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A guide to managing performance concerns in general practice registrars

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

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Introduction

Performance concerns in general practice registrars may range from relatively minor, transient concerns to more significant and persistent concerns. They may occur in isolation or, more commonly, in combination, and their presentation may not always be overt but sometimes subtle or disguised. Therefore, depending on the presentation, managing performance concerns in general practice registrars can sometimes be complex. However, most problems and concerns that arise are of a relatively minor nature and are easily managed.

These guidelines will enable Regional Training Organisations (RTOs) to:

- assess and address the needs of general practice registrars having performance concerns
- determine the appropriate level of intervention
- effectively document, manage and evaluate an intervention, including formal remediation.

All RTOs should have documented policies and guidelines in place for managing performance concerns (refer to the RACGP's *Standards for general practice training* second edition, Outcome 2.3.3). While the detail of these policies will reflect each RTO's particular circumstances and structures, there are certain principles that should be followed if performance concerns are to be managed effectively. Policies should:

- be clear and robust
- reflect current best practice
- be available to general practice registrars and other stakeholders
- ensure patient safety
- ensure that processes are open, honest and fair
- be defensible.

The four cornerstones of an effective remediation program are:

1. the remediation officer
2. performance reviews
3. early identification
4. good documentation.

The key elements of an effective remediation process are:

- adequate information from multiple sources
- good communication with all involved, but particularly with the general practice registrar
- minimal delay with both notification and any action taken
- impartiality
- continuous support for the general practice registrar
- tailored management plans executed in a supportive learning environment.

The remediation officer

Ultimately, there should be one person responsible for overseeing performance concerns in general practice registrars to ensure that processes are being followed, and that performance concerns are identified and addressed.

The remediation officer's role is to:

- investigate concerns – this initially entails talking to the general practice registrar and to those who have knowledge of the situation or who have had contact with the general practice registrar (in present and previous general practice terms)
- advise and assist medical educators and general practice supervisors who have concerns
- assess concerns and take appropriate action
- determine the appropriate intervention and who should be involved
- delegate responsibilities appropriately
- formulate or assist in the formulation of a suitable intervention
- liaise with all parties involved in an intervention (the general practice registrar, medical educators and general practice supervisors) to ensure that everyone is well informed about and in agreement with the proposed plan, including its outcomes
- monitor all general practice registrars with performance concerns
- periodically review and/or assess identified general practice registrars
- assist medical educators and general practice supervisors in reviewing the progress of general practice registrars receiving extra assistance
- decide if the support/assistance being given to a general practice registrar needs to be continued
- document all information (concerns, actions taken, decisions made) regarding identified general practice registrars
- periodically liaise, as appropriate, with key individuals regarding the general practice registrar's progress and any decision making
- facilitate the lines of communication between anyone directly involved in the general practice registrar's learning and those who need to be informed
- regularly review guidelines and processes with respect to performance concerns so they are up to date and reflect best practice.

Performance review

All general practice registrars should have performance assessments conducted on a regular basis during their training – refer to the RACGP's *Standards for general practice training* second edition, Standards 1.1, 3.1 and 3.2. Performance assessments should be conducted:

- just prior to, or soon after, commencing training
- at appropriate stages during training.

Performance assessments are used to:

- determine each general practice registrar's particular needs
- monitor and assess progress

- identify performance concerns as early as possible
- enable the early enactment of suitable interventions when required.

A range of assessment methods is listed in Appendix C of this guide.

A formal review of the progress of all general practice registrars should be conducted each semester:

- by the general practice supervisor in the practice
- at the RTO level.

Performance reviews will consider information from such sources as:

- the general practice registrar's learning needs and other assessments
- feedback and reports from general practice supervisors, medical educators and training advisors
- external clinical teaching visit reports
- feedback and reports from the remediation officer.

Early identification

The earlier a performance concern is identified, the more likely an intervention will result in positive outcomes. Low-level problems may not seem significant enough individually to be reported, but several such problems, possibly in different areas, may cause sufficient concern to require action. It is preferable to report an identified problem or concern promptly, rather than wait to see if it will persist or escalate. The remediation officer should be the person to determine the level of concern, the appropriate action and the urgency required.

Early identification and reporting of problems is encouraged and may be facilitated by:

- informing general practice supervisors and increasing their awareness about general practice registrars at risk – general practice supervisors are in a key position to identify problems because of their regular contact with the general practice registrar
- informing medical educators and increasing their awareness about general practice registrars at risk
- encouraging prompt reporting of problems
- conducting learning needs assessment at the commencement of training
- directly observing the general practice registrar (by the general practice supervisor or an external clinical teaching visitor) early in the first general practice term or early in subsequent general practice terms when concerns have been raised.

The following is a checklist of the types of concerns that should be reported.

- **Communication skills**
  - comprehension issues (hearing, understanding)
  - poor rapport
  - serious lack of empathy

- **Clinical skills**
  - significant knowledge deficiencies
  - inadequate clinical skills
  - serious clinical errors and safety concerns (eg misdiagnosis, mismanagement)
  - unorthodox or dangerous prescribing
- **Cognitive skills**
  - disorganised or rigid thinking processes
  - not seeking advice or asking questions as expected for their level of training
  - seeking assistance excessively and/or for seemingly minor things
  - rigidity in their role and their opinions (eg poor tolerance of ambiguity, difficulty prioritising, inability to compromise, being argumentative)
  - lack of insight
  - difficulty reflecting
  - difficulty accepting feedback, defensiveness
  - inability to change, difficulty acting on feedback that has been given, poor progress (despite feedback, past experiences and learning)
- **Organisational, integrative and collaborative skills**
  - poor interpersonal skills (paucity of interactions or negative interactions with colleagues and practice staff, anger outbursts, believing that they are victimised)
  - poor (unjustified) time management for the level of training
- **Professional behaviour**
  - unprofessional behaviour
  - poor work ethic
    - frequently arriving late and/or leaving early
    - absences (eg frequent and/or unjustified)
    - poor work performance (eg deliberately slow, blocking out appointment times)
    - deliberate overbooking of patients
  - not accepting responsibility for the patient
  - teaching and learning
    - poor attitude to teaching
    - not proactive with respect to their learning
    - late with submission of tasks
- **Other**
  - overt signs of impairment (eg mental illness, substance misuse)
  - serious complaints from staff, patients and others.

Refer to Table 2 in Appendix B for a checklist of ‘red flags’.

Good documentation

There should be clear lines of communication and clear processes with respect to the documentation of performance concerns and any problems regarding general practice registrars.

All relevant discussions and interventions about the identified general practice registrar should be documented contemporaneously. Consideration should also be given to privacy and confidentiality and, consequently, to the levels of access to this documentation among medical educators, general practice supervisors, RTO staff and management, regardless of the form of the documentation (paper-based or electronic).

Communication of important information to key individuals in the performance management framework is vital but, once again, this needs to be weighed against considerations of privacy and confidentiality.

Inadequate or insufficient information and poor documentation can make it difficult to enforce processes and regulations when a general practice registrar disputes the issues and is either reluctant or refuses to comply with a planned intervention.

