality or behaviour problems cannot be overestimated. Even if initial health assessments are negative, the possibility of illness or an organic condition must not be forgotten. Many doctors who have performance difficulties become stressed and the root cause of their problem is overlooked. Although not an issue in this case, bullying and harassment as a cause of poor performance should not be forgotten.^{2 3} A skilled occupational health assessment is a key tool for helping to diagnose and support doctors in difficulty. It has replaced the "Three Wise Men Procedures" that used to be in place in NHS trusts for dealing with health problems.
- It is now considered a "reasonable management request" to require a doctor, suspected of having health problems, to undergo an occupational health assessment. Refusal may require disciplinary action to be considered.
- The GMC, in its publication *Good medical practice*, sets out the standards that all doctors are expected to adhere to: "Duties of a doctor".¹² Most of the medical Royal Colleges have refined these and made them specialty specific and the RCPCH has published its own guidance.¹³ Managers too have their own standards.^{14 15} Methods of assessing and improving performance are summarised in table 8.

Table 8 Ways of assessing and improving performance

- Informal feedback
- Peer pressure
- Formal appraisal
- Occupational health assessment
- NHS trust disciplinary procedures⁹
- National Clinical Assessment Authority (NCAA) assessment¹⁶
- General Medical Council (GMC) revalidation¹⁷
- General Medical Council (GMC) performance procedures¹⁸

Relevant links

British Association of Medical Managers (BAMM)	http://bamm.co.uk/
British Medical Association (BMA)	http://www.bma.org.uk/
Department of Health (DH)	http://www.dh.gov.uk/
General Medical Council (GMC)	http://www.gmc-uk.org/index.htm
Healthcare Commission	http://www.healthcarecommission.org.uk/
Institute for Healthcare Improvement	http://www.ihl.org/
National Clinical Assessment Authority (NCAA)	http://www.ncaa.nhs.uk/
National Patient Safety Agency (NPSA)	http://www.npsa.nhs.uk/
NHS Counter Fraud and Security Management Service (CFSMS)	http://www.cfsms.nhs.uk/
Royal College of Paediatrics and Child Health (RCPC)	http://www.rcpch.ac.uk/
Alcoholics Anonymous	http://www.alcoholics-anonymous.org.uk/
Sick Doctors Trust	http://www.sick-doctors-trust.co.uk/
National Counselling Service for Sick Doctors	http://www.ncssd.org.uk/
Doctors' Support Network	http://www.dsn.org.uk/

- Involvement of the relevant deanery is mandatory for any doctor in a formal training scheme. Issues involving locum doctors and doctors "in training", who are not in a formal scheme or recognised post, present particular difficulties. In these circumstances consideration should be given as to whether referral to the GMC is indicated. This is mandatory in all cases where it is judged that the doctor's standards of care do not meet, or may not meet, the standards set out in *Good medical practice*.¹² In less serious cases, referral to the NCAA or discussion with "NHS professionals", or the medical agency through which the doctor is employed, should be considered.

FURTHER READING

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Conflict of interest: The author is a GMC Associate.

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