17 Professionalism: Fitness to practise

This competency area is about the doctor's awareness of when his/her own performance, conduct or health, or that of others might put patients at risk and the action taken to protect patients.

The document 'Good Medical Practice' is the key. This area of the competence framework is in large part informed by how the profession itself defines professionalism through this document. GMP is written in generic terms for all medical specialties and then fleshed out in more detail within the context of each specialty. 'GMP for GPs' is therefore an important resource document for us as generalists. Through its descriptions of the unacceptable and the exemplary GP, it helps us understand the standards that we must abide by in professional life and also helps us to benchmark our own performance in relation to these standards.

There are five themes in the performance area 'Fitness to practise'. The first three concern the **maintenance of optimal performance** in the following areas:

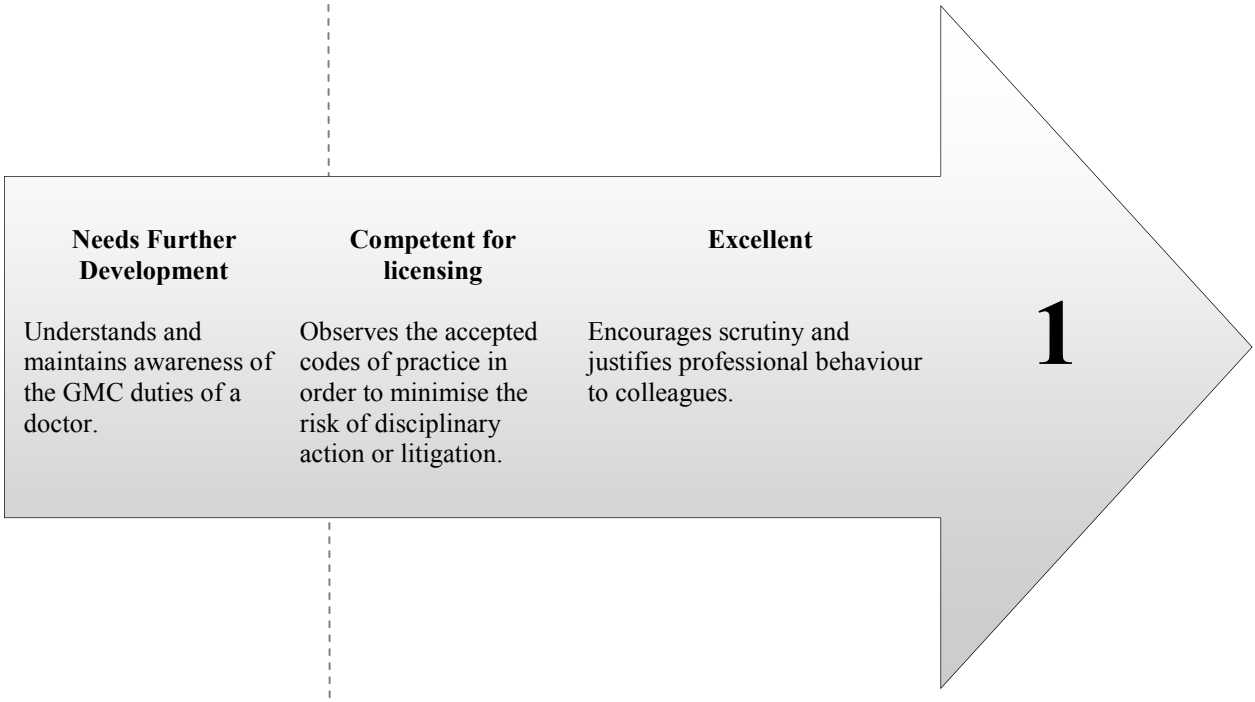
- professional performance
- work-life balance
- health

The fourth and fifth themes deal with how we engage in **specific feedback loops** i.e.

- monitoring ones own performance & that of colleagues
- responding to feedback (in particular, complaints)

These are elaborated through the competency progressions, which we will now consider in more detail.

Joined up?
See p14



This first competency progression is principally about understanding our professional duties as set out in key documents such as Good Medical Practice and showing the ability to monitor and justify our own performance. We move from:

Understanding our duties as described by the broad themes of GMP.

Monitoring our performance and comparing personal standards with the expectations of the profession, for example by using GMP as a tool rather than simply a reference document.

Participating proactively in the process of performance review and clinical governance, for example by using audit or by encouraging feedback on consultations.

Looking at each of the word pictures in turn:

Understands and maintains awareness of the GMC duties of a doctor.

To achieve this competency, we must demonstrate that we understand these duties, by being familiar with GMP. At the competent level (the next step up) we would also need to demonstrate that we can *apply* this understanding to practise.

To understand GMP, we need to know its range and the standards so we will begin with a brief summary of GMP and then consider the situations in which GMP is seriously breached to the extent that the GMC might be involved. This sounds rather dramatic, but understanding the latter helps us to ensure that our standards are kept well within these limits.

Overview of GMP

In broad terms, the GMC requires GPs to provide care that is 'effective, personal and safe'. To continue in independent practice, we have to demonstrate through revalidation that our conduct justifies the trust that is placed in us by patients.

GMP sets out the standards of competence, care and conduct expected of us, under the following main headings:

Good clinical care –to provide good standards of clinical care within the limits of our competence, ensuring that patients are not put at unnecessary risk.
Maintaining good medical practice –to keep up to date with developments in general practice, maintaining our skills and auditing our performance.
Relationships with patients– to develop and maintain successful relationships with our patients.
Working with colleagues – to work effectively with our colleagues.
Teaching and Training– where we have teaching responsibilities, to develop the skills, attitudes and practices of a competent teacher.
Probity –to be honest and trustworthy.
Health – to ensure that any problem with our health does not endanger patients.

We can become more familiar with these by dividing them under the GMC's four performance areas. These are the performance areas that are used in annual GP appraisal:

Knowledge, skills and performance
Maintain professional performance
Apply knowledge and experience to practice
Keep clear, accurate and legible records

Safety and Quality
Put into effect systems to protect patients and improve care
Respond to risks to safety
Protect patients from any risk posed by the doctor's health

Communication, partnership and team work
Communicate effectively
Work constructively with colleagues and delegate effectively
Establish and maintain partnerships with patients

Maintaining Trust
Show respect for patients
Treat patients and colleagues fairly and without prejudice
Act with honesty and integrity

We collect evidence of our performance under these four performance areas for NHS appraisal and revalidation, where the tools of MSF, audit and the PDP are particularly important.

Assessor's corner: is the doctor is aware of GMP?

Evidence may come from professional conversations, e.g. in teaching sessions or through case-based discussion. For example, does the doctor know and understand the GMP headings?

A good test of this is to ask what evidence the doctor would collect under each heading and to ask which GMP headings would be covered by a particular piece of evidence (e.g. the PDP)

With reference to these headings, what behaviours would suggest that a doctor might be underperforming or even be a cause for concern?

Serious breaches of GMP

Most doctors achieve the high standards of GMP, but the GMC has legal powers to take action in the small number of cases where 'Serious or persistent failures to meet the standards puts registration at risk'.

The GMC reassuringly recognise that: 'All human beings make mistakes' Whilst one-off mistakes need to be investigated by those immediately involved, harm addressed and lessons learned, they are unlikely in themselves to indicate a fitness to practise problem. So what constitutes such a problem?

A question of fitness to practise is likely to arise if:

A doctor's performance has harmed patients or put patients at risk of harm
For example, if a series of incidents cause concern. These incidents may indicate persistent technical failings or other repeated departures from good practice which are not being, or cannot be, safely managed locally.

A doctor has shown a deliberate or reckless disregard of clinical responsibilities towards patients
An isolated lapse from high standards of conduct – such as an atypical rude outburst– would not in itself suggest a fitness to practise issue. But the sort of misconduct, whether criminal or not, which indicates a lack of integrity on our part, an unwillingness to practise ethically or responsibly or a serious lack of insight into clear examples of poor practice could bring our registration into question.