Performance management

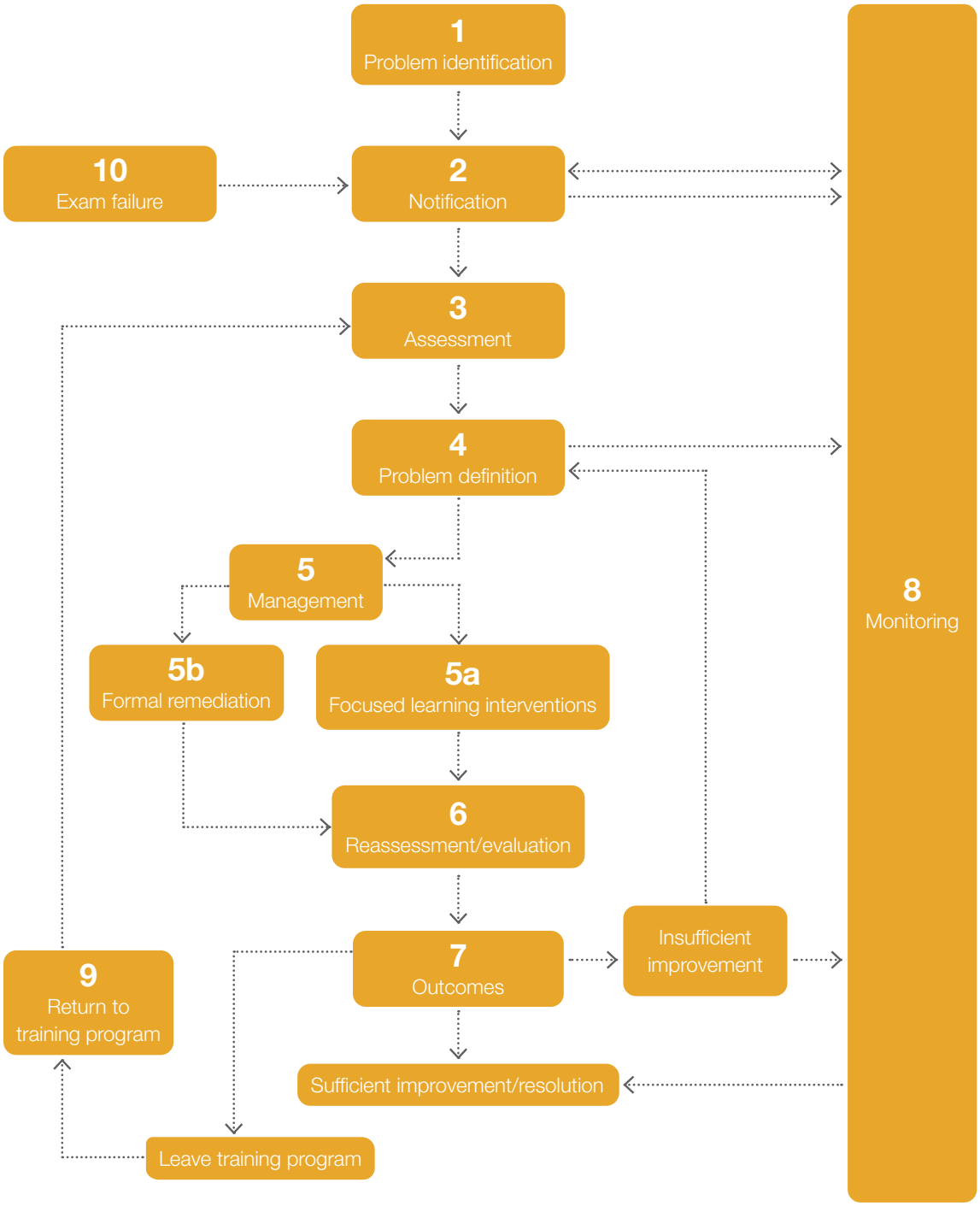

Figure 1. Performance management process

Appendix A contains a number of case studies that illustrate the dilemmas that can arise when managing performance concerns.

1. Problem identification

In the practice, performance concerns may be identified through:

- regular appraisal of the general practice registrar in various situations (eg tutorials, case discussion, random case analysis, discussion of learning needs and progress, direct observation of consultations, review of videotaped consults)
- feedback from other doctors in the clinic, the practice manager, reception staff and patients
- feedback from previous general practice supervisors
- self-identification by the general practice registrar (rare).

At the RTO level, performance concerns may be identified through:

- the various assessments that are conducted during training, including external clinical teaching visits
- feedback from general practice supervisors, medical educators, training advisors and administration staff following their encounters with general practice registrars
- attention and adherence by the general practice registrar to training program regulations and requirements
- exam failure
- self-identification by the general practice registrar.

Possible barriers to identification of performance concerns include:

- inexperience of the general practice supervisor, medical educator or training advisor
- minimisation of the problem
- no acknowledgement that a problem exists
- uncertainty as to whether there is a problem
- unwillingness to be seen as negative or critical of the general practice registrar
- unwillingness or reticence to report
- belief that the problem can be easily managed or will resolve
- fear of repercussion from the general practice registrar.

Wherever possible, discussion should be held with the general practice registrar to allow them to voice their perspective with respect to any identified concerns. Discussion may also provide a better understanding of the situation, while at the same time motivating and engaging the general practice registrar, in case intervention may be required.

2. Notification

When a concern is raised or a problem identified, the responsible person should be notified. Generally, this should be the remediation officer. Clear processes and lines of communication will avoid delays. Wherever possible, the general practice registrar should be informed that a notification with respect to their clinical performance will be made, not as a punitive measure but in the interests of assisting them to progress in their training.

Possible barriers to notification include:

- delays in identification and/or reporting
- unwillingness or reticence to report
- underplaying of the problem
- not acknowledging that a problem exists
- hoping the problem will resolve
- ignoring or putting up with the problem.

3. Assessment

When a performance issue or concern has been raised, the key question to ask is: 'Does it matter?' If no, then the general practice registrar may be monitored to observe any other concerns.

If yes, then further information should be obtained to:

- corroborate what has been reported
- ensure that as much information as possible is available before any decisions are made.

Further information may be obtained from:

- the general practice registrar (most importantly)
- the person notifying
- anyone who has had direct involvement with the general practice registrar either past or present (general practice supervisors, medical educators, external clinical teaching visit reports, and other staff).

All discussions, but especially those with the general practice registrar, should be done with sensitivity and impartiality because the general practice registrar is likely to be feeling apprehensive and even vulnerable at this point in time.

The next key question to ask is: 'Can they normally do it?' If no:

- 'Why not?'
- 'Are they trainable?' If yes:
- 'Why are they not doing it now?'

It may be necessary to conduct an assessment to further clarify the identified issues and/or to ensure that all the issues have been identified (refer to 'Problem definition' below). It is important to have a well-considered approach to assessment. Various assessment methods are available (refer to Appendix C), with the following being particularly valuable:

- direct observation of consultations
- review of video-recorded consultations
- role-play of structured clinical scenarios
- multiple-choice questions and/or Key Feature Problem (KFP) test.

Following an assessment, feedback (verbal at least but in some instances written as well) should be given to the general practice registrar so that they are aware of and understand the issues. In situations where concerns are of a serious nature, it is feasible to ask the general practice registrar to sign a copy of the written feedback, in acknowledgement of the seriousness of the concerns and that they have been discussed.

The case study in Appendix A (Nidhi) is an illustration of a clinical skills assessment.

4. Problem definition

Once a performance issue or concern has been raised, another important question to ask is: 'What else is going on?'

An identified problem doesn't usually occur in isolation. It is important to look beyond the presenting concern and to identify any other problems that may be contributing, or perhaps may be at the root of the presenting concern. Serious performance concerns do not occur frequently but they do take up a lot of time and resources.

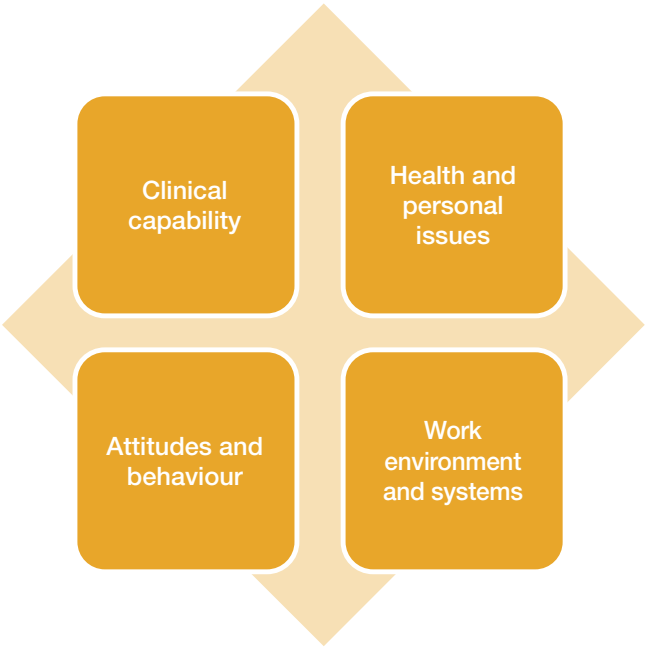

Figure 2. The four broad areas of performance concerns

Performance concerns can be broken up into four broad areas:

Clinical capability

- Language and communication skills (verbal, written)
- Knowledge
- Application of knowledge, core clinical skills (history-taking, physical examination, investigations, diagnosis, management, procedural skills)
- Clinical reasoning (ability to interpret and synthesise, decision making)

Health and personal issues

- Physical and mental health
- Substance misuse
- Acute and ongoing problems
- Personal and family issues impacting on health and/or work performance
- Periods of transition (changing jobs, moving regions, moving house)
- A second job

Attitudes and behaviour

- Professional behaviour
- Ethical and moral values
- Personal cultural factors (values, attitudes, beliefs)
- Insight and self-awareness, intuitiveness and 'sixth sense'
- Confidence

Work environment and systems

- Work and work environment (workload, interaction with general practice supervisor and practice staff, teamwork, bullying, harassment, discrimination)
- Systems (training and practice regulations, working hours and rosters, employment contract)

Possible errors with problem definition include:

- insufficient information
- incorrect or misleading information
- assumptions made
- inappropriate decisions
- a lack of objectivity
- preconceived ideas and bias
- an ill-considered approach.

In defining the problem/s, there are five key questions to consider:

1. Is the general practice registrar practising safely?
2. Can the general practice registrar reason (problem solve) effectively?
3. Is the general practice registrar practising to a satisfactory standard?
4. Does the general practice registrar behave professionally?
5. Does the general practice registrar have insight?

The first three questions relate directly to the general practice registrar's level of clinical knowledge and skills, the standard of their practice and whether they have the capability to improve.

The fourth question relates directly to the general practice registrar's behaviour towards patients, colleagues and staff, and their behaviour in general. It has indirect implications for clinical practice.

The fifth question relates to the general practice registrar's awareness of their limitations and deficiencies in their knowledge and skills, and their ability to accept feedback. It has direct implications on patient safety and willingness to learn and change.

In order to answer these key questions, the general practice registrar's clinical performance needs to be looked at more closely. The following questions pertaining to specific skills and behaviours provide a useful framework.

Specific skills and behaviours

Communication skills

Does the general practice registrar:

- communicate effectively (language, verbal and non-verbal skills)?
- develop rapport and show empathy?

