2005 Chief Health Officer Seminar Series

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The dilemmas of managing the performance of clinicians.

Abstract:

Performance management is a core human resource management function however it is only in recent years that its application has been deemed relevant to the medical profession.

These two papers consider performance management of medical staff with particular emphasis on an acute care setting. In the first paper, Associate Professor Bassett considers the philosophy that underpins performance management and its application. The second paper by Associate Professor Ramsey, explores one particular element of performance management, peer review and how it might apply and draws on experience gained at the ANU Medical School where peer review is used to assess personal and professional behaviour of medical students.

Transcript:

My talk will be about looking back at what's happened with performance management, what we've done, and looking forward at what we might do. Essentially, performance management is about an agreement between employees and managers and their roles and expectations for the forthcoming year and it is an agreement that is developed in a collaborative way, obviously taking into account the strategic aims and the core business of the organisation.

I believe very strongly that it's not a disciplinary process. There's no doubt that information gained through an agreement could at some point be used in a disciplinary way. But I believe if we use performance management in a disciplinary way, as a quasi industrial tool, people won't do it or they'll be defensive about it, and we won't get the value out of it. Performance Management is a way of establishing a shared understanding about what we're trying to do rather than being a disciplinary process.

We're probably behind the rest of the country in performance management for our medical officers and other clinicians. We're certainly behind in the health sector compared to other organisations. I previously have worked with some employees at a university in a university teaching hospital setting and even at that time performance management was well established, as it is in the private sector as well.

Many Australian hospitals have now introduced performance management for clinicians. The Australian Council on Healthcare Standards has a strong interest in this. I've had a look at the systems that are in place in some other hospitals around Australia and in fact the templates and the systems that we've developed, that we're ready to go with, have been derived from looking at best practice elsewhere.

Let's look at the legal, industrial and policy framework. Others in this audience will comment on this with greater knowledge than myself, though I am aware that there is an extensive framework. Possibly it's an area that needs some strengthening. There's a reference to performance in enterprise bargaining agreements for nursing and medical officers. Maybe that reference hasn't been adequate, maybe it hasn't been implemented for a variety of reasons, but the framework is developing.

When you look at performance and compare under performers with over performers, if you plot the results you get a bell shaped curve. I just wanted to make the point that in between low and high performers there are a lot of people in the middle. What we're trying to do is to move the low performers to become better performers through better performance management.

There are two components; there's review, which is retrospective, and there's planning for the future, which is prospective, and both of them are very important.

There can be different ways of reviewing performance and the different components and measuring feedback. The review could be with reference to the person's duty statement. Now unfortunately, as many of you will probably know, duty statements fall out of date and need to be reviewed. So if you're going to use that as a means of review then you have to keep the duty statement and the job description up to date. There could also be feedback on clinical skills and competence, patient communication, workplace relations, professional maintenance, professional standards, participation in audit, safety and quality programs and on teaching and research work.

These are the sorts of things that would come up during a review and I think a clinician would expect to have some sort of summary of the strengths as well as of the weaknesses. Clinicians like any other people want to know the good things that are going on as well as the things that are not so good. They want some identification of the areas for improvement and for training.

Self-review is also important and it can often, but not always, give an accurate description of behaviour. Most people have a good knowledge of where they do well and where they don't. There are some stand-out gaps, though. I have had a number of clinicians say, 'look, I didn't know there was a problem with that because nobody's communicated it'. So self-review while important has to be complemented by the other steps.

I think we should consider a 360 degree review. This could also be called, as the Americans do, multi-rated or multi-level review. This is very appealing to me, but peer review requires that we should be sitting down and listening to what our same professional peer groups say and what the other professional peer groups say. What's more, doctors should find out what the nurses think, as well as other staff for whom the person is responsible - you might say subordinate staff, but I won't use that term. It can be very revealing to find out what your patients actually think about you in terms of your clinical performance.

The review should be a two way process so that it's not just the clinician being reviewed by the manager, it's also the clinician saying what he or she feels the hospital or the organisation hasn't provided. I've developed a template for staff specialists and for visiting medical officers that has a component in it so that the clinician can actually write down what he or she perceives to be the areas where support was lacking.

Performance planning is logical. We have to think of what the goal is, what we are trying to achieve. Clinicians who are busy with the care of patients very often do not understand what the strategic directions of the organisation are. They very often do not understand the business plans that are in place. There is a gap between what happens at the higher level in terms of hospital management, and the clinician, because the clinician is focusing on doing a good job looking after patients. This is a perennial problem. For instance, if there is a strategic plan that relates to, say, how we cooperate with NSW for the care of patients with cardiac disease, and it's been worked out at the level of the Health Departments that we're going to send people who need implantable cardioverter defibrilitates to Sydney, how will the clinician know this?

That's the sort of thing that happens at the higher level that needs to be communicated to the clinicians because they need to know what's going on behind the scenes and what the resource implications are, why it's all come about. But we need to communicate that to our clinicians so that they understand it and then we can set some goals for the clinicians. There's no point in having a goal that is not feasible or that there's no funding for. It's a collaborative process.

It's quite interesting to ask people to rewrite their duty statement, to take the statement they wrote when they first were appointed and ask them to rewrite it. It usually results in a fairly accurate duty statement for the future. Probably the manager will want to change some things, but it's a good starting point and I think it's a good way of getting the employee really involved in what's going on.