A doctor's health is compromising patient safety

A doctor has abused a patient's trust or violated a patient's autonomy or other fundamental rights.
This is a situation in which we act without regard for the patient's rights or feelings, or we abuse our professional position.

A doctor has behaved dishonestly, fraudulently or in a way designed to mislead or harm others
In this situation, our behaviour is such that public confidence might be undermined if the GMC does not take action.

Observes the accepted codes of practice in order to minimise the risk of disciplinary action or litigation.

As we have seen above, to achieve the competent level of performance we must understand GMP and the circumstances in which it is seriously breached. However, the intention is not simply to avoid disciplinary action and litigation, but to maintain and improve standards in line with personal, professional and patient expectations.

The standards that are expected relate mainly to clinical performance but also cover personal health, ethical views and trustworthiness including honesty. Ethics and conflict of interest are covered in the chapter 'maintaining an ethical approach' and in the current chapter we will look more closely at maintaining performance and personal health.

Professional performance

The Chief Medical Officer in his paper on 'Revalidation principles' has stated that

the approach to maintaining standards will be to encourage doctors to 'keep up to date and improve their practice, through continuous professional development and reflective practice'. The paper goes on to state that the information on performance available to individuals through clinical governance will be made more available, so that judgements can be better informed.

This approach is already incorporated in WPBA. Essentially, we have to demonstrate that our insight (as shown through reflection) and performance (as shown through behaviour) are improving over time. Because these are fundamental to professionalism and to maintaining fitness to practise, a significant and persistent deficiency in either insight or performance is an early warning that we may be, or may become, a cause for concern. The need to have early warning is critically important to training programmes so that remedial action can be taken.

This competency is concerned with the ability to satisfactorily monitor performance and take action when necessary. The following equation helps us to understand the factors underlying improvement in performance:

d performance =d (insight x motivation x application x opportunity)

d (delta) represents change, reflecting the fact that if the absolute level of performance does not improve with time, in real terms it deteriorates because (to take clinical care as an example) treatment options will improve with medical advances. 'Standing still' therefore translates in the real world as 'going backwards'.

d could be positive or negative. The effects are multiplicatory, not additive, because a zero value in any one of these measures means no (not just less) improvement. We can see that the elements of the equation are not context specific, which means that they can be identified by any observer at any stage of training.

As attributes, we shouldn't think of performance and insight as being separate from each other as the following table explains:

Performance	Insight	Comment
Good	Good	**Ideal**
Good	Poor	**Unconsciously competent**: because the doctor fails to understand why s/he is (currently) competent, the doctor may not adapt to changing situations. The doctor may also engage in risky practices through lack of insight about the connection between action and effects.
Poor	Good	**Consciously incompetent**: the doctor might be difficult to remediate because s/he has low motivation to improve. The causes of low motivation, such as stress need to be looked for and addressed.
Poor	Poor	**Unconsciously incompetent**: this doctor may be the most difficult to remediate because despite regular exposure to deficiencies in performance, s/he may lack the ability to change.

As we can see, we need to both show insight *and* use that insight to improve performance, where this is needed.

Assessor's corner: is the doctor applying GMP?

Evidence will come from personal observation and from feedback. Does s/he have a mechanism to gauge insight and link this to changes in performance?

How good are the monitoring processes? For example, does s/he recognise the value of data on performance as material that can be used to drive learning?

What range of data does s/he use? This range should include feedback, audit, and the follow-up of cases.

What is the doctor's interpretation of this data; does it show insight and is this level of insight improving over time?

Is personal health discussed? What are the doctor's attitudes to health and work-life balance? What about ethical views?

Are ethical dilemmas recognised and given appropriate thought?

If evidence does not seem to arise naturally, it can be generated through discussion, for example through targeted questioning in CbD.

Assessor's corner: how can educators gauge insight?

Insight is an important marker of fitness to practise. When insufficient, it may be an early warning that remedial action is needed

To gauge insight, for example following structured assessments, trainees could explain which competencies in the competence framework they think they are meeting or failing to meet, giving their justification. This could be compared with the views of the educator, looking for significant gaps between the two.

Narrowing of gaps in insight and the gaps in performance related to these, could be looked for over time using evidence from the trainee's completed learning cycles.

Our insight can be progressively gauged through frequent opportunistic contacts, particularly through case discussion with colleagues. However, we can and should contribute other meaningful work that demonstrates professional growth beyond evaluations and self-assessment. Examples include:

- Critical incidents of patient events
- Reflective journal or diary
- Clinical care audits
- Articles reviewed using critical appraisal skills

These allow a more substantial opportunity for our insight and critical thinking to be witnessed and they provide evidence of performance in areas that are not easily assessed through the structured tools.

Probity: Being honest and trustworthy

Probity means being honest and trustworthy and acting with integrity ,and is at the heart of medical professionalism.

Integrity is a word that is widely used, but what does it mean? Integrity is not a synonym of fairness, but suggests being 'whole' through adhering to an ethical and moral code and of being someone who would not threaten that wholeness by behaving in adverse ways.

The GMC highlight circumstances in which certain action has to be taken if probity is not to be compromised. They say that:

- The GMC should be informed if, anywhere in the world, we have accepted a caution, been charged with or found guilty of a criminal offence
- We must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents.
- We must always be honest about our experience, qualifications and position, particularly when applying for posts.
- We must do our best to make sure that any documents we write or sign are not false or misleading. We must make clear the limits of our knowledge or competence.
- We must co-operate fully with any formal inquiry into the treatment of a patient and with any complaints procedure that applies to our work.
- We must disclose to anyone entitled to ask for it, any information relevant to an investigation into our own or a colleague's conduct, performance or health.

Financial and commercial dealings are also part of probity and are mentioned in the chapter on 'maintaining an ethical approach'.

Encourages scrutiny and justifies professional behaviour to colleagues.

If we are performing at the 'excellent' end of this scale, we can demonstrate that maintaining performance is a communal activity. In reality, no doctor can maintain performance in isolation of those around him or her. This is because good insight depends upon high-quality feedback, which is in turn related to high-quality data and to good feedback skills.

To demonstrate this competency, we need to talk about our performance, for example our case management, with colleagues and be proactive in doing so rather than just responding defensively when things go wrong. In practice, 'Justifying professional behaviour' occurs not so much when problems arise as when we share management approaches with colleagues and discuss interesting cases in order to improve our *communal* understanding and insight.

This is particularly important in primary care, where so much of our clinical ability depends upon an understanding of probabilities and an appreciation of what the earliest signs of deviations from an expected path of recovery might look like. Learning from colleagues is therefore invaluable as this allows us to learn from the experience of others, rather than just being reliant upon ourselves.

'Encouraging scrutiny' is qualitatively different. Scrutiny (voluntary or not!) happens routinely during training, because continuous assessment is mandatory. However, *voluntary* scrutiny of performance in independent life is much less frequent and the reasons are understandable. No doctor likes to be seen to perform at a below-average level, let alone poorly. This may be a strong deterrent from being open with others about our 'failures'. The additional complication in practice life is concern about our reputation, in particular the fear of loss of respect from colleagues with whom we have a long-term relationship.

The counterargument to this is that external scrutiny can greatly help us to establish where our weaknesses (and indeed our strengths!) lie. For example, observing consultations through COT can quickly provide objective evidence that can help us to target our learning in a way that self-reflection may not achieve. Far from losing respect, those who encourage such scrutiny are often respected even more by their colleagues for being brave enough to do so and for setting a praiseworthy example of professionalism.

The more that such scrutiny becomes routine, the more that we will see that 'perfect' performance is unattainable and that every doctor has something to learn. In turn, this may help us to have more realistic expectations of each other and encourage us to help each other to maintain performance.