Clinical skills

Does the general practice registrar:

- demonstrate a sufficient level of clinical knowledge and skills?
- recognise urgent situations and respond appropriately?
- prescribe appropriately?

Cognitive skills

Does the general practice registrar:

- synthesise information and problem solve appropriately (clinical reasoning)?
- recognise their limitations (reflective skills and insight) and seek appropriate advice and/or assistance?

Organisational skills

Does the general practice registrar:

- have a structured approach to the consultation?
- manage their time appropriately?
- record the relevant medical notes in a timely manner?
- work effectively in a team (staff and health professionals within and outside the practice)?

Professional behaviour

Does the general practice registrar:

- behave professionally (including being non-judgemental)?
- accept and reflect on feedback?

In accordance with the above framework, Table 1 in Appendix B provides a guide with respect to what observations would raise concerns. Answering these questions is useful not only in providing a sense of the adequacy of the general practice registrar's consulting, but also for providing the general practice registrar with constructive feedback for improvement.

If the answer to one or more of the key questions is 'no', then the concerns are serious and the RTO remediation officer should always be involved in such instances.

Serious concerns ('red flags')

It may be that serious concerns have already been identified. Table 2 in Appendix B is a checklist of serious concerns. Identification of one or more of these requires urgent reporting to the RTO's remediation officer and director of training. How these concerns will be addressed will depend on the context. Mandatory reporting to the Australian Health Practitioner Regulation Agency (AHPRA) may be necessary; however, this can only be done when there is direct evidence of practitioner impairment and/or risk to patient safety.

Applying analytic rigour to judgement and decision making

Every medical educator has an individual approach to conducting an assessment and certainly when making judgements and decisions. It must also be acknowledged that everyone has personal biases, therefore it is important to be objective and fair. In order to do this as best as possible, the following should be considered:

- Reflect on personal biases
  - Am I too stringent or too lenient?
  - What are my pet likes/dislikes?
  - Is there something about the general practice registrar that I like/dislike?
- Have I ignored information or certain observations?
- Is there any information that refutes certain judgements that I have made?
- Are my judgements explainable by the observations that I have made? If not, what information is missing?
- Is there information from other sources (including the practice) that supports or refutes my judgements?
- What is the general practice registrar's opinion about their performance and my judgement?
- How adequate was this assessment? Was it sufficient to make the judgements that have been made? Is further information and/or assessment required?

Once the performance concerns have been defined, the general practice registrar may require one of the following outcomes:

- monitoring
- assistance through implementation of a focused learning intervention
- assistance through implementation of a formal Remediation Plan.

5. Management

Once the issues have been defined, a management plan (which will include a Learning Plan) should be drawn up. Most management plans will address clinical capability. Concerns that exist in other areas should also be addressed and included in the management plan.

Management plans should always:

- be developed in consultation with the general practice registrar
- be personalised to the general practice registrar's needs
- have clear objectives
- have a set timeline, with regular reviews and a clear end point
- have provision for reassessment and evaluation of the outcomes
- have defined actions with respect to the outcomes.

There are two types of management plans:

1. Focused learning interventions address identified problems that can be readily corrected in the normal course of training using available resources (refer to 'Clinical capability' below).

2. Formal Remediation Plans are required when serious performance concerns are not expected to be readily corrected in the normal course of training and where previous focused learning interventions have not succeeded.

5a. Focused learning interventions

Clinical capability (clinical knowledge and skills)

A variety of clinical skills interventions is available; however, the following points require highlighting:

- The type of intervention will depend on the cause of the performance concern. If the root cause is not addressed, the general practice registrar will not progress.
- A well-considered, tailored management plan that addresses all the issues at play is more likely to be successful.
- Determining the learning style of the identified general practice registrar may be helpful.
- The learning environment must be supportive.
- The general practice registrar needs to be fully engaged.

Possible interventions for addressing deficiencies include:

- tutorials to address knowledge deficits
- case discussion, including random case analysis
- direct observation of consultations with feedback
- review of video-recorded consults with feedback
- role-play of a variety of clinical scenarios.

Health and personal issues

General practice registrars may become ill like any other individual. Any significant illness, whether physical or mental, acute or ongoing, has the potential to:

- affect the general practice registrar's judgement or performance
- impact on patient care
- impact (to varying degrees) on self, family and friends, colleagues, and work capability.

Chronic illness and disability is not a contraindication to clinical practice. While allowances and adjustments can be made so that the general practice registrar may function to the best of their ability, patient safety is always paramount.

The more common health problems affecting performance are:

- psychological disturbances (eg depression, anxiety)
- unhealthy lifestyle, including substance misuse.

The stress of daily medical practice should not be underestimated. For general practice registrars coming out of hospital practice and entering general practice training, there is a significant adjustment and much to learn in their first term. It also takes time to settle in to general practice, particularly for part-time general practice registrars. Anxiety, therefore, is not uncommon for general practice registrars.

When a clinical capability problem has been identified, consideration should be given as to whether a concurrent health issue exists and procedures should be in place for identifying and managing a general practice registrar with health issues. While enquiry about health issues is appropriate, it should be motivated primarily out of concern

for patient safety and also for the welfare of the general practice registrar. Sensitivity should be exercised, as well as care, to comply with anti-discrimination and privacy legislation. The general practice registrar should be encouraged to evaluate their situation objectively and to consider whether patient safety might be compromised. It is not appropriate for a medical educator to take on the role of treating doctor or therapist with respect to the registrar. The educator's role can only be advisory.

General practice registrars with a health problem should be encouraged to seek appropriate care from a health professional (their own GP, treating specialist or psychologist). It may also be appropriate for them to take leave from training in order to adequately address their health issues. Refer to the Australian General Practice Training (AGPT) Program Leave Policy.

Where a serious or ongoing concern exists, to the extent that patient safety is being compromised, consideration will have to be given as to whether it is necessary to report the general practice registrar to AHPRA. If the general practice registrar is reported, the RTO must ensure that:

- the decision of the relevant Medical Board is implemented
- the Department of Health is informed of the Medical Board's decision.

If the general practice registrar does not comply with the Medical Board's decision or is unlikely to regain their fitness to engage in general practice training, then the general practice registrar may be:

- required to take leave from general practice training until such time they are well enough to return, or
- excluded from general practice training (refer to the AGPT Withdrawal Policy.

Attitudes and professional behaviour

Unprofessional behaviour can have a significant impact on the general practice registrar's functioning in the workplace, as well as the functioning of that workplace. RTOs are encouraged to have a professional behaviour policy in place that:

- identifies the expected professional behaviour
- identifies the possible consequences of unprofessional behaviour
- supports the development and maintenance of a culture of professionalism within the organisation and throughout training time
- is committed to the early identification of, and response to, professional behaviour problems
- provides suitable mechanisms for monitoring and addressing problematic situations
- provides suitable mechanisms for addressing serious and/or continued breaches of professionalism.

Without such a policy that identifies the expected behaviour, including the consequences of serious and/or continued breaches of professionalism, it will be very difficult to manage the concerns effectively.

Refer to the RACGP's *Standards for general practice training* second edition (Outcome 3.1.2) and *Competency profile of the Australian general practitioner at the point of Fellowship* for more information.

Work environments and systems

Work environment and systems issues have the potential to indirectly precipitate a deterioration in performance either on their own or in conjunction with other problems. Resolution of these issues will generally occur by:

- face-to-face discussion between the disputing parties
- a formal mediation process
- seeking legal advice.

5b. Formal remediation

Formal remediation will be required for general practice registrars:

- whose clinical capability does not improve, despite the implementation of a suitable focused learning intervention
- who have a serious performance concern from the outset.

The Remediation Plan must be developed by the remediation officer in consultation with the general practice registrar, the remedial general practice supervisors, remedial medical educators and the director of training, as required. The plan should be documented in a formal Remediation Agreement or contract that also specifies:

- the requirements
- the role of each party to the agreement/contract
- the time frame for the remediation, which should not exceed six months
- the objectives of the remedial term
- the possible outcomes
- how the outcomes will be evaluated
- the action that will be taken with respect to the outcomes.

A template for a suitable Remediation Agreement is found in Appendix D.

A formal remedial term requires a suspension of training time for the duration of the remedial term and must be recorded as such in the general practice registrar's training record.

An application can be made to the RACGP for funding to support the extra resources that will be required for the remediation. Funding must be approved first before the remedial plan can be enacted (refer to the RACGP's Registrar Remediation Policy).

Processes should be in place to identify general practices and general practice supervisors that are suitable and willing to take the general practice registrar for remedial training.

In circumstances where the RTO cannot accommodate remediation within its region, a transfer to another location may be appropriate. Refer to the AGPT Transfer Policy, Item 6.1.1.

If a suitable remediation placement cannot be sourced at all, the general practice registrar may be required to take leave until an appropriate remedial placement can be found (refer to the AGPT Program Leave Policy).

6. Reassessment and evaluation of outcomes

Any management plan should have provision for periodic assessment during the execution of the plan and certainly at its completion. At completion, the outcomes of the intervention will be evaluated, to determine whether the objectives have been achieved and what this means with respect to the general practice registrar's progression in the training program.

A list of suitable assessment methods is found in Appendix C.

