

## 2005 Chief Health Officer Seminar Series

### Seminar Two – 16 June 2005

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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:**

I'm going to challenge you with peer review - a performance management tool that's poorly understood and little utilised, but has a lot of science behind it. Then I'm going to explain this by way of case study.

That case study is the application that I've been involved in using for peer review as a performance management tool for performance appraisal. In particular I've used it for medical students at the ANU Medical School, a pilot that we're running with junior doctors at The Canberra Hospital.

The notion that I'd like you to get is, does it have a much wider application?

So, this presentation is around peer review. Mark Bassett has just talked about performance management and we understand the notions behind performance management. As he said, the fact is that we need a robust performance management system that allows people to understand why they're being performance managed and what they're going to get out of it.

It's also widely accepted now that potentially poor performance needs to be recognised and needs to be managed.

It's interesting to note that there's actually evidence behind performance management and its impact on the health care system. Studies were done in the UK around five or six years ago that indicated that there's actually a correlation between performance

management practices and hospital performance in clinical terms. Indeed there was a direct correlation between a robust performance management framework and patient outcomes in terms of mortality. I think that for our clinical colleagues it's always worthwhile explaining that there's actually some science behind some of this management mythology that they always say is very soft when it comes to evidence.

Mark has provided us with a very solid performance management framework that we can use in our minds. I'd like to talk to one small element of it that reads into peer review -competencies. A robust performance management framework is based on an agreed set of competencies.

What's really interesting though is that there's little agreement on what competencies are in medical practice in particular. For example, in the United States, from a national perspective their competencies are defined in terms of patient care, medical knowledge, practice based learning, improvement, interpersonal skills, communication, professionalism and the like.

The UK has, if you have a look at it, a similar set of competencies but they're not exactly the same. We're talking about good clinical practice, maintaining good medical practice, teaching and training, relationships with patients, working with colleagues, probity and health. If you think about it, they're similar concepts, but not exactly the same.

In Australia there are no nationally agreed competencies and the best that I've been able to identify that are most relevant to our jurisdiction come out of NSW. They come from the postgraduate medical counsellor for NSW – who's responsible for the junior medical workforce in the ACT as well - and who has listed a series of competencies around clinical and knowledge skills and communication. This includes communication between teams, communication with patients and the like, the personal-professional elements of responsibility, awareness limitations, professional obligations, teaching learning and the like.

When it comes to our students at ANU, the competencies are based around four domains – medical sciences, clinical skills, population health, and personal and professional development. Again there are common threads running through those domains. And if you explore others you'll see that there are common threads there too. But there's no agreed set of competencies and that's something that we must acknowledge here from the start - that if we're going to enter into a performance management framework then we need to have an agreed set of competencies that are relevant to us.

Having said all of that, when it comes to performance management, the review of performance or, within academic terms, the assessment, then there are a number of formats that are available. But I argue all of them under-emphasise one particular domain and that's professionalism; the personal and professional elements of performance. And if you recall those examples I gave previously, they all identify personal and professional one way or another, and it's ironic that that's the domain that's most undermanaged when it comes to performance review.

From an academic view, for junior medical staff and medical students, the tools that are most often used monitor the written free form. Comments with formal evaluation sessions are completed by supervisors and/or other staff.

This is where I'd like to take a step sideways and talk about peer review and put it into the context of my discussion thus far. So what is peer review? It's a pretty simple notion. It's a system of review that uses reviewers who are the professional equals of an individual or group of people. They're also responsible for directing or participating in a particular activity. The process of peer review itself depends on the context and be structured or unstructured. It can involve an individual or group exchange of information and may occur spontaneously or in a planned setting.

For today in our construct I am proposing that I have a more formal form of peer review performance appraisal, that's what I'd like to explore with you by way of example from the work that we've been doing at the ANU Medical School.

Before I do that though I'd like to highlight the fact that in a clinic, peer review has been used for many years, but it's usually concerned with clinical practice improvement, as well as personal and professional behaviours. Indeed, four or five years ago the Royal Australasian College of Surgeons put out an edict that provided the guidelines on surgical audit and peer review and that's one of the professional colleges that had that focus.

In another context peer review can be used as a performance appraisal tool and again it's worthwhile noting that there's evidence behind that that can justify this argument. It has been demonstrated that peer ratings are an accurate, reliable measure of a physician's performance when it comes to the personal and professional.