For this competence to be achieved, feedback skills are all-important. It is all well and good exposing oneself to the scrutiny of peers, but if feedback is not given sensitively and formatively, the experience could be damaging, rather than nurturing. Rather than assume that such skills exist, it is better for team members to learn the straightforward principles involved.

Assessor's corner: how can we gauge probity?

Probity has traditionally been demonstrated through self-declaration in NHS appraisal. However, those who work with the doctor are in a position to comment on honesty and trustworthiness as a general feature of the doctor's behaviour and may also be in a position to say whether or not they know of any situation in which this has been breached.

Needs Further Development	Competent for licensing	Excellent	
Attends to professional demands whilst showing awareness of the importance of addressing personal needs.	Achieves a balance between professional and personal demands that protects professional obligations and preserves health.	Anticipates situations that might damage the work/life balance and seeks to minimise the adverse effects.	**2**

This second competency progression is concerned with work-life balance. We move from:

Assessor's corner: how do we assess whether the doctor is aware of work-life balance?

The doctor should demonstrate awareness of work-by balance by showing that s/he recognises why the issue is important by talking about personal circumstances and how work and life are in tension with each other and at the same time, are mutually beneficial.

The doctor's attitudes towards work and life should be explored. What is this attitude and is it likely to lead to a healthy or unhealthy balance?

Being dependable with work commitments but not yet thinking seriously about work-life balance.

Being dependable with work but at the same time taking active steps to optimise work-life balance.

Thinking ahead so that the threats to work-life balance can be identified and reduced.

Looking at each of the word pictures in turn:

Attends to professional demands whilst showing awareness of the importance of addressing personal needs.

'Doing the job' is the obvious priority and it may seem odd to even be concerned about what we do in our spare time. It may even seem that, provided work commitments are being attended to, what happens outside work is no-ones business but our own.

Why then do we make an issue of work-life balance? Should we live to work or work to live? Here are a few points to help us explore this issue:

Firstly, time and energy are finite and what happens outside work may affect the ability to fulfil practice and other professional commitments. These commitments include the inevitable paperwork generated by patient care (and from which trainees are relatively protected), the time-consuming process of keeping up-to-date through personal study and attending meetings along with the extra time needed to deal with problems and to help develop the practice. Too much time or energy expended elsewhere may limit our motivation or ability to fulfil these responsibilities.

On the other hand, given that doctors are generally highly motivated and tend to work hard without being told do so, there is a risk that time spent on work commitments may seriously limit our ability to engage with the family, develop relationships, develop other interests and take adequate rest. This can lead to physical and emotional problems, as we will discuss later in this chapter.

Work and life need to be in balance because when they are, we feel less stressed and more fulfilled-- as do those who work or live with us. Ask them!

Time spent outside work is time spent in the 'real' world. This helps us to gain vital life experience, which can greatly help our ability to relate to patients and understand their priorities. Because of the length of training we are relatively deficient in personal life experience in our younger years compared to our non-medical contemporaries in society. Therefore, creating time for a 'normal life' is particularly important if we are to gain a balanced view of the world.

When we think about our careers, it is important to think not only about the here and now, but also about how to keep a career sustainable. This has implications for the work-life balance, which if kept under control can help us to prevent burnout. In addition, sustainable careers are usually those that have variety. A good balance allows variety and stimulation from outside sources and helps us to feel fulfilled for a greater proportion of our careers. Examples of ways of achieving work-life balance include part-time and flexible working patterns.

Achieves a balance between professional and personal demands that protects professional obligations and preserves health.

This competency is a step beyond the previous one in that we think about what an adequate work-life balance would be by considering whether the balance is enough to meet work commitments and at the same time maintain physical and mental health. What are the steps involved in this process?

Firstly, we need to think about our current situation. Are work commitments being met? What about life outside the practice? Are important relationships (partner/ family) being intended to? These are sensitive areas and although we can answer these questions by ourselves, it is even better to find out what our colleagues and family think. We need to get into the habit of doing this periodically to check on the balance, because such people are much less likely to pretend that everything is okay than we are!

Of course, colleagues and family are likely to always want more from us, but to get the balance right it can be helpful to talk to someone independent such as a friend, colleague, trainer, mentor or appraiser.

Once the current position has been established, the next step is to decide whether any changes in the balance are needed. If this is the case, the obvious step is to the increase the time spent on one by simultaneously reducing the time spent on the other. However if it is possible to be more time-efficient, it may be that the time spent on work can be reduced whilst still meeting the same professional obligations. If efficiency can't be improved, then a reduction in professional obligations may be needed. To do this requires good negotiation skills.

Alternatively, flexible ways of working may help a sustainable work-life balance to be achieved. Here are some examples:

Flexible hours	Simply not having to be at the surgery at 9am can relieve much of the stress of domestic management. Travelling outside the rush hour can take stress out the beginning and end of the day.
Part-time work	Part-time work is particularly beneficial for people with substantial caring commitments, those who are returning to work after looking after young children and those who wish to create time for a portfolio of interests.
Home-based working	Most of us work informally from home but in the future, remote computer access may make this an option for some of our activities, especially consultations that do not require face-to-face meetings. On the other hand, working from home can intrude on family life and may simply lead to taking work home and thereby extending the working day.

Assessor's corner: what is the evidence that the doctor is achieving an appropriate work-life balance?

Assessors could look at a number of areas. 'Protecting professional obligations and preserving health' requires a good deal of insight along with the motivation to repeatedly gauge one's position in relation to these.

To meet this competency, doctors need to engage periodically with colleagues, family and friends and discuss whether the balance is right or needs modification.

Does the doctor discuss these issues? What is his/her assessment of the current balance and on what is this based? How does the doctor maintain work-balance? Is this simply a matter of chance, or does s/he take active steps?

Try posing hypothetical situations (e.g. change of life circumstances/the possibility of a 'special interest' post); how would the doctor address the possible changes to work-life balance?

Anticipates situations that might damage the work/life balance and seeks to minimise the adverse effects.

Assessor's corner: what is the evidence that the doctor anticipates adverse changes to work-life balance?

Doctors who demonstrate this competency are people who think ahead, rather than firefighting when problems arise.

Assessors will only know that this competency is being achieved if the doctor discusses work-life balance issues with colleagues.

Therefore, the doctor must also be someone who communicates well and keeps people in touch with their thoughts about significant changes in their lives.

In addition, these doctors think about themselves in a wider context, looking at the impact of events on others, particularly colleagues and family.

They consult with the others who are affected and are often able to suggest a number of ways forward.

At the 'excellent' end of the scale, we are not only adept at maintaining work-life balance, but can think ahead to situations where this might change.

On the work front, this might occur when there are significant changes in practice that might affect workload such as changes to the service we provide, personnel changes and seasonal variations in workload.

On the home front some 'life changes' will occur that can be anticipated, for example children, family commitments, extramural activities and health issues such as elective surgery.

Career developments can also be anticipated, for example taking on an additional commitment such as becoming a trainer, delivering an extended-hours service or taking on a managerial role.

We can make minimise the adverse effects to our work-life balance in a number of ways such as obtaining advice, getting help (e.g. with childcare) or by altering work commitments. The latter may include simple measures like altering work rotas or more complex ones like renegotiating contracts in order to work flexible hours or take a sabbatical.

Anticipatory action may not simply be the responsibility of the individual. For example, service changes such as offering longer opening hours are likely to affect the work-life balance of doctors, practice nurses and reception staff. Discussing the work-life implications of these changes can help team members decide how the service should be developed and the degree to which they wish to be personally involved.

On a wider scale, doctors may be involved in national negotiations on the terms and conditions of service so that a reasonable work-life balance for *all* doctors can be maintained. An example of this is the way in which GPs lobbied for additional mechanisms of providing out of hours care so that they did not have to be available 24/7.

