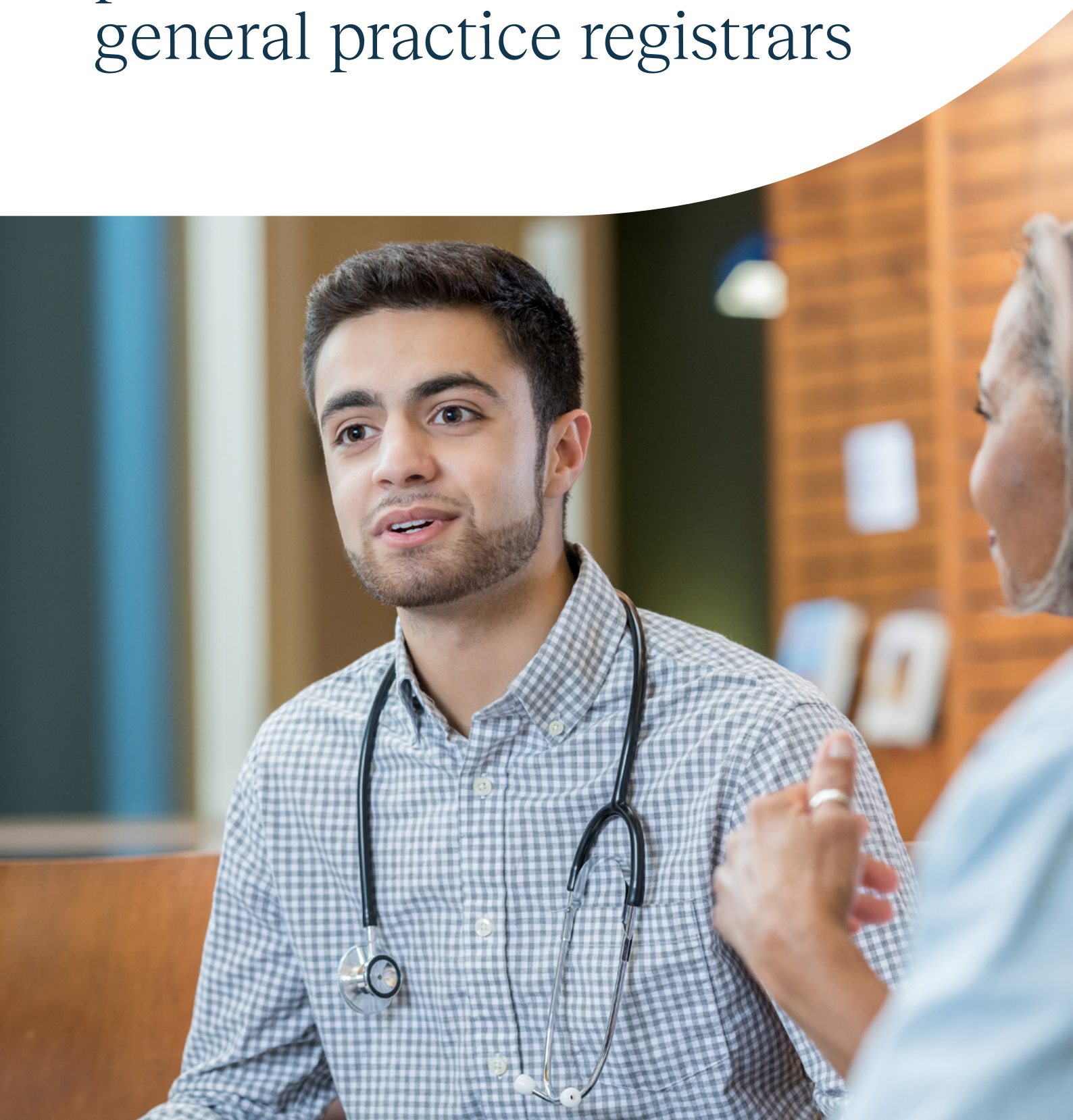
RACGP
Royal Australian College
of General Practitioners

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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Contents

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Introduction

General practice is a broad and complex discipline and requires a wide range of skills and knowledge. Registrars come to GP training with a varied skillset which is unique to each one of them. While many registrars will gain the required skills and knowledge during the standard training program, some registrars may require extra assistance and educational interventions to achieve the required level of competency to meet the requirements of fellowship for independent Australian general practice. It is important to emphasise that performance management interventions are available to support the registrar in training. Successful completion of educational interventions will not detrimentally affect a registrar's career path in any way, including working for the RACGP. Once training is completed information about educational interventions is not a part of the Fellowship record.

Performance concerns in general practice registrars may range from 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 be complex. However, most problems and concerns that arise are of a minor nature and are easily managed.

The following guidelines for managing performance will enable regional training teams and supervisors 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.