I stress what it's good at. However, it's not good at measuring clinical performance and there are studies that demonstrate that. It's not reliable in those circumstances. That should be self-evident because of the halo effect of one clinician reporting on another. The stand-out clinician will always receive a glowing report when it comes to clinical practice. That actually then prevents clear and accurate and reliable reporting against other domains. So peer review is best applied for personal and professional competencies.

Let's talk about the process. The first step needs to be a determination of the criteria, the competencies that are going to be assessed and they need to be agreed by peers. The way that this was undertaken at the ANU Medical School was that an indicative set of competencies characteristics were identified. These were identified from a number of sources that are available from around Australia, including other universities, the AMA and professional colleges. The Australian Medical Students Association also had some draft characteristics. We synthesised all those sources and we took them back to the student body. The student body voted on them anonymously and rated them and at the end of the day we identified twenty characteristics.

For this audience it doesn't really matter what characteristics they identify, they are pretty self-evident. An example would be, is this person all that punctual? Does the person apply ethical standards and perform with those ethical and legal standards identified by the university? I won't go through them now but we agreed our set of criteria.

Epstein and Hunter argued that, for the assessments to be useful, you required a critical number of reviewers. They argued for eight. For us at ANU this was a convenient figure because our PBL group was 8-10 students so we were able to conform to the number of reviewers that were required to make it a reasonable rating. Why is that number

required? Well, if you get to very small numbers it's easy to identify reporters and the whole notion of this is to maintain anonymity.

So the rating itself occurred blind and we applied a five point criteria from excellent to poor. The students were reviewed by all their colleagues against each criterion. This information was then analysed centrally and from there a decision was made about what to do with those students who rated at the marginal or poor level by a peer or peers. We had agreed with the students before we started that every student required all of their colleagues to at least assess them at average. If any student received a marginal score on one or more of the criteria or if they received more than one unacceptable score then the rating of the peer reviewers was confirmed with the reviewers. If it was deemed that the ratings were justified then disciplinary action was taken, meaning referral to a professional behaviour committee of the medical school for further determination on what next to do.

The students each received at the end of this process their pooled individual scores so they knew how they scored. They also knew how their colleagues scored and how the whole course scored. So they received feedback. At the end of each peer review session the group was provided the opportunity to debrief because one of the final questions was 'was your group functional?' If it was a dysfunctional group we were worried about bias because of personalities and we provided each group with the chance to have a group debrief, though last year that wasn't taken up.

I'd like to indicate that we believe it was a very successful process that we completed at the end of first year at ANU. Out of interest, the medical school has eighty students and that at the end of the process eight students were identified by their colleagues with marginal or unacceptable scores. Of those eight, four were identified as unacceptable and were reviewed by professional behaviour committee.

For us it was a very interesting process. Of those four students that we interviewed, two had mental health problems that we weren't aware of. They required further support and we were able to counsel them and provide them with recommendations on what they might do to improve their mental health problems that were impacting quite clearly on their performance from their peers' perspective. We didn't know at the faculty, but their colleagues did.

Of the other two, they had basically unacceptable behaviours. One was a recalcitrant or a late attender. The student appreciated there was a problem and, by chance, at the beginning of this year I was his tutor. I can now assure you that he attended every session and was always on time. What is interesting too is that I understand that in block 5, which he's in now, he's also continued to attend appropriately. So behaviours can change, simple behaviours, if feedback is provided in a timely and appropriate fashion.

What have we done with it? We're now going to apply the instrument to the same students in their second year. They were given a chance to review the feedback and whether they wanted the criteria modified. Two of the criteria received minor modifications and it will be interesting for us to see how the students deal with this in their second year.

There's a summative assessment at the end of Year Two. The assessments have been taken up well by students because of the understanding that they now have to take responsibility for their actions. We're finding it to be a very powerful tool.

Out of interest we've piloted a very similar tool with a group of interns and junior medical staff at The Canberra Hospital. It's interesting too that the interns took it up readily. The second and third year AMOs were more resistant and we think that that might be because they were too far down the pipeline to understand the value of it so there were some lessons for us to take out of that.

What we're hoping though is that we'll eventually be able to roll out peer review so that it can be used for performance appraisal specifically for personal and professional performance. We would hope that in years to come the system, like the one that we're developing and exploring now, will see medical professionals being reviewed basically from cradle to grave.

So that's a way forward. Peer review is a tool that's, as I said, poorly understood and it has limited use in Australia today. But there's good evidence behind it and hopefully we can use something like this to say that at the end of the day ACT Health is at the cutting edge of performance management rather than at the marginal edge.