Needs Further Development	Competent for licensing	Excellent	
Attends to physical or mental illness or habit that might interfere seriously with the competent delivery of patient care.	Proactive in taking steps to maintain personal health.	Promotes an organisational culture in which the health of its members is valued and supported.	**3**

The third competency progression concerns our personal health and the health of those we are responsible for in the organisation. We move from:

Identifying a personal physical or mental problem and managing this appropriately

Taking active steps to maintain health, thereby reducing the likelihood of avoidable health problems in the future

Going beyond personal health issues by thinking about the medical and non-medical members of the team and the steps that can be taken to promote health.

Looking at each of the word pictures in turn:

Attends to physical or mental illness or habit that might interfere seriously with the competent delivery of patient care.

Our health matters, because there is little point in achieving competence if our work becomes unsustainable because of health issues.

The first two competencies in this theme are related to each other. To achieve the first, we need to 'attend to illness or habit' in other words, deal with a problem that *already* exists. In the second competency, we act in a preventative capacity by taking steps to maintain our health.

Time off work

Being doctors does not make us immune to ill health. We are prone to same range of diseases as the general population and would be expected to deal with these in a similar manner to other patients. This is much easier said than done, for a number of reasons:

- GPs have plenty of experience with self-limiting illnesses and may feel that it is reasonable to manage these without seeking independent medical advice. Surveys suggest that two in five of us prescribe antibiotics, painkillers and other medication for ourselves.
- With more significant conditions, we may feel reticent because of practical issues in getting to see a doctor ('there is nobody to cover me if I have to take time off to visit my own GP').
- There may be concerns that confidentiality will not be maintained if ill-health is disclosed, with possible effects on career progress.
- We may be concerned that we will be signed off sick and therefore be unable to work, putting a strain on our colleagues, incurring locum costs etc.
- There is a perceived lack of tolerance towards ill health among doctors. We are 'not allowed to be ill', because it is seen as a form of weakness or liability.
- The occupational health service may be poorly developed and difficult to access.

The literature suggests that we are less likely than other professions to take time off work for ill health. When we are off work, it tends to be for longer periods.

What are the main reasons for early retirement in GPs?

Whilst poor morale and motivation are often given as reasons for leaving medicine, a study of early retirement in the NHS showed that the most common reasons were psychiatric issues such as depression, anxiety and alcoholism.

Not surprisingly, these three are also the most common health issues for doctors.

Watch out for burnout!

Burnout describes the syndrome of emotional exhaustion, cynicism, low productivity, and feelings of low achievement. We may think that cynicism is simply a character trait, but some believe that it can be a method of coping with the stress caused by dealing with unmanageable expectations and workload.

If a colleague is frequently cynical, it can be worth exploring stress and workload issues rather than just passing it off.

Dealing with stress

The three most common disorders from which GPs suffer are depression, anxiety and alcoholism, i.e. this doesn't just happen to other people, it happens to us! In doctors, the prevalence is around 20% compared with around 18% in the general working population.

A common cause of these is stress and it is therefore worthwhile for us to know more about stress and how to manage it.

Why is stress increasing? The RCGP offer a useful perspective on this:

'Where GPs would previously accept any professional hardships due to the respect, deference, autonomy and job security offered by the profession, these rewards have now been replaced by greater accountability, a growing blame culture and greater consumer expectation by patients'.

Why are we vulnerable?

GPs become close to their patients, dealing with physical and psychological problems which are often distressing. It can be difficult (i.e. stressful) to maintain an appropriate balance between being empathetic to the patient and sufficiently detached to avoid damaging our health. We may not have the opportunity either at work or at home to debrief or feel adequately supported. In addition, we may exacerbate the problem by being overcritical of ourselves.

What are the main causes of stress for GPs?

Surveys suggest that in descending order of frequency the main stressors are:

- Emergency calls during surgery hours
- Time pressure
- Working after a sleepless night
- Dealing with problem patients
- Worrying about patient complaints
- Interruption of family life (particularly for female doctors)
- Unrealistically high expectations by others of the doctor's role
- Partner on holiday.

Older GPs are more stressed by *contract demands* compared to younger doctors, but younger doctors are more stressed by unreasonable *patient demands*.

If we look at the main causes of stress for GPs we can see that several elements relate to problems with the work-life balance as discussed earlier. Attending to these elements not only helps the balance, but can help to preserve our health.

Wives of GPs are four times more likely to commit suicide than other women, with the main stresses for them being the GPs' detachment from the family, workload concerns and communication problems.

Stress isn't limited to GPs and in fact, we are often the *cause* of stress in other members of the team. Just ask them! A survey of stress in the healthcare team, excluding doctors, suggested that in descending order of frequency the main stressors are:

- Patient demands
- Too much work
- Patient abuse/aggression
- Time pressures concerning appointments
- GP demands
- Poor communication

Team members (unless they have good assertiveness skills!) may feel reticent about discussing the factors that are partly the GP's 'fault'. It is worth asking our team members, whether our behaviour is a significant cause of stress to them and whether there are ways we could change our behaviour. A less stressed and more harmonious team is also likely to reduce the stress on ourselves, so the benefits are two-way.

What are the signs and symptoms of stress to look out for? Again, it is as relevant to look for these in ourselves as in others.

- Lack of concentration, increased errors and adverse significant events
- Poor timekeeping
- Poor productivity
- Difficulty in comprehending new procedures, increased tendency to make mistakes and resisting change.
- Lack of motivation or co-operation along with irritability, aggressiveness, withdrawal behaviour and resentment.

Proactive in taking steps to maintain personal health.

This goes beyond achieving work-life balance. Doctors who achieve this competency demonstrate the ability to think ahead and maintain health, rather than just deal with health issues when they arise. We have illustrated the importance of stress and how it underpins the three most common health issues. Let us now think about how we can be proactive with our health and particularly with managing stress.

How can stress be made manageable?

How can you help yourself?

Here are some practical suggestions. Please think about them.

Registering with a GP

- Register with a GP *before* you need help. It's OK to share information with your colleagues, but not to have informal consultations with them.
- It's important to admit vulnerability. We are human and need support from colleagues and family like anyone else.
- It is much better to behave like any other patient and go through the usual channels. That way, well-meaning but inappropriate shortcuts (like avoiding physical examination) won't be taken and potentially serious problems will not be so easily missed. It's often said that doctors, when they get ill, don't have anything 'straightforward'. Could this partly be because we don't tell anyone early on?
- Remember that the GMC state 'You must ask for and follow your doctor's advice about investigations, treatment and changes to your practice that they consider necessary. You must *not* rely on your own assessment of the risk you pose to patients'

Work & life

- Control the workload. Create appropriate boundaries and don't take on more than you can manage.
- Live healthily, taking the lifestyle advice you give your patients and being careful about alcohol, which is a particular risk for doctors.
- Keep work-life balance under review. It's not just a concept, it's a tool to maintain health, so talk about it periodically. Don't ignore feedback and be prepared to change the balance when necessary.

- Have a life! Make space for yourself; build social networks inside and outside work.
- Make sure that you have activities outside medicine.
- Be organised e.g. make good childcare arrangements, have reliable transport, avoid stressful commutes, arrive with enough time to avoid rushing to catch up throughout the day. Wherever possible, do today's work today so that you are not constantly working to overcome a backlog.
- Give yourself challenges, but not so much as to cause unhealthy stress.
- Make sure you have social support at work. This means investing in your relationship with colleagues and the team.
- Develop stress management skills; there are lots of good resources
- Make sure the work you do continues to have meaning for you. This is vital to maintain motivation over the years.

Stress awareness and SWOT analysis

Once we understand more about stress, it can be useful to ask ourselves, 'what are our strengths, weaknesses, opportunities & threats' regarding the stress in our professional and personal lives?

This may help to raise our awareness of areas that we need to attend to and give us ideas on how we might reduce stress before it becomes a problem.