There's a whole range of different appraisal tools and companies that make money out of doing this and all sorts of different software you can get for performance management. Quite frankly, I don't think it's really necessary. I think a lot of it can be done as a narrative. When it comes down to clinicians I am quite happy to have the clinician write a letter to me and I write a letter back and we might go through a few iterations of that, but an exchange of letters can be all that's required.

At The Canberra Hospital we have developed a template. There is some value in having a template because it identifies the key areas we want to look at. I looked at behaviourally anchored rating scales, which are putting little dots and filling in the circles on a form. In the other hospitals we looked at around the country, I didn't see that these were very popular. I had one hospital that used them and they weren't terribly popular so I went more to a 'management by objectives' approach. This leaves some freedom for the individuals to actually write down what they see as their goals and then at the end of that period of time what their achievements are.

The template we developed for senior medical officers has on one side the attributes we're looking at, it has the goals, and then on the other it has a part to be filled out at the end of the year. This provides for goals achieved at the end of the period. This would then be reviewed a year later. It's very simple in format.

One other option to think about with clinicians is not just to take the individual review, but to do a review of the whole clinical unit. This happens in New Zealand. John Mollett my General Manager has had some experience with it and claims that it has been quite successful. I have no experience with it, but I think it does have quite a lot of appeal, although it requires a fairly mature organisation to do it.

My own view is that performance management forms don't need to be filed in the human resources management file. There's probably more than one view on that. At the Alfred Hospital in Melbourne, in order to get performance management amongst senior doctors, in order to get them to agree with it and to comply with it and to support it, they changed their attitudes. They began initially with the view that it was an HR function, but they negotiated that out and the paperwork was kept in the unit director's office. I think the clinicians were more comfortable with that because they saw it as being a positive tool rather than something that would be used in a disciplinary process.

I would include in the supports system an appeals process, because whatever system you have, there'll be some people who won't like something and who will not agree with something. The manager is entitled to a view on it and I think that one can envisage there will be a situation where the manager says 'this is not good enough' and the employee says 'this is good enough' and they'll be at loggerheads. An appeals process is one way of sorting that out.

Let's move on to the application of the process. For the purposes of this discussion, I've tried to grade the behaviour of employees. For the majority, there's no problem at all. Such people would enter into a performance agreement with the objective that it is preventing problems, certainly lifting their performance. Then there is the group for whose members there may be a minor problem - the sort of thing that one can manage quite easily within a performance management framework.

And then there's something a bit worse than that, the moderate problem. It might be workplace relations, a concern about possible professional misconduct or something like that. Then I think one needs to move towards some form of control that's stronger. In that case I would define the response to the problem behaviour as requiring a legal instrument, meaning a certified agreement or VMO contract - something that has some legal force. That then becomes the framework, provided it's adequately developed, for dealing with that problem.

Then of course there's the major problem, one that might cause serious risk to patients or staff. This would also require a legal instrument and maybe something more. There may be a need to refer to a Clinical Privileges Committee, head of unit, or even a professional College. In the case of clinicians, the involvement of other bodies might include a health board. The *Health Professionals Act* has a significant bearing on the processes followed here.

At the next stage hospital management takes a more formal approach, later it becomes external. However, I don't believe we should be running off to Colleges at an early stage. Colleges have an important role perhaps in advising how we might deal with particular matters in terms of recommending external reviewers but Colleges don't have a strong track record in dealing with the sorts of things that we are talking about here today. Indeed the College of Physicians, of which I'm a member, has a policy of not getting involved in these areas because there are other players such as medical boards already in place.

For anyone not familiar with the process within a hospital environment or health service environment there's a Clinical Privileges Committee that can review clinical competence issues involving senior doctors. Generally a CPC only determines privileges for those doctors who have an appointment beyond one year or for locums. The vast majority of our junior doctors have a one year appointment only and then they are reappointed in mid January for the next year so they don't come under a CPC. Currently we don't have clinical privileges defined for senior nurses or for allied health professionals.

The CPC at The Canberra Hospital has two roles, one is determining the clinical privileges at the start of an appointment and the second is dealing with problems that arise with practitioners along the way. We are about to review the process. Currently, on referral of a clinical competence issue the CPC reviews all information available, requests more information if necessary and also, if necessary, coopts internal or external experts before deciding if something should be done about clinical privileges.

The Canberra Hospital policy quite clearly states that the CPC advises the Chief Executive Officer. If there is a problem this committee advises the Chief Executive Officer and the General Manager. But at the end of the day it's the General Manager's job to actually make the decision and this is embodied in the ACT Health Act 1993.

To date though it's a process that's fairly immature because we haven't utilised it a great deal. It's also a process that I strongly believe we need to use a lot more so that doctors become a lot more comfortable with it.

Investigating clinical competence requires considerable care. If you're the person who lays the charge you need to step back when it comes to determining the charge and things go horribly wrong when that does not happen. It's like walking through a minefield. Similarly, the person who is the subject of concern must know all the allegations against him or her and has a right to be heard and to put his or her case.

At the end of the day we are dealing with three parties. There's the community that we serve, the patients, there's the organisation and then there's the practitioner. They are in that order of importance, but the decisions that we have to make will not keep all of those three groups happy. The reality is that we serve the community first, secondly we serve the organisation and then thirdly the practitioner.

Performance management is really about how we get the organisation as a whole to lift its game, to lift its performance. It's not necessarily about working harder, just about doing a better job so at the end of the day we achieve what we're trying to achieve for the benefit of the community. It's also about trying to identify where there are problems and to do something about them. The ultimate objective of this is to get a better outcome for the community, that is our consumers, our patients.