Measuring progress or change can be difficult but should be as objective as possible and have consideration for the expected standard for the general practice registrar's level of training (benchmarking).

7. Outcomes

When evaluating a management plan, the key questions to ask are:

- Is the general practice registrar progressing?
- Is progress sufficient?
- Is the general practice registrar capable of achieving the expected clinical standard?
- What resources are required to assist the general practice registrar to achieve the expected standard?
- Should the general practice registrar continue to be supported?

If improvement has been 'insufficient', the reasons why should be determined.

These include:

- the general practice registrar themselves (eg poor engagement, learning difficulties, inability to progress because of unresolved personal or health issues)
- the general practice supervisor or medical educator (eg inadequate/insufficient support)
- the management plan used (not well formulated, inadequate resources, insufficient time frame).

After an evaluation has been made, the following actions are possible:

- the general practice registrar will be allowed to resume training under any of the following conditions
  - without additional support
  - with a focused learning intervention in place which will enable them to reach the required level of training
  - with placement in a remedial term
- the general practice registrar will be excluded from general practice training (refer to the AGPT Withdrawal Policy) because
  - the identified problems have not improved sufficiently and the general practice registrar is not expected to reach the required level of training even with additional support
  - the identified problems have not improved at all.

Appeals

General practice registrars who oppose the need for remediation as determined by their RTO may access the RTO's appeals process to review the matter.

Where the RTO determines that remediation has failed and further remediation is unlikely to be successful and where the general practice registrar disputes the RTO's decision, the general practice registrar has access to the following mechanisms for appeal:

- the RTO's grievance and appeal procedures for review and mediation
- applying to the RACGP for a review of the RTO's decision, but only after the RTO's avenues of appeal have been exhausted – refer to the RACGP's Registrar Clinical Appeals Policy.

8. Monitoring

Monitoring is an important aspect of managing performance concerns. While many concerns will be of a minor nature and easily resolved, the general practice registrar's progress should be monitored because the initial concern may escalate or new concerns may arise. Monitoring also ensures that concerns aren't forgotten, only for them to resurface later, potentially as major issues. It also allows for minor interventions to be put into place along the way, hopefully preventing escalation of problems.

The remediation officer is best placed to monitor identified general practice registrars. Monitoring involves regular contact with the general practice registrar, general practice supervisor, medical educators and others, as appropriate.

Possible outcomes of monitoring include:

- resolution of the problems/concerns
- the problems/concerns have become more serious and intervention is required – the situation then has to be reassessed and a management plan formulated.

9. Return to training program

The reasons a general practice registrar might leave the training program include:

- temporary leave for personal or health reasons
- permanent leave for personal or health reasons
- removal from the program because of a serious performance concern. This will generally be because of
  - failure to progress despite remedial intervention
  - a serious breach of professional behaviour.

When a general practice registrar indicates that they wish to return to training, having been absent from the program for a substantial period of time (longer than 12 months), a number of things need to be taken into consideration:

- the period of absence
- the registrar's level of confidence with respect to returning to work and what supports might be helpful
- any unresolved concerns (clinical skills or otherwise) that existed prior to the registrar leaving
- the possibility that the registrar's clinical skills may have deteriorated during their absence

- any new concerns that may have arisen during the registrar's absence, such as personal or family issues, illness or disability, and the ensuing implications for clinical practice, such as
  - accommodations that may have to be made
  - supports that might be required
  - any conditions that may have been imposed by AHPRA on the registrar's practice.

A clinical skills assessment may also be appropriate to determine what assistance, if any, the registrar might require to ensure a smooth transition back into practice.

AHPRA has its requirements with respect to doctors re-entering practice, particularly when that absence has been for longer than 36 months. Those requirements are essentially with respect to:

- recency of practice
- continuing professional development
- professional indemnity standards.

More information can be found on the AHPRA website or in the RACGP document, *A guide for re-entry to general practice*

10. Exam failure

Passing the RACGP Fellowship exam should not be viewed as an easy exercise. Preparation is necessary and registrars should be encouraged to commence preparations earlier rather than later. Failure can easily occur and results in significant distress for the registrar.

On its own, first failure is not necessarily concerning. While there are many possible reasons for failure, they are generally easily addressed and the general practice registrar will, more than likely, pass at the next sitting. The reasons generally relate to the general practice registrar's:

- particular circumstances (personal and family issues, health problems)
- limited exposure to a sufficient range of presentations (including chronic disease)
- approach to study.

For a small number of general practice registrars, the exam presents a significant obstacle. Once again, there are many possible reasons why this might occur. Sometimes, the reasons for failure may not be immediately apparent, may not have been considered previously or may be deep seated. Second and subsequent exam failures therefore, should be taken seriously and the possible reasons for failure should be explored thoroughly:

- clinical knowledge
- clinical reasoning
- clinical practice
- exam technique
- study
- other factors (including health and personal).

Using this information, a Learning Plan to preparing for the next sitting may be formulated. For more specific guidance, refer to 'Exam support guidelines' in *A guide to understanding and managing performance concerns in international medical graduates.*

Resources

Policies and standards

Australian General Practice Training (AGPT)

- Program Leave Policy
- Withdrawal Policy
- Overview of the AGPT Program

Australian Health Practitioner Regulation Agency (AHPRA)

- Mandatory reporting
- Performance assessments
- Professional indemnity insurance arrangements

Medical Board of Australia (Medical Board)

- *Good medical practice: A code of conduct for doctors in Australia*
- Information on the management of impaired practitioners and students
- FAQ: Recency of practice (and return to practice)
- Registration standard: Continuing professional development

The Royal Australian College of General Practitioners (RACGP)

- *Competency profile of the Australian general practitioner at the point of Fellowship*
- *A guide for re-entry to general practice*
- *A guide to understanding and managing performance concerns in international medical graduates*
- Registrar Clinical Appeals Policy
- Registrar Remediation Policy
- *Standards for general practice training*, 2nd edition

Regional Training Organisations (RTOs)

- Grievance and dispute relations procedures
- Professionalism policies
- Remediation guidelines

Employment

- National Terms and Conditions for the Employment of Registrars (NTCER)
- *Fair Work Act 2009* (Cwlth)
- Fair Work Commission
- Individual practices' policy and procedure manuals and individual employment contracts

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Appendix A. Case studies

The following case studies are based on real situations and illustrate the dilemmas that can arise when managing performance. These case studies do not necessarily provide the 'correct answers' to the different situations. They are best used as reflective exercises or for discussion regarding possible solutions to a problem. In remediation, while commonalities exist, the optimum solution to a particular problem must take into consideration the individual context.

Case 1 – Andrea

Andrea is part of the way through her first general practice term. At a peer learning workshop, Andrea mentions to one of the medical educators that she is enjoying general practice but having issues with time management.

How common are time management difficulties for a registrar in their first term?

Does the medical educator need to inform the remediation officer (RO) about the conversation with Andrea?

The educator decides to report her conversation to the RO. On face value, the educator says, Andrea appears to be having the usual settling-in problems for a first-term registrar. However, given that Andrea has spoken up, the educator wonders whether Andrea might need some support.

Should anything be done to assist Andrea?

The RO decides to investigate further. Andrea has recently had her first clinical teaching visit, so the RO looks at the report. The visiting medical educator has reported that Andrea is highly capable and progressing well; however, she is a 'worrier' and might benefit from some support.

Is there cause for concern? What should be done now?

The RO decides to speak to Andrea's supervisor. The supervisor is surprised to receive a call from the RO. He reports that Andrea is coping but she is 'sensitive'. He acknowledges that patients in that practice can be 'difficult' in that they have certain expectations and that Andrea may be struggling with this. Furthermore, he says that Andrea had spoken to him about reducing her hours to part time, and that he advised her against it. He believes that she underestimates her abilities.

What questions do the supervisor's comments raise? What should the RO do now?

The RO decides to speak with Andrea.

What should the RO's approach be?

In the meantime, Andrea contacts the RO. She says that there has been a series of events in the preceding week that have caused her to become quite distressed. This has culminated in her having a 'meltdown' at work, just a few minutes ago, when her supervisor spoke to her curtly. She believes that there is a 'personality clash' between them. She doesn't understand why her supervisor insists that she do things his way when she is capable of making decisions on her own. Andrea doesn't want to rock the boat. She says she can 'put up with the situation' until the end of the term, which is four months away.

What are the concerns?

Should Andrea be allowed to 'put up with the situation'?

Not long after Andrea has hung up, Andrea's supervisor calls to report that Andrea has just had a 'meltdown' and that he doesn't know what to do with her.

What should the RO do now?

The RO decides to meet with Andrea and her supervisor. *What should the RO's approach be in arranging a meeting? How should the meeting be conducted?*

The RO arranges a meeting with Andrea and her supervisor. Andrea is quite nervous about it. In the meeting, Andrea expresses her feelings of inadequacy because she can't meet the standards of the clinic as well as her supervisor's expectations. She feels intimidated. Furthermore, she reveals that this has brought back memories of being bullied when she was an intern.

How should the situation be managed? What are the management goals?

What about Andrea's expectations of herself?

Case 2 – Malcolm

Malcolm is in his third general practice term. There have been no concerns regarding his clinical practice. In fact, several medical educators have commented that he is 'high functioning'.