Consulting

Be comfortable and improve the 'feelgood' of the environment that you spend so much time in. For example, look at ergonomics, decoration, personal items and mementos such as a holiday picture on your desktop, photographs and thank you cards in the room.
In surgery, don't be more stressed than you have to be. For example, avoid:

- Starting surgery late
- Overbooking
- Accepting commitments that begin too soon after surgeries are due to finish
- Making insufficient allowances for urgent fit-ins
- Allowing inappropriate telephone or other interruptions in surgery

You don't have to solve these problems on your own. Your manager can help you to achieve much of this.

Keeping healthy and avoiding burnout

- Avoid exhaustion by making sure that you get adequate sleep, periodic breaks, relaxation and regular exercise.
- Deal with problems and with problem people
- Avoid burnout through time management, delegation and being appropriately assertive. LADDER describes a six-stage process for handling problems in an assertive way. These are:

Look at your rights and what you want, and understand your feelings about the situation
Arrange a meeting with the other person to discuss the situation
Define the problem specifically
Describe your feelings so that the other person fully understands how you feel about the situation
Express what you want to say and what you propose clearly and concisely
Reinforce the commitment of the other person by explaining the mutual benefits of adopting the action you are suggesting.

The box describes assertion, not negotiation. GPs are used to negotiation and may find it difficult to be assertive. However an assertive approach can be a fair way of raising and dealing with relationships with people you find difficult and/or powerful. The approach can promote mutual respect because it avoids both inappropriate passivity and inappropriate aggression and allows the facts to be presented relatively dispassionately. This makes it more likely that, through dialogue, a satisfactory solution can be found.

One word of warning: do not apply this approach to problem patients or other vulnerable people to whom you have a duty of care. The situation with them is more complicated and needs to be handled carefully.

Another way of anticipating problems is to complete a questionnaire related to health. An interesting one is MAGPI (Morale Assessment in General Practice Index) authored by McKinstry, Porter, Wrate, Elton &Shaw. An example of a completed questionnaire is shown below:

MAGPI

Please indicate ✓ which statement in each of the following groups best reflects how you feel about yourself and your job ***in the past month:***

A score of **greater than 20** is high and indicates a high possibility of stress.
If you have a high score, take time to discuss the issues and think about getting practical help.

Based on the responses shown above, we might reflect on our ratings as shown in the example below:

		Score	Comments
1	(a) I feel in control of my work	Control 2	Paperwork is the main problem-this seems to fill the 'gap' between surgeries and isn't getting any better!
	(b) Sometimes I find it hard to keep on top of my work ✓...		
	(c) I am having great difficulty managing my workload		
2	(a) I get on very well with all my partners ..✓..	Partners 1	My partners are friendly towards me and a recent MSF confirms good relationships.
	(b) I am not getting on well with my partners from time to time		
	(c) My partners and I do not get on well		
3	(a) I am more up to date with modern practice than the majority of doctors	Up to date 2	I've taken on more duties with teaching undergraduates as a tutor, so I suspect I'm more up to date than the average doctor, but I think that the overall standard for doctors has risen anyway
	(b) I am as up to date as most with modern general practice ..✓..		
	(c) I have not kept up to date with modern practice		

4 (a) I feel well supported at work ✓.....	Support at work 1	Generally supportive colleagues and staff, I am fortunate to say
(b) Sometimes I feel a bit let down by the people who work with me		
(c) I really can't rely on the people I work with to support me		
5 (a) I am in good health ✓....	Health 1	I play badminton regularly
(b) I have only minor worries about my health		
(c) I have been quite worried about my health		
6 (a) I am well supported at home	Support at home 2	The children are approaching teenage and my wife works part-time as an accountant. She is proud of my new teaching commitments, but I don't think she appreciates the extra demands that this makes on my time. Having said that, I also feel that I haven't the time to support her in ***her*** career
(b) I could be better supported at home ✓....		
(c) I have little support at home		
7 (a) I can keep my home life and work in balance satisfactorily	Work/ Home balance 2	I've had to go to more meetings and have also had to do preparation work in the evenings. As a result, I don't play with the kids as much as I used to. I like to pretend that the kids don't notice, but I'm sure they do.
(b) It is difficult to keep a balance between work and home life ✓.....		
(c) My work and home life often conflict		
8 (a) I am a happy person	Happiness 2	Strange, really. In some ways, things are coming right and my career is developing, but life just seems to get busier. More is not necessarily better.
(b) I feel OK but there have been happier times in my life ✓.....		
(c) I am unhappy a lot of the time		
9 (a) I have family or friends I can turn to ✓.....	Help 1	I have a small number of close friends, who I know would listen if I needed it although I try not to bother them.
(b) I don't always feel I can turn to friends or family		
(c) There is no-one I can turn to for help		

1 (a) My patients think I do a good job for them	Valued by pts	I think they probably value me, but I haven't formally asked for some time-maybe I should do another feedback questionnaire.
(b) I am not sure what my patients think of the job I do for them ✓....	2	
(c) My patients do not value the job I do		
1 (a) My colleagues generally value me ✓.....	Valued by colleagues	They are friendly, but I'm not sure how much they value me as they are not particularly demonstrative.
(b) I don't know how my colleagues view me	1	
(c) I don't think my colleagues value me much		
1 (a) I have no problems with alcohol ✓....	Alcohol	I restrict myself to a glass of wine in the evening and I don't drink & drive. However, I've noticed that my wine glass is a large one.
(b) I occasionally wonder if I have become too reliant on alcohol	1	
(c) I am worried about my use of alcohol		
1 (a) I know that I've chosen the right career ✓.....	Career choice	I've never really had any doubts about this. I'm sure that teaching will also increase my job satisfaction.
(b) I quite often wish I had chosen a different career	1	
(c) I really regret having chosen my career		
1 (a) I have no particular worries about my family at the moment.....	Family worries	I feel guilty that I'm not pulling my weight at home.
(b) I have some worries about my family at the moment ✓.....	2	
(c) I have serious worries about my family at the moment		
To score the MAGPI, (a) = 1, (b) = 2, and (c) = 3	**21**	
Total score		

Assessor's corner: what is the evidence that the doctor is being proactive about health?

At a basic (but often neglected) level, we might ask whether the doctor has registered with a GP. Does s/he comply with any treatment is required?

Beyond this, what, if anything, does the doctor do to maintain health?

Does the doctor maintain his/her immunisation status? Has the doctor tried to assess risk factors for the work-life balance?

Does the doctor show an awareness of stress? What steps does s/he take to manage stress?

If s/he has had health issues, is there any evidence that these could have been anticipated or prevented?

Learning from MAGPI

Summary

I have a high(ish) overall score, which surprises me. I don't think of myself as being stressed, although I'm certainly busy.
I think that my highest scores reflect the pressure that my work puts on my family priorities. I'm fortunate to be working with enthusiastic colleagues, but that may be part of the problem. We tend to spur each other on and don't particularly talk about achieving a balance.

Issues identified

Getting the work/life balance right. (Could also be an issue for my colleagues generally?)
Being less busy.
Finding out whether my patients value my work.

Learning/ action points

I need to talk to my family and particularly my children. I really don't want to mess things up for our future.
Do less and play more.
Do a patient satisfaction survey.
Possibly raise the 'balance' issue with my colleagues. Perhaps we could share what we have learned from MAGPI?

Changes made

I talked to a clinical lecturer, who was sympathetic and helpful. I was overdoing the preparation for my teaching sessions and probably setting my sights too high. She helped me to set more reasonable goals so that I could have more time with the family.
My colleagues thought that talking about MAGPI was a good idea. We did this in pairs and found that some common themes arose. Even though this did not lead on to any immediate changes, we felt that talking openly in this way was a useful start. I think it has also brought us closer.

Promotes an organisational culture in which the health of its members is valued and supported.