Malcolm complains to the RO that his supervisor has shouted and berated him in front of clinic staff. He says that he does not wish to make a formal report nor that any further action be taken because he doesn't want his supervisor to give him a bad report. Furthermore, he is 'used to it' because he has had similar issues at a previous clinic.

There have not been any previous negative reports about Malcolm's current supervisor or the practice where he is now working.

What are the issues in this situation?

Does the fact that there have not been any previous reports about the practice or the supervisor make any difference?

What can be done with registrars who make a complaint 'just for the record'?

Similarly, what can be done with supervisors who make a complaint about a registrar 'just for the record'? Should supervisors be required to document concerns such as these in the registrar's term report?

What should the RO do now?

Case 3 – Marguerite

Marguerite is in her first general practice term and is working part time. Midway through the term her supervisor calls the RO to say that he is very concerned. His specific concerns are that:

- Marguerite is at medical student level with respect to her clinical skills and requires a lot of supervision
- despite regular tutorials, she is not studying and not retaining information
- she appears distracted and is not focusing on her work

- she seeks the supervisor's advice very frequently and for very minor things that she has asked about before
- her physical examination skills are inadequate
- her progress is very slow.

How is the supervisor's comment that Marguerite's 'progress is very slow' to be interpreted?

How should the supervisor's concerns be addressed?

The RO speaks with Marguerite, who reports that she:

- has a four-month-old baby who is very unsettled and won't let her sleep at night; consequently, Marguerite is tired all the time
- lacks confidence
- has difficulty with managing uncertainty and finds it difficult to know what to do
- tries to study but can't focus because she is so tired.

Is Marguerite's tiredness sufficient to explain all of the supervisor's concerns? Is more information required?

What should the course of action be now?

The RO decides to observe Marguerite's consulting, and he notes the following:

- While there were some issues with Marguerite's clinical skills, they were certainly not as bad as her supervisor had reported.
- Marguerite called her supervisor for advice on every consultation.
- The supervisor would tell Marguerite what to do rather than guide her to problem solve.

Is Marguerite lazy?

How can we know whether Marguerite is capable?

If Marguerite is capable, is she then also remediable? What is the plan of management now?

Should Marguerite be required to take time off until her home situation is in order and she is less stressed?

Case 4 – Theo

Theo is a part-time registrar in his first general practice term. Close to the end of the term, a distressed supervisor reports to the RO that he doesn't know what to do with Theo. Despite having spoken to him several times, Theo has not acted on any of the feedback that he has given him. The supervisor says that he has serious concerns about Theo's knowledge, clinical reasoning, documentation and, most of all, his behaviour.

How would you respond to the supervisor?

Why has the supervisor left it till the end of the term to report his concerns? What other information is required?

What is the management plan from here?

Other than quoting the rule book, how can unprofessional behaviour be addressed? Can such behaviour be changed?

Case 5 – Samantha

Samantha is in her third general practice term. Her supervisor reports the following concerns about Samantha to the RO:

- Her progress notes are poor (scant statements about the presentation, diagnosis and management).
- She is not checking the results of investigations.
- She has a tendency to ring her specialist friends for advice rather than take her questions to her supervisor.
- Even when she does ask questions of her supervisor, she doesn't appear to follow the advice that is given.
- She is prescribing drugs of addiction inappropriately.
- Her billing is sometimes inappropriate.

Supervisors are familiar with clinical skills issues such as these, and are generally capable of managing them. Why has this supervisor resorted to speaking to the RO?

The supervisor reports that she tried to speak to Samantha about these issues but Samantha became quite defensive to the point that the discussion broke down. Consequently, the supervisor does not want to engage with her again. In fact, she has been actively avoiding Samantha. Furthermore, the supervisor believes that Samantha's concern for her patients borders on the inappropriate. As an example, Samantha has given her mobile number to a few patients 'in the event of an emergency'. Also, patients from Samantha's previous posts have followed her to the current practice even though they have quite a distance to travel.

What are the issues here?

Has Samantha crossed professional boundaries? How should the various issues be addressed?

The RO decides to get more information. Reports on Samantha's progress in her previous terms have all been satisfactory. They report that 'Samantha establishes good rapport with her patients … is well liked … friendly, chatty manner … shows concern for her patients … management, on the whole, is appropriate'. The RO also speaks with Samantha. Samantha becomes very defensive, saying that 'other doctors in the clinic do worse things than me. Why should I be targeted like this when I am the only one in this clinic who cares about the patients?'

Have the issues/concerns changed?

What should the course of action be now?

How should Samantha's comments regarding the other doctors in the practice be addressed? Should the supervisor be included in the discussion between the RO and Samantha?

Case 6 – Evan

Evan is a part-time registrar. His first general practice term was uneventful, and he is now six weeks into his second term. He has contacted the RO because he is feeling anxious and worries about his patients, particularly about missing something. He says he is not coping. Because a couple of doctors are away, he has had to manage an increased patient load. He is quite exhausted by the end of the day and he doesn't know what to do.

How would you respond to Evan?

How would you explore Evan's anxiety?

Do you require any other information?

Evan describes always feeling a little anxious and having a tendency to worry. His anxiety has been exacerbated, he says, by having little or no time to discuss patient presentations with his supervisor. He is also feeling distressed about the future. His partner stopped work recently to look after their children, aged three and five years. They recently bought a new house and are experiencing financial stress.

Is there anything else that you would say to Evan now?

Should he be encouraged to take time off to address his anxiety?

Evan's supervisor reports that Evan is asking questions for just about every patient. This is an extra pressure for the supervisor because he is also trying to cope with an increased patient load. The supervisor acknowledges that the patients are complex and difficult to manage; however, Evan appears to ask questions because he is an excessive worrier, not because he doesn't know. The supervisor asks you whether Evan is intending to take time off because, if he is, he won't allow it.

How do you respond to the supervisor? How should the situation be managed?

Case 7 – Marion

Marion has failed her written exams for the third time. While she only 'just missed out by 0.1%' with the first sitting, her scores in the subsequent sittings have been consecutively lower (2% and 5%). She cannot understand why she has failed, because certainly with the second and third sittings she 'studied very hard'.

Her supervisor is equally dismayed. He cannot understand how 'a good and capable doctor' can fail.

What are possible explanations for Marion's repeated exam failure? Could these exam failures have been prevented?

Is there an underlying clinical skills issue? How should the situation be managed?

Case 8 – Mikhail

Mikhail is an overseas-trained doctor who is now in his third general practice term. His supervisor is angry because he finds Mikhail difficult and argumentative. They frequently clash and Mikhail has often shouted, in front of staff, that he won't be told what to do. According to the supervisor, 'Mikhail doesn't understand Australian general practice'. He says that Mikhail is intolerant of his patients because 'they present with minor ailments, they ask too many questions and they don't follow instructions'. The practice staff report that patients don't rebook appointments with him.

Reports from Mikhail's previous general practice terms state that his clinical skills and knowledge cannot be faulted and that he has a very good command of the English language.

When contacted, Mikhail doesn't deny that he has behaved in this way to his supervisor. He is frustrated because his supervisor doesn't give him credit for his abilities, the patients at the clinic are 'spoilt' and staff members are racist.

Why has the situation escalated to such serious proportions? What are the issues? For Mikhail? For the supervisor?

How should the situation be managed?

Case 9 – Sandrine

Sandrine is a general practice registrar in her second general practice term. Midway through the term, the supervisor reports several concerns to the RO regarding Sandrine, including:

- significant knowledge deficits
- clinical skills at the standard of a medical student
- inability to perform basic procedures such as suturing, administering injections and immunisations, dressings
- a number of patient complaints.

Is this information sufficient to act on?

On further questioning, the supervisor adds the following:

- He is devoting extra time in tutorials with Sandrine, as well as answering her many questions regarding patients during consultations.
- While no specific complaints have been made, patients have been unwilling to see Sandrine again and certain doctors have been worrying that the reputation of the clinic will be affected.
- The practice manager reports that Sandrine's cultural background prevents her from engaging with patients in the same way that previous general practice registrars have.
- The problem with procedures was discovered when the practice nurse happened to be away.

What judgements have been made? What should be done now?

The RO visits the practice and speaks to the supervisor, the practice manager and Sandrine. Sandrine had not been told that the RO would be visiting and she is visibly distressed when she sees the RO.

How should this situation be addressed?

Sandrine is reassured by the RO that the purpose of the visit is to ascertain what the issues are and how best to support her in her training. Sandrine says that the practice manager is racially prejudiced against her and doesn't book patients with her on purpose.

Does this information change anything?

How should Sandrine's claim be addressed?

An experienced medical educator attends on a different occasion to observe Sandrine's consulting and assess her clinical skills. Following this, concerns regarding Sandrine's clinical skills are confirmed (although they are not as bad as initially reported by the supervisor). The RO decides that she would benefit from a remedial term.

Should Sandrine remain in her current practice for the remedial term?

The RO decides that it is in Sandrine's interests to be placed elsewhere. Because a suitable practice isn't immediately available, she is obliged to take leave. However, the opportunity is taken to commence tutorial work immediately. Sandrine is motivated to improve. She engages in all the educational activities and progresses well. At the end of the remedial term she undergoes an assessment of her clinical skills. From the assessment it is determined that Sandrine has progressed well and that there are no outstanding concerns.