There is an implicit onus on us and other healthcare workers to set a good example by living healthy lifestyles. Doctors who achieve this high level of competence are not only proactive about their own health, but also seek to make health an issue for the team for example by encouraging personal health promotion and by looking at ways in which health could be influenced by the conditions at work.

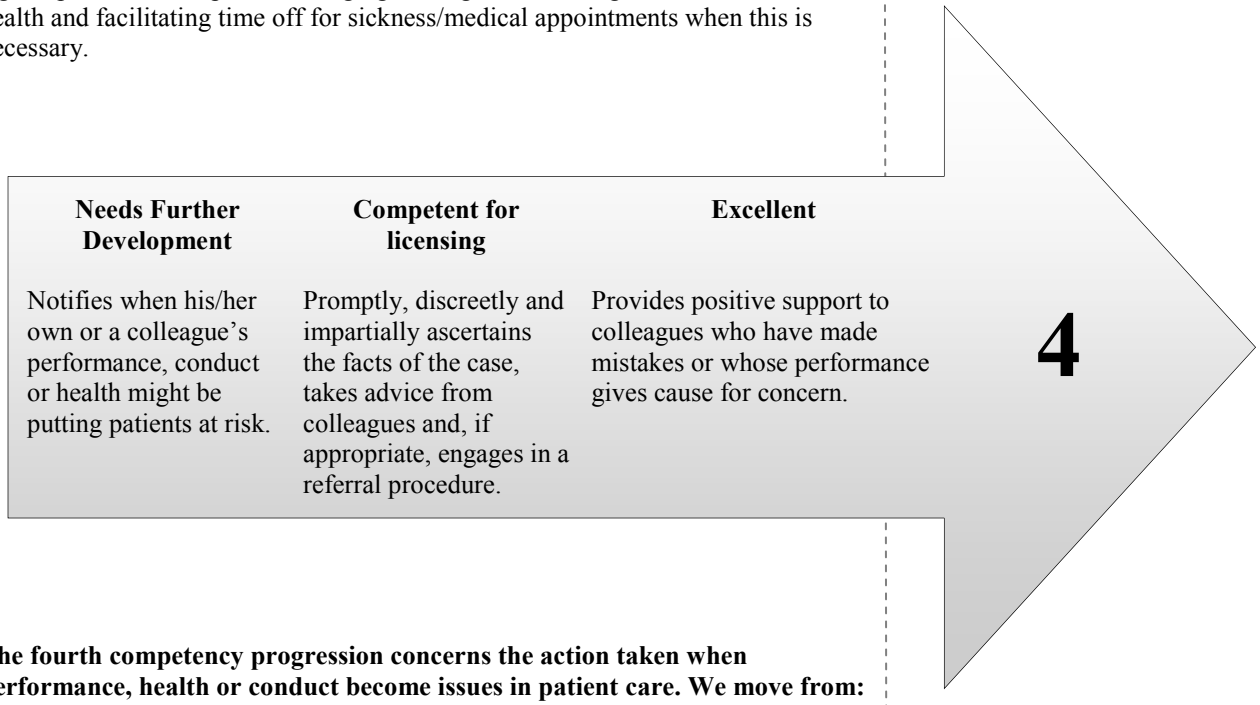
Why is the health of the team important? Healthy workforces are known to be more productive and to have higher morale, so there are sound *business* as well as compassionate reasons for being proactive. As an employer, there are a number of ways in which the health of the team could be addressed:

- Assess the risk by looking at health and safety issues. These might be physical, such as the risks of strain injuries and infection that could be prevented through ergonomic furniture and appropriate vaccination respectively. Back pain and stress are two very common causes of days lost through illness.
- There may be psychological risks that could be prevented by accessing training on how to manage difficult or violent patients.
- Optimise working conditions (Toilets, space, lighting, temperature) to improve performance by making team members comfortable
- Encourage staff to walk or cycle to work. Provide secure cycle parking, a shower, and encourage physical activity such as charity runs.
- Limit work stress by making reasonable demands and creating an open atmosphere so that problems can be voiced.

- Enable work-life balance rather than assume it. Monitor workloads to keep them sensible, and make sure employees take regular breaks and annual leave so they are getting away from work when they need to.
- Support employees when they become ill. Sick staff often feel under pressure to return to work before they are fully recovered, putting their own health and even the health of colleagues at risk. Stay in contact while they are ill, but do so sensitively. Delegate their work to someone else and reassure them they don't need to return until they are ready.
- Be fair. Make sure that bullying and discrimination are picked up early and dealt with effectively.

We've talked about prevention, but it is worth looking at whether health is *already* a problem. If staff turnover is high or increasing days are being lost to sickness, we should ask ourselves how healthy the workplace really is.

Additionally, 'valuing and supporting the health of the team' also applies to relationships with medical colleagues. Doctors who demonstrate this competence are supportive of their colleagues through a number of mechanisms such as setting a good personal example, encouraging colleagues not to neglect work-life balance/ health and facilitating time off for sickness/medical appointments when this is necessary.



The fourth competency progression concerns the action taken when performance, health or conduct become issues in patient care. We move from:

Being vigilant about performance conduct and health and discussing any concerns before they affect patient care

Acting proportionately, collating information and using professional judgement to decide whether a problem or potential problem exists and if so, whether it needs further investigation

Providing support, but also being constructive in helping colleagues to overcome problems and improve performance.

Assessor's corner: what evidence suggests that the doctor notifies colleagues?

Hopefully, the situation may not arise in which patients are put at risk. However, the trainee could be asked what s/he would do in hypothetical situations posed for example in CbD.

Also, how open has s/he been about related matters. e.g. does the doctor talk about *their* health, admit to stress and share how this affects their work?

Another source of evidence is the doctor's learning plan. In effect, this is a notification of an area of performance that needs attention.

How well does the doctor monitor their performance, how proactive is s/he in suggesting learning needs and how much insight into performance do these suggestions show?

This progression describes a series of competencies that are not often seen in general practice, or indeed in secondary care. This is partly because these circumstances are (thankfully) rare, but also because the profession is undergoing the culture change that these competencies require. This culture change particularly relates to our willingness to accept joint responsibility for patient safety.

Looking at each of the word pictures in turn:

Notifies when his/her own or a colleague's performance, conduct or health might be putting patients at risk.

The previous competency progression concerned personal health and this new theme leads on from this by highlighting the implications for patient safety should personal health become an issue. Beyond health, this competency also describes the action that should be taken if professional performance or conduct put patient safety at risk

This competency does not simply require us to reflect on the issues, but to take personal action. At the 'needs further development' level, we must report the issue to others and at the 'competent' level, we must also take responsibility for looking into the issue and making a judgement on what to do next.

The competencies may sound prescriptive, even intrusive but they reflect the GMC guidance on patient safety, which says the following:

- You must protect patients from risk of harm posed by another colleague's conduct, performance or health.
- If you have reason to believe that patients are, or may be, at risk of death or serious harm for any reason, you should report your concern to the appropriate person or organisation straight away. Do not delay doing so just because you yourself are not in a position to put the matter right.

Obstacles to reporting

During the training period, educators keep trainees' performance under review and therefore performance issues are likely to be noticed. In independent practice this is quite another matter because, legitimately, doctors are not supervised so intrusively. There is therefore a need for us to monitor our own performance and inform colleagues if significant problems arise that they may not be aware of.

Reporting one's own behaviour is difficult, but surmountable. However, reporting the performance of colleagues raises other issues. We may be reluctant to report concerns for a variety of reasons including fear that we might have got it wrong, that reporting will cause problems for colleagues, adversely affect working relationships, have a negative impact on careers or result in a complaint. The GMC remind us that 'if you are hesitating about reporting a concern for these reasons, you should bear in mind that:

- Your duty to put patients' interests first and act to protect them must override personal and professional loyalties.
- The Public Interest Disclosure Act 1998 provides legal protection against victimisation or dismissal for individuals who disclose information in order to raise genuine concerns and expose malpractice in the workplace.
- You will be able to justify raising a concern – even if it turns out to be groundless – if you have done so honestly, promptly, on the basis of reasonable belief and through appropriate channels.