What should be done in the event that Sandrine had not progressed in her clinical skills?

Case 10 – Hans

Hans was accepted into a rural pathway and he completed his first general practice term in a remote country town. Because of a change in personal circumstances, he moved to the city and is now in a general pathway. At the time of transfer, no reports regarding his progress were available. The administration staff handling the transfer report that Hans 'has attitude'.

Does it matter that no past reports are available?

What significance do you place on the comment made by the administration staff?

The supervisor and the visiting medical educator report that Hans's clinical skills are appropriate for his level of training and that he is progressing satisfactorily. However, the supervisor reported one incident of 'significant disagreement' with Hans, but when that is followed up by the RO, the supervisor reports that 'it has been resolved'. Periodically, there are reports from different medical educators that Hans has 'attitude' and is sometimes rude.

Is there anything that should be done about Hans's 'attitude'?

At the end of the second term, Hans takes two weeks' holiday. While on leave, Hans has a fall, fracturing his elbow. He returns after an absence of two months. Several weeks later, a concerned supervisor reports to the RO that Hans:

- is taking sick days very frequently and that this is disruptive to the practice
- often appears to be very tired and not focused on his work.

The supervisor wonders whether Hans might be taking strong analgesia, which might be impacting negatively on his cognition.

How should this situation be managed?

The RO meets with Hans and reports the supervisor's concerns to him. Hans confides that he is having significant problems because of his injury (complications of the fracture as well as chronic pain). He has to take opioids for pain sometimes, but never when he is at work. When his pain is very bad, he stays home or he leaves early from work.

How should this situation be managed, particularly as Hans has confided personal information to the RO? Should Hans be compelled to take time off to address his medical concerns?

The RO decides to observe Hans's consulting. With the first few patients, the RO notes minor memory lapses with the history-taking, a tendency to order investigations excessively and to refer early. The last patient presents with asthma and in a moderate degree of respiratory distress. Hans immediately becomes very flustered, has difficulty deciding what to do (prevaricating between trialling him with nebulised salbutamol first and immediate referral to hospital). After some searching he finally finds the nebuliser, at which point the supervisor has already taken over because the patient is in considerable respiratory distress.

How should the situation be addressed with Hans?

The RO tells Hans that his management of the asthma patient was less than satisfactory, that for his stage of training he should have been able to manage the situation with ease and that it could only be inferred that his cognition is significantly affected by his medical problem.

Hans's response is that he was flustered because he felt that he was 'under intense scrutiny'. He also adds that the supervisor stepped in unnecessarily. In light of this, has the RO been overcritical of Hans?

What should be done with Hans now?

Hans is advised to take extended leave from the training program and not to return until his medical issues are under better control.

Is there anything else that should be done? Would it be useful to:

- have an independent person observe Hans's consulting?
- obtain information from Hans's treating doctors regarding his medical conditions and fitness to practice?

With respect to the concerns about patient safety and Hans's work impairment, is there a requirement for:

- the RO and the RTO to report the concerns to AHPRA?
- Hans to self-report?

Hans is told that when he is ready to return to training, he will have to undergo a clinical skills assessment to ascertain his safety to practise, and, specifically, that he will have to demonstrate that there will be no concerns regarding his cognition.

Two years later, Hans wishes to return to training. He presents a certificate of fitness to practise from his treating pain specialist.

Should the clinical skills assessment still be conducted?

Hans undergoes the clinical skills assessment. He completes a multiple choice paper and role-plays a number of clinical cases. He performs poorly with the clinical cases where significant cognitive lapses are noted. His level of skills is found to have regressed and to be below the standard that he had achieved just before the time of his injury. It is determined that he is unsafe to practise, even under close supervision. Consequently, he cannot re-enter the program.

Is this judgement fair to Hans?

Case 11 – Maryse

Maryse is a general practice registrar working part time in her first general practice term. After only two months into the term, she takes time off for health reasons. She returns 18 months later to continue her training in a different practice. A few weeks later, her supervisor contacts the RO, expressing his concerns about Maryse's clinical skills. He says that she is requiring a lot of assistance with almost every patient that she sees. She lacks confidence and appears not to retain what she has learnt because she frequently asks the same questions that she has asked before.

The RO attends the practice, observes Maryse's consulting and confirms the supervisor's concerns. The RO's opinion is that Maryse requires formal remediation because her skills are well below the expected standard. At this visit, the supervisor also reveals to the RO that Maryse has conditions on her registration because of a medical condition. For reasons of confidentiality however, he is unable to tell the RO what the medical condition is.

Should the RO (and for that matter, the RTO) be told what Maryse's medical condition is?

How does knowing/not knowing affect the course of action?

The RO provides Maryse with feedback on her clinical skills and expresses his concerns. In fact, he says, compared to when she first commenced her training, her skills have regressed significantly and she will require extra assistance if she is to attain the expected standard for her level of training.

Could the regression in Maryse's skills be attributed purely to her 18-month absence form training?

Maryse says that she recognises that there is room for improvement in her skills and she is quite happy to receive assistance. The RO asks Maryse whether there might be a reason, such as a medical condition, to explain why her skills have fallen so far behind.

Is it appropriate for the RO to be asking Maryse about her medical condition?

Maryse says that she took time off from training because of a medical condition; however, she has fully recovered and while she is taking medication, it is not affecting her. The only condition on her registration is that she be under supervision.

Should the RO ask Maryse for more information about her medical condition?

How does having/not having more information assist/hinder the RO in managing the situation?

Maryse commences her remedial term. Four weeks into the term, her supervisor and the medical educator providing her with educational support report to the RO that Maryse has made minimal improvement. The RO provides Maryse with this feedback and asks Maryse whether she can account for this and whether her medical condition might be impacting on her ability to progress. Maryse is offended and states quite clearly that her psychiatrist has told her that it has nothing to do with her medical condition and that it is all purely educational.

How should the RO act now?

Conducting an assessment of clinical skills – Nidhi

Scenario	Considerations
Nidhi is in her third general practice term. Soon after commencing it, her supervisor terminates her employment because he considers her 'unsafe to practise'. The RO is called to investigate.	
How should the RO proceed?	Specific information required: • details of what has transpired • further evidence • other examples that support the concerns • any conflicting information • anything that can be said in favour of Nidhi.
The RO asks for more information. The supervisor reports that there were quite serious concerns about Nidhi's management of two patients, including: • inability to provide adrenaline in a timely manner to a patient experiencing anaphylaxis • poor clinical reasoning and decision making (believing that the patient had asthma rather than anaphylaxis) • no awareness of her limitations (attempting an excision of a skin lesion, one requiring a skin flap, but having not done one before and without consulting the supervisor) • inability to reflect on the above incidents and recognise her errors.	
What other information would be useful?	Enquiry should be made about the following areas where problems might exist: • knowledge and clinical skills • behaviour • health and personal issues. Enquiry should also be made about Nidhi's training history (all reports, past concerns, clinical capability and progress to date).
Information from Nidhi's previous general practice terms identifies: • that she took time off, for family reasons, at the end of her second general practice term, and returned after six months' absence to commence her third term • no particular issues with her clinical skills prior to going on leave; she appears to have been well-functioning and progressing satisfactorily.	
What about Nidhi's perspective?	This should always be considered. Nidhi may feel that she has been dealt with unfairly or that she has been misrepresented.
Nidhi accepts that she made errors of judgement with the two patients in question, but she plays them down. She says that she has difficulty with being assertive in consultations and that with new patients she is unsure of their agenda. Nidhi also accepts that home life has been stressful lately but denies suggestions that her family circumstances may be impacting on her performance.	

Scenario	Considerations
How concerning is this? **Would an assessment of clinical skills be helpful here?**	The situation is concerning because: • of the nature of the incidents • sufficient cause for the regression in Nidhi's skills has not been established • of Nidhi's lack of insight and her inability to reflect on her performance. An assessment would be useful in order to: • obtain a clearer picture of what her clinical skills are like • determine whether she has the capability and the will to change • inform a Remediation Plan.
An expert is called to conduct a formal assessment of Nidhi's skills and to make appropriate recommendations.	
What about Nidhi's perspective?	Does Nidhi understand the seriousness of the concerns? Is she aware that an assessment is proposed and, if so, does she agree to it? What are her thoughts and concerns?
Nidhi is quite happy to undergo an assessment and she is keen to be assisted in whatever way necessary because she wants to finish her training and be a good general practitioner.	
What should be assessed? **Should it be a focused or comprehensive assessment? What other questions need answering?**	This will depend on what the issues/concerns are. It may be that the identified concerns require clarification or that all issues affecting performance require elucidation (eg knowledge, skills, insight, attitudes, health and personal problems).
The goals of the assessment are to: • assess Nidhi's clinical skills and determine whether they are commensurate with her stage of training • determine the level of Nidhi's skills and whether they are remediable (if deficiencies are identified) • make recommendations that will assist Nidhi to further improve her clinical skills and inform a Remediation Plan.	
Will this be a fair test?	Validity and reliability of the testing are important: • Will the registrar have opportunity to demonstrate their abilities adequately? • What are the criteria for benchmarking? • What is the experience of those making observations and judgements? • What opportunities are there to triangulate information (eg independent assessors in the entire assessment, medical educator participants acting also as observers, independent assessors of the video-recorded consultations, feedback from simulated patients)?
Have any untoward effects of the assessment been considered?	All assessments are stressful and this should be acknowledged. Measures for mitigating the effect of stress on performance should always be considered.
What information will Nidhi be given during, and at the completion of, the assessment?	Feedback should be an integral component of all assessments. It is important that what is communicated during the assessment does not contradict anything that is said later.

Scenario	Considerations
Nidhi is given feedback on her performance after the first role-play session. This gives her the opportunity to put some of those suggestions into practice in the second role-play session. At the completion of the assessment, the assessor provides Nidhi with overall feedback (what has been done well, and aspects of her clinical skills requiring attention). The assessor: • determines that Nidhi is remediable and makes recommendations with respect to a Learning Plan • recommends reassessment once the remedial term has been completed • writes a formal report.	
Should the full report be made available to Nidhi?	Yes. Transparency is important.
Who makes the decisions about the action that will be taken? How are decisions communicated?	While decisions will be based largely on the findings of the assessment, they should not preclude the consideration of new information or new developments. Decisions should be acted upon in a timely manner.
The decision is made to place Nidhi under remediation. Nidhi accepts the Remedial Plan and signs an agreement with respect to the outcomes for the remedial term and, depending on the outcomes, the actions that may be taken. At the completion of the term, Nidhi undergoes reassessment. The assessor determines that Nidhi has not progressed and that further remediation would not be of benefit.	
What should be done with Nidhi now?	Decisions should not be based on the assessment alone. It is important to take into consideration all documented information from all supervisors and educators involved in the remedial term.
A decision is made to remove Nidhi from the training program.	
How should the situation be managed? What recourse does Nidhi have now? Should Nidhi be provided with counselling?	Nidhi should be given information about the training organisation's appeal policy and her available options. If Nidhi is removed from training, she should be offered career counselling.

Appendix B. Checklists

Table 1. Observations that raise concern

It is important to consider the standard of all the observed consultations and hence the overall level of concern. Isolated concerns in one or more areas will probably be addressed by relatively simple recommendations and adjustment to the Learning Plan. Multiple concerns in multiple areas and an overall paucity in the quality of the consultations would be deemed as serious and requiring urgent reporting and management.

Area of competency	Skills and behaviours	Observations raising concern
Communication	Communication skills	Inadequate communication skills, in particular: • insufficient patient focus (poor patient-centredness), especially during consultation (poor eye contact, distracted, focused on the computer) • not being sympathetic to the patient • difficulty engaging the patient and establishing rapport (frequent interruptions, poor body language, disrespectful to the patient, patronising, judgemental) • lacking confidence; not listening • not responding to important cues (verbal and non-verbal)
	Language (spoken and written)	• Using language that is not clear and easily understood • Using jargon frequently • Inadequate clinical notes and referral letters (insufficient information, difficult to understand [poor diction], poorly structured)
Clinical skills	Knowledge	• Weak knowledge base, especially with respect to common presentations and presentations of low-level complexity • No knowledge of or awareness of 'red' and 'yellow flags, or the 'masquerades'
	History	• Difficulty or inability in eliciting an appropriate history (eg excessive closed questioning) of the presenting problem with an appropriate systems review • Insufficient awareness of biopsychosocial issues (impact of illness on the patient as well as more broadly) and the patient's agenda (ideas, concerns and expectations)
	Examination	Difficulty or inability in conducting a focused physical examination – important elements of the examination not performed, poor examination technique
	Investigations	• Ordering unnecessary investigations (inadequate mindfulness for relevance of the test to the context) • Difficulty in interpreting investigations, knowing what to do with false positive results
	Diagnosis (including development of differentials and working hypothesis)	Difficulty or inability in: • recognising and effectively assessing the acutely ill, deteriorating or dying patient (and potentially or actually placing the patient at risk) • synthesising clinical information and generating an appropriate list of differentials/ diagnosis/working hypothesis
	Management (including patient education, health promotion, illness prevention)	• Poor structure and flow to the consultation (information gathering and management phases) • Inappropriate prescribing and referrals • Difficulty or inability in regard to: – decision making (particularly with relatively straightforward presentations and problems) – managing serious illness, urgent and emergency presentations (including inability to seek help or refer the patient) – providing information and explanations in a manner that is clearly understood – addressing basic lifestyle issues – shared decision making – addressing both the patient's and doctor's agenda

Table 1. Observations that raise concern

	Procedures	Difficulty or inability in performing: • cardiopulmonary resuscitation (CPR) • electrocardiography (ECG) • intramuscular injections • vaccinations • suture of simple lacerations • blood glucose • cervical cytology • simple dressings • cryotherapy
Cognitive skills	Clinical reasoning	Difficulty or inability in: • interpreting findings (history, physical examination signs, interpretation of investigations) • synthesising information • tailoring management to the individual context • using tacit knowledge and past experiences • managing uncertainty • prioritising • problem solving • making judgements and decisions • recognising serious illness • developing a problem list/differentials list/working hypothesis/diagnosis
	Ability to learn, adapt, change	• Formulaic/rigid approach to the consultation • Difficulty or inability in adapting to the context, and in changing behaviour where it is required
	Awareness, insight, reflection	• Insufficient awareness of limitations to the point that the patient is at risk • Difficulty with self-reflection (knowledge, skills, feedback that has been provided)
Organisational, integrative and collaborative skills	Organisational skills	• Unstructured consultations • Inadequate computer skills • Not using practice systems, particularly where it places patients at risk (checking results, managing abnormal results, patient recalls) • Poor time management • Inappropriate certification • Inappropriate billing
	Integrative skills	• Having a doctor-centred approach • Inadequately addressing illness prevention and health improvement • Not considering the impact of psychosocial problems on health (disease focused)
	Collaborative skills	• Inability to work in a team (with colleagues, staff, other health professionals in the practice) • Inability or difficulty with coordination of patient care
Professional, ethical, legal, attitudinal skills	Commitment to general practice, the patient and self	• Poor commitment to general practice and the patient (duty of care) • Poor attention to self-care • Poor compliance with medico-legal requirements (statutory and regulatory)
	Ethical, moral and legal stance	With respect to patients/colleagues/other health professionals/staff/assessors, not behaving professionally (respect, boundaries, team work) or adhering to principles of justice, beneficence and non-maleficence, patient autonomy and confidentiality • Not obtaining appropriate consent • Inadequate or no regard for the patient's 'culture' • Insensitive to the patient's feelings
	Continuing professional development	• Unwillingness to extend oneself, accept feedback and be challenged (ie reacts unprofessionally) • Inability or difficulty with identifying and addressing learning needs

Table 2. Red flags checklist

Isolated observations, especially if only in one consultation, may raise concern but may not require urgent reporting. A single red flag observed across several consultations and multiple red flags would certainly constitute seriousness and require urgent reporting and management. What should be considered is the overall quality of all the observed consultations as well as whether patient safety has been compromised, or has the potential to be compromised if the behaviour is not corrected.

Check	Red flag	Comments
Communication skills		
☐	Comprehension issues	
☐	Poor rapport	
☐	Lack of empathy	
Clinical skills		
☐	Significant knowledge deficiencies	
☐	Inadequate clinical skills	
☐	Serious clinical errors and safety concerns	
☐	Unorthodox or dangerous prescribing	
Cognitive skills		
☐	Disorganised or rigid thinking	
☐	Not seeking advice/not asking questions	
☐	Excessive need for assistance	
☐	Rigidity in role and opinions	
☐	Lack of insight	
☐	Poor reflective skills	
☐	Difficulty accepting and acting on feedback	
☐	Inability to change or lack of progress	
Organisational, integrative and collaborative skills		
☐	Poor interpersonal skills (with staff and colleagues)	
☐	Poor (unjustified) time management	
Professional behaviour		
☐	Unprofessional behaviour	
☐	Poor work ethic	
☐	Not accepting responsibility for the patient	
☐	Poor attitude to teaching and learning	
Other		
☐	Overt signs of impairment	
☐	Serious complaints from patients, staff, others	

Appendix C. Assessment methods

Assessment method	Use	Strengths	Limitations
Written papers			
Multiple choice/extended match questions	Knowledge	Easy method for assessing content areas; good predictor of overall capability; summative and formative assessment	Difficulty writing questions; benchmarking
Key Feature Problem (KFP) test	Knowledge application; problem solving; clinical reasoning	Tests problem-solving ability while avoiding cueing; summative and formative assessment	Difficulty writing questions; benchmarking
Clinical observation			
Direct observation of consultations (DOCS)	All clinical skills	Direct evidence; formative feedback	Time consuming; intrusive; observer's abilities; variety of consultations; legal requirements (seek patient consent)
Review of video-recorded consults	All clinical skills	Direct evidence; formative feedback; fosters reflection	Time consuming; observer's abilities; variety of consultations; equipment; legal requirements (health records legislation)
Role-play of clinical scenarios	All clinical skills	Direct evidence; summative and formative assessment	Time consuming; observer's abilities; difficulty of writing suitable scenarios; resource intensive
Direct observation of procedural skills (DOPS)	Procedures	Direct evidence; formative feedback	Time consuming; legal requirements (seek patient consent)
Case-based discussion	Knowledge application; problem solving; clinical reasoning	Direct evidence; formative feedback; fosters reflection	Educator's abilities
Reports			
Reports – formal/informal	Behaviour (professional, interpersonal, work habits); clinical skills	–	Reliability of the source; whether first-hand or second-hand information; timing of the report
Portfolios	All clinical areas	Fosters reflection and development of learning	Learner driven; ability to reflect and be self-directed
Patient feedback (Doctors' Interpersonal Skills Questionnaire [DISQ])	Patient satisfaction; communication skills	–	Global impression mostly; reliability
Multi-source feedback (MSF)	Behaviour (professional, interpersonal, work habits)	Anonymous and confidential; multiple raters	Reliability; general practice registrar's cooperation required

Appendix D. Remediation Agreement

Registrars must enter this agreement to join the remediation program. The agreement will assist their progress by providing a clear summary of the expectations and requirements, and the support that will be provided. It must be read in conjunction with the relevant Royal Australian College of General Practitioners (RACGP) and Australian General Practice Training (AGPT) policies.