The GMC injunction reminds us that health, performance and conduct are not simply personal issues. However, we are not being asked to behave as 'practice

policemen'. In an organisation such as a GP practice, we have a joint responsibility to maintain these three factors at acceptable standards and the way of doing this is by:

- Having a *culture of openness and support* in which health, performance and conduct are talked about routinely rather than just when problems occur.
- *Early, routine notification* of adverse incidents or near misses that allows issues to be addressed, problems rectified and lessons learned without patients coming to any harm. Each such event usually involves several people and systems, not just one 'error'.
- Having enough *information available* so that we can adequately reflect on performance and take action early before significant problems arise
- Having the *personal commitment* to act upon recommendations that are made about our own performance (perhaps through clinical audit) and to check whether the necessary change has occurred.

Raising a concern

The mechanism of raising a concern may be different for doctors in training, but there should be a protocol that provides advice on local procedures. Wherever possible, concerns should be raised with a manager, senior doctor or partner in the first instance. For doctors in training it may be appropriate to raise concerns with a named person in the Deanery.

We should be clear, honest and objective about concerns and when the issue concerns a colleague, we should acknowledge any personal grievance that may arise from the situation and keep the focus on the issue of patient safety.

Professional organisations including medical defence bodies can provide advice on what to do if concerns persist despite notification and it is always sensible to seek such advice before taking further action.

Because this is a complex area with significant implications, it is prudent to keep a record of concerns and any action taken to resolve them.

Promptly, discreetly and impartially ascertains the facts of the case, takes advice from colleagues and, if appropriate, engages in a referral procedure.

This competency moves the game on and is concerned with the performance of colleagues rather than one's own performance. To achieve this level, we must understand and feel comfortable with the idea that good performance is a communal responsibility in which each member of the team must play their part. The competency concerns the practical measures that we take should significant concerns arise.

Because it is highly unlikely that the training doctor will get a real-life opportunity to look into a case where performance, health or conduct is of concern, educators need to think about proxy measures that help to gauge whether the doctor is likely to take the appropriate action should the situation arise. Firstly, let us consider some points relating to the process of investigation.

As suggested earlier, we should seek advice, for example with a senior colleague, before taking any further action.

Assessor's corner: how do we assess whether the doctor is likely to take the appropriate action?

There are three important elements. Firstly, does the doctor understand what action is being expected of him/her?

Secondly, how alert is the doctor to the performance, health and conduct of colleagues? For example, does the doctor (either spontaneously or when asked) comment on the part other doctors have played in the patient's management? Can the doctor give constructive and appropriate feedback on the performance of others?

Thirdly, how appropriate are, or would be, the doctor's actions? For example, where is the doctor's threshold for looking at performance issues in more detail? Do they understand the risks of doing so, as well of not doing so? Do they demonstrate the ability to be discreet, impartial and collaborative when discussing this sensitive area? Is their action proportionate to the problem?

When should we take further action?

The types of behaviour that might trigger action include:

Misconduct, such as misusing information about patients, treating patients without consent, making sexual advances towards patients or otherwise ill-treating them.
Poor performance, such as making serious or repeated mistakes in diagnosing and treating the patient's condition, failing to assess (including examine) the patient properly or not responding to reasonable requests for treatment. Poor performance also includes poor teamwork and poor administration that might compromise patient care.
Criminal or dishonest behaviour in financial matters, in dealing with patients or in research. Behaviour such as driving under the influence of alcohol and viewing illegal Internet sites would also fall under this category.
Physical or mental ill health, including misusing alcohol or drugs, that might put patient safety at risk in situations where the doctor has failed to follow remedial advice.

When would further action not be appropriate?

In some circumstances, the investigating doctor's motivation may be suspect and 'taking things further' would be inappropriate. These circumstances include:

- As a mechanism for addressing personal or practice disputes
- To make a doctor apologise to a patient or professional colleague
- To make a doctor provide a patient with the treatment they want

We need to ensure, through dialogue with colleagues, that any proposed action is justified and does not have some ulterior motive.

What are the characteristics of the doctor that may cause concern?

The comments here should be interpreted with caution as it is important not to be unfairly biased or prejudiced but to take each case on its merits. Feedback from those who deal with poorly performing doctors suggest that there are some personality factors that may predispose to problems. The main ones are:

- Unable to delegate
- Reactive rather than proactive
- Difficulty maintaining relationships
- Unable to team build
- Poor judgement
- Slow learner

Additionally, in recent years doctors who have serious performance issues have been characterised by a combination of common features, principally :

- Professional isolation
- Lack of awareness of their poor performance
- Substantial gaps in their knowledge and skills
- Poor 'people' skills
- Advancing age
- Male sex

This information can help practitioners to be more alert to those colleagues who may require support. If we think of the information as describing the risk factors, it can help us to look for these within ourselves and identify those that might be remediable, for example delegation skills, team working skills and important knowledge gaps.

What action could be taken?

This competency suggests that when faced with a performance issue, we should look 'promptly, discreetly and impartially' into the facts of the case. Our duty is not to conduct an investigation, but to obtain more information on which to base a decision as to whether further investigation is needed. We should then to discuss this information with an appropriate colleague.

In practice, this may mean undertaking some simple checks:

- What are the facts (rather than the rumour)? This may involve looking at the medical records and possibly talking through relevant cases/issues with doctors involved.
- How significant (i.e. serious) is the problem? One way to gauge this is to look at the impact on patient care, particularly patient safety. Has patient harm already occurred, or is it imminent?
- Does this appear to be a one-off or is there evidence that there have been a number of other events that suggest a pattern?
- Is the problem confined to one area of performance, or might there be problems elsewhere? For example, poor interpersonal skills with patients may be mirrored by poor relationships with staff.

Assessor's corner: how can we tell whether the doctor is appropriately supportive?

'Being supportive' can be gauged from feedback received from colleagues and patients. The ability to provide constructive support depends upon the ability to be constructively critical.

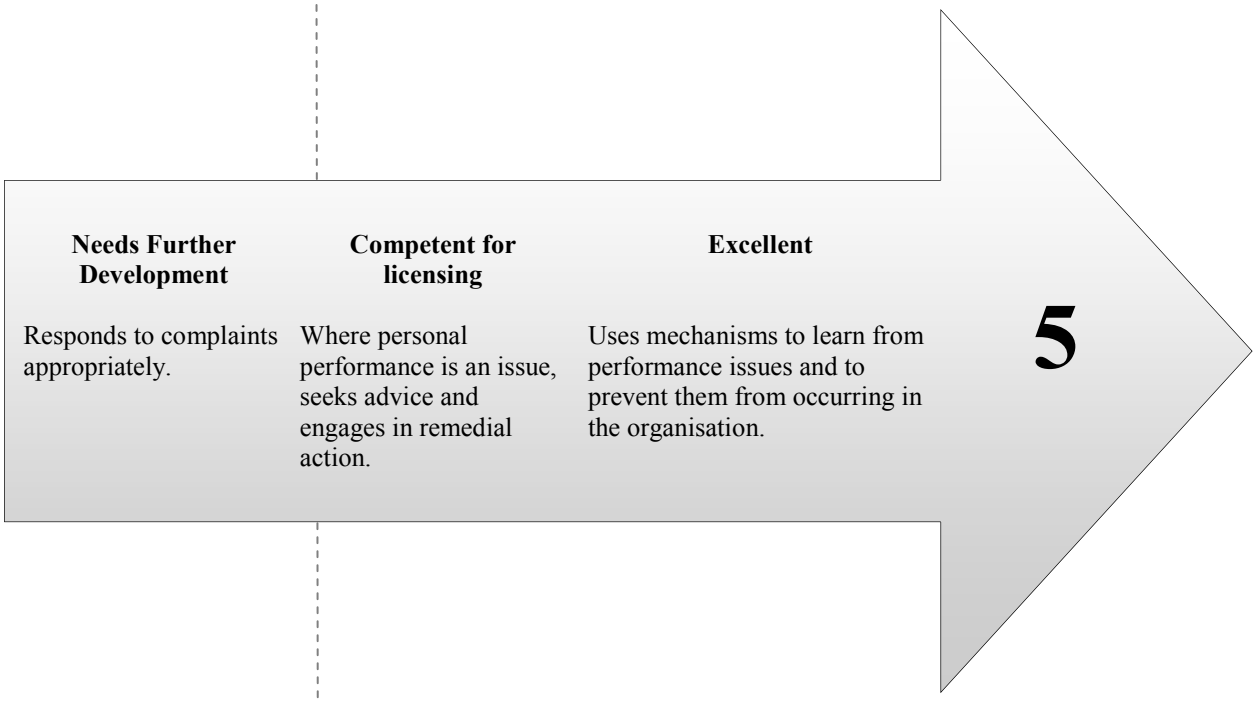
A way of assessing this would be to look at the doctor's feedback skills and ability to be both supportive and constructive, rather than just sympathetic.