Remediation Agreement

Schedule 1

Registrar

Name | Medical registration number

Address

Phone | Email

Regional training organisation

RTO representative

Phone | Email

By signing below, you commit to the Remediation Plan. Please read this document carefully. It constitutes an agreement between you, your Regional Training Organisation (RTO) and your supervisor concerning your Remediation Plan participation. If necessary, consider obtaining advice about its contents. You may be removed from the Remediation Plan (and the AGPT Program) if you do not comply with this agreement.

I, **[insert registrar name]**, have read, understood and will comply with this agreement.

Registrar signature | Witness

Date | Witness name

Signed by and on behalf of **[insert RTO]**, which will satisfy its obligations as your RTO under this agreement.

RTO delegate signature | RTO delegate name

Date

I, **[insert supervisor name]**, have read, understood and will satisfy my obligations as your supervisor under this agreement.

Supervisor signature | Supervisor name

Date

Schedule 2

Objectives and activities

In undertaking your Remediation Plan, there are a number of milestones you need to satisfy (your 'objectives'). These objectives are listed below, as are the activities that you will undertake in order to meet those objectives.

A. Objectives

(The following list should be edited accordingly [items removed/added] to reflect the registrar's specific and individual learning needs.)

1. Communication skills and the patient–doctor relationship

- Developing good listening and language skills appropriate to the patient
- Engendering confidence and trust
- Responding appropriately to patient cues
- Confirming the patient's understanding of the problem, the management, advice given and follow-up

2. Applied professional knowledge and skills

- Competently managing common problems
- Recognising and managing the significantly ill patient
- Negotiating, prioritising and implementing structured and individually tailored management plans and agreeing on respective responsibilities and limits
- Prescribing safely and cost-effectively from an informed knowledge base
- Making valid and timely decisions about referral and follow-up

3. Population health and the context of general practice

- Eliciting and taking into account the patient's background (sociopolitical and cultural), relationships with family and significant others
- Understanding and responding to the special needs of the practice population
- Addressing public health concerns
- Working as a team member and coordinating patient care
- Billing appropriately

4. Professional and ethical role

- Having responsibility for the optimal care of patients (respecting patient–doctor boundaries, confidentiality, recognising own limitations, appropriate reporting and follow-up, advocating for the patient)
- Developing the capacity for self-awareness and reflection
- Developing professional networks for personal and clinical support
- Developing time management and coping skills to maintain care of self and family
- Maintaining professional standards
- Adhering to professional codes of conduct

5. Organisational and legal dimensions

- Using personal, organisational and time management skills in practice
- Using and evaluating practice management skills relating to staff management, teamwork, office policies and procedures
- Incorporating medico-legal knowledge and responsibilities relating to certification and prescribing

B. Activities

The activities for addressing these identified needs are [state the specific intervention measures, including monitoring process]:

- a general practice term of [insert number of weeks] duration
- participation in [list the specific educational activities in accordance with AGPT and RACGP requirements]
- [number of] external clinical teaching visits (ECTVs) during the term [either the standard number or more as deemed necessary for monitoring]
- regular [weekly, fortnightly etc; as deemed necessary] placement reviews encompassing a review of personal, clinical, team and professional performance, assessment of the practice environment, an evaluation of teaching sessions and review of patient consultations
- regular contact with a medical educator to monitor progress and provide ongoing support/education
- regular contact with the remediation officer to monitor progress and provide ongoing support.

1. Remediation Plan overview

The Remediation Plan supports registrars identified by their RTO as having remediable clinical skills deficiencies. The Remediation Plan aims to address those deficiencies by providing targeted learning and support.

Only AGPT Program registrars pursuing Fellowship of the RACGP (FRACGP) are entitled to participate in this Remediation Plan. As part of this agreement you will be assigned a supervisor, medical educator and an RTO officer. These people will assist you to develop a Learning Plan addressing your identified learning needs. To complete the Remediation Plan, you must satisfy your individual Learning Plan formulated to your specific learning needs.

Upon commencement of the Remediation Plan, your training time will be suspended to support the remediation. Remediation decisions may be appealable. Refer to your RTO's appeals policy.

2. Your obligations

To satisfy your agreement obligations you must:

- complete the required Remediation Plan
- complete the required ECTVs
- actively participate in all educational activities and demonstrate adequate progression
- keep a log of teaching sessions, learning activities and personal progress against your objectives
- regularly review your own progress
- work with your supervisor and medical educator to satisfy your objectives
- comply with all applicable policies, requirements and conditions from your RTO
- demonstrate satisfactory improvement in the areas identified in the Learning Plan
- exercise the degree of professionalism, skill, care and diligence expected of an Australian GP.

It is expected you will do all things necessary to complete all educational activities and satisfy the requirements of your targeted learning areas within the remedial term.

3. Supervisor's obligations

Your RTO will provide you with a supervisor during your Remediation Plan.
Your supervisor will:

- support you to implement your Learning Plan
- regularly review your progress in meeting your objectives
- regularly report your progress to your RTO officer
- keep records of all your meetings and submit them regularly to your RTO officer
- regularly discuss and provide feedback to you, including on whether your objectives are being or have been met
- provide a written report to your RTO officer outlining whether your objectives have been met at the completion of the Remediation Plan.

4. RTO's obligations

4.1 Medical educator

Your RTO will provide you with a medical educator during your Remediation Plan.
Your medical educator will:

- support you in implementing your Learning Plan
- regularly review your progress in meeting your objectives
- regularly discuss with you your progress in meeting your objectives
- regularly report on your progress to your RTO officer
- keep records of all your meetings and submit them regularly to your RTO officer
- provide regular feedback to you on whether your objectives are being met, or have been met at the completion of the Remediation Plan.

4.2 RTO officer

Your RTO will provide you with an RTO officer during your Remediation Plan.
Your medical educator will:

- monitor your progress in attaining objectives
- maintain regular contact with you, your supervisor and your medical educator
- review all documentation, including that relating to your ECTVs, the Learning Plan and other reports
- collate all reports in relation to your progress provided by the remedial medical educator and the remedial supervisor
- regularly report on your progress to the RACGP
- make a decision regarding the final outcome of your Remediation Plan
- provide feedback to you on whether objectives have been met at the completion of the Remediation Plan
- report the final outcome of your Remediation Plan to the RACGP.

5. Outcomes

Upon completion of the Remediation Plan, the following outcomes may occur.

- If the remediation officer in consultation with the director of training consider you have satisfied your obligations in this agreement, they will recommend to the RTO that you may resume training, with your training time extended by the duration of the Remediation Plan.
- If the remediation officer in consultation with the director of training consider you have not satisfied your obligations in this agreement, they will recommend to the RTO that you be withdrawn from the AGPT Program.

6. Resignation and removal

6.1 Resignation

You may resign from the Remediation Plan. If you do so, you will also resign from the AGPT Program. To resign, provide your RTO with written notice of such. Your resignation will be effective from your RTO's acceptance of your letter. This agreement will simultaneously end.

6.2 Removal

The RACGP and your RTO offer the Remediation Plan in good faith, to assist and support medical practitioners.

However, if this good faith is not reciprocated, the RTO may determine to remove you from the Remediation Plan. Such determinations will not be made unreasonably.

Your RTO will provide you with a removal notice. You will be removed from the Remediation Plan from the date of your RTO's removal notice. You will also be removed from the AGPT Program. This agreement will simultaneously end.

In addition, the RTO may remove you for either of the following reasons:

- no adequate progression demonstrated
- pursuant to the RACGP's Fit and Proper Fellow Policy.

Abbreviations/glossary

In this agreement:

- AGPT Program means the Australian General Practice Training Program.
- ECTVs means external clinical teaching visits.
- FRACGP means Fellowship of the RACGP.
- Learning Plan means the plan developed between yourself and your RTO, which will be annexed to this document and form part of your Remediation Plan.
- Objectives means your objectives as stipulated in the Learning Plan.
- Registrar means you, being a medical practitioner pursuing FRACGP.
- RTO means your Regional Training Organisation as stipulated in the Remediation Agreement.
- RTO officer means the RTO delegate with decision-making authority concerning your Remediation Plan.

RACGP

Royal Australian College *of* General Practitioners

Healthy Profession.
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