Provides positive support to colleagues who have made mistakes or whose performance gives cause for concern.

At the excellent end of this competency progression, we not only take personal responsibility for acting upon concerns but show the ability to support colleagues during a difficult period.

The competency is partly about providing emotional support and showing compassion. This may be inferred from teamworking abilities and from feedback from colleagues.

In addition, we should be capable of helping a colleague to develop a plan of action, provide support with implementing it and provide feedback on the changes that the colleague tries to make. The competency talks about doctors who have made mistakes. It therefore means all of us. Because mistakes and significant events are inevitable, we will all need support at some stage of our careers and it's in everyone's interest to make sure that this competency is done well.



The final competency progression concerns complaints, what they say or don't say about performance and how the team can learn from them. We move from:

Observing the rules about responding to complaints, using appropriate behaviour when doing so.

Evaluating whether the complaint has implications for personal performance and then taking the necessary steps to change where necessary.

Learning from complaints as a team-based exercise, helping the organisation to become more effective and less error-prone.

Looking at each of the word pictures in turn:

Responds to complaints appropriately.

Sadly, no matter how well we and our practices function, complaints are inevitable in professional life. Patient education and expectations are increasing and the media widely publicise the (comparatively rare) examples of serious issues. These are some of the factors leading to the increase in complaints.

Despite being commonplace, complaints are frequently a source of upset to ourselves as well as those who feel aggrieved. It is best not to take criticism personally as this can adversely affect the response that should be made. For example, we could become defensive or angry, both of which could lead to inappropriate reactions.

Most complaints are dealt with successfully at local level and an appropriate response to a complaint involves a number of steps:

Firstly there are suggested time limits in place for replying to complaints and these should be met. In general practice, the practice manager can make sure of this. Once a complaint is received, there are different approaches for formal (written) and informal complaints with the former requiring a written response and usually needing more investigation and record-keeping.

It is important to deal quickly with the issue and to deal with it positively. Expressing concern and sympathy for what has happened can greatly help. It provides what most patients are looking for, which is to be heard, and is not an admission of guilt or liability.

Once a complaint is received, it can be useful to offer a meeting and give the complainant an opportunity to voice concerns and speak openly and freely without fear of recrimination. It should be made clear that the complaint will be taken seriously, investigated appropriately and that the outcomes will be discussed with the patient. In particular, complainants need to know that *lessons* from legitimate complaints will he learned and changes made so that the chances of recurrence are reduced. This is often a prime motive that patients have when making a complaint. A meeting is also an opportunity to clear the air and to correct any misunderstandings. Showing willing in this way is often enough to stop problems escalating.

Assessor's corner: is the doctor responding to complaints appropriately?

Trainees may not receive any complaints during the training period because of limited patient contact and responsibility, close supervision and perhaps a more forgiving attitude from patients towards students.

However, trainees could talk about how they would respond should complaints arise. What is the doctor's attitude? Is it appropriately constructive?

How would s/he conduct a meeting with the complainant? Role-play could help to disclose this and is good practice for the real thing!

Where personal performance is an issue, seeks advice and engages in remedial action.

Complaints are an important opportunity to look at performance. The *pattern* of complaints may indicate a specific weakness, for example in a clinical area. Communication skills are known to be vital in helping to resolve complaints, but poor communication is itself a frequent source of complaints. When complaints occur more frequently than might be expected, this might point to problems with communication, but may also be indicative of poor health or poor decision-making.

To achieve this competency, we would be expected to use significant events, near misses and complaints as triggers to reflect upon our performance, learning any lessons that may be necessary. The following is an example of a reflection on performance following a written complaint:

Assessor's corner: is the doctor learning from complaints?

If complaints do not arise, there are opportunities through the educational process to gauge whether the doctor is ready to accept negative comments and take remedial action through the learning plan.

When gauging their own performance, does the doctor show adequate insight, avoiding being defensive or (when performance is in fact OK) inappropriately submissive?

The latter is important because doctors must be capable of defending their actions where these actions have been justifiable.

Review of a written complaint	
Date received:	**Outline of the complaint and its background:** A 24 year –old single mum, new to the area and unregistered, rang to sign on and to request an emergency visit for her 3 year old daughter who had a temperature. Mum said she didn't have transport to bring her daughter to surgery and then made out that the daughter was too ill to come anyway. I established that the daughter was not seriously ill and gave telephone advice. Mum took the daughter to casualty, where antibiotics for an ear infection were given, although there were no pathognomonic physical signs. Mum then complained about my 'refusal' to visit. I explained our policy for emergency visits and that lack of transport was not usually an acceptable reason to visit. In the end, the family have decided to register with another practice, which is probably the best outcome for both sides.
Issues arising	Responding to emergency visit requests for new patients who are not familiar with our system. How to handle patients who act unreasonably
Process of resolution/ non-resolution	I was surprised and annoyed by the complaint, as although I had no previous knowledge of the patient I did not refuse to accept her on the list and I did my best to assist her in what she thought was an emergency. I responded by return of post to the complaint, expressing my feelings and my justification for what had been done. I also pointed out that the hospital doctors found no evidence of pathology, supporting my assessment on the phone. I didn't suggest that she register elsewhere, but I was glad that she did as relationships would certainly have been difficult.
Learning points / action points	I may not have been entirely clear about the follow-up arrangements following my telephone advice and this may have led to the patient feeling that I was refusing to visit. I knew that the patient hadn't insisted on a visit and that she seemed to accept the advice, but I had no record of this. In future, I will confirm that the patient accepts my advice before finishing the call and make a note to this effect.
Changes implemented	In future, I'll add a note in my records 'patient happy with the advice given by telephone'

Uses mechanisms to learn from performance issues and to prevent them from occurring in the organisation.

As so often with the descriptors of excellence, the distinguishing feature is that we move beyond our own performance and think about the organisation that we are a part of. As we discussed earlier in this chapter, performance is a communal responsibility. Lessons learned and shared more widely, help the whole team to be more effective and reduce the number of avoidable errors. Cumulatively over time, the impact on patient safety of making lots of little improvements, can be dramatic.

Performance issues, particularly when they lead to significant events such as missed diagnoses, patient harm or complaints, can be important drivers of useful change. The mechanism of conducting significant event review as a team-based exercise that avoids recrimination and maximises learning opportunities, is well described in the books and it should become second nature to us.

Assessor's corner: is the organisation learning from performance issues?

Does the trainee note performance issues and bring them for discussion as SEAs?

Are the lessons that are learned through group discussion then shared with the team? Is there evidence of change in practice behaviour and performance?

Does auditing contribute to this process? How much of a part in this process does the trainee play?