An overview of RACGP performance management interventions

There are two types of performance management interventions:

1. Focused learning interventions (FLIs) address identified problems that can be readily corrected in the normal course of training using available resources. It does not affect the registrar's training progression. This form of support addresses one or two discrete concerns and has a low financial cost.
2. Formal remediation plans are required when serious performance concerns are not expected to be readily corrected in the normal course of training and/or where previous focused learning interventions have not succeeded. This intervention suspends training time for the duration of the term. Remediations incur larger costs and address more significant progression concerns e.g. Professionalism, exam fails, clinical reasoning, and insight issues. Applications for funding for remediation terms are made to the National Clinical Lead-Performance Management via registrar.remediation@racgp.org.au.

Performance management intervention plans should be created and assessed with input from the relevant training team, registrar, and supervisor. The following principles and assessment framework are aimed to support the creation and assessment of these plans.

Principles for working with performance concerns in registrars

Having a framework to approach performance concerns in registrars can improve the effectiveness of the medical educator and supervisor, and of the interventions utilised. The following principles are important to consider when working in this space.

Recognition of the importance of the work you need to do.

A registrar who is underperforming is one who can have significant impact on many people's lives. Every patient they see is someone else's mother/father/sister/brother/child. Every patient is part of our community and deserve the best possible health care. Failing to identity and support the registrar in improving means that their patients may be subject to substandard care for the rest of the registrars' career.

An approach of compassion.

Very few people get up in the morning to say, "I am going to do a bad job today." Most people approach their work with at least an intention to do things well. Most registrars who are underperforming want to do better. They may be unaware of what they are doing (unknown unknowns) or not sure how to change. This does not mean that we do not address the person about their underperformance. Diane Komp, an American Paediatric Oncologist coined the term "carefrontation" – which is confrontation with care. When there are performance concerns, we are challenging this doctor because we care about them and their patients. It is done with the intention to help.

A sense of curiosity.

We have heard the term "premature closure" in consultations. We can do the same when considering performance concerns. As medical educators and supervisors, we must be aware of our own personal biases so that we remain objective and fair when assessing a registrar with performance concerns. Questions to ask ourselves include: Am I too stringent or lenient? What are my pet peeves? Can I be objective with this registrar? Do I have any conflicts that may affect my assessment of this registrar? Do I have enough information to make an assessment? Do I understand the registrar's point of view? Approaching the issue with genuine curiosity, trying to understand what is happening, and considering many potential causes for the difficulty, helps in supporting the registrar towards change.

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 and communication among medical educators, general practice supervisors, and regional training team members, regardless of the form of the documentation (paper-based or electronic). 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.

With these principles in mind, we can move to an assessment framework.

An assessment framework for performance concerns

To effectively treat a problem, you first need to make an assessment. This is not always simple as there is often uncertainty and competing possibilities for the probable cause of the difficulty. Considering multiple causes is the way we help to manage some of this uncertainty and to ensure we are considering more broadly than the immediately obvious choices. Identifying the probable cause is necessary to develop a management plan that is going to give the greatest chance of success. Not considering a potential cause may result in missing management options that may be critical to success. Many of these causes interact. The purpose of the process is not to label an underperforming registrar; but rather to identify the behaviour/s and identify what will give the greatest point of leverage, to gain the maximum probability of success, with the least resources. There are many frameworks to assess the registrar with performance concerns. A useful one is outlined below:

A framework for assessment

1. **Pre-requisites for learning**
   a. Learning difficulties
   b. Interpersonal skills
   c. Awareness of context
   d. Self-awareness
   e. Ability to learn from experience.
2. **Knowledge**
3. **Skills**
4. **Professionalism**
   a. Roles
   b. Attitudes & motivation
5. **Systems**
6. **Health of the individual & family**
7. **Inherent characteristics**

1. Pre-Requisites for learning

These are the essentials that must be present to ensure that the learner is able to learn. They include self-reflective ability, sufficient interpersonal skills to be able to interact effectively for learning, and the ability to be aware of their environment so that they may interact with it, learn from it, and translate that learning into other situations. Without these prerequisites, it is unlikely that success will be able to be gained in any other area.

a. Learning Difficulties

Unmanaged specific learning difficulties can impact on a person's ability to learn. For example - dyslexia, difficulties with attention and other specific learning disorders (SLD) may all impact areas of learning that can set a registrar up for failure. These can be undeclared, unrecognised, and/or not managed and may become unmasked during the General Practice training program.

b. Interpersonal Skills

This relates to the broader ability to interact, communicate, and relate to others. It includes skills necessary in clinical consultations, however specific consulting skills are an additional level required for the conduct of medical consultations. For anyone to learn, they need to have the ability to effectively relate to others, not just within medicine. The ability to read emotions, respond appropriately and be articulate in speech all fall within the core components of interpersonal skills.

c. Awareness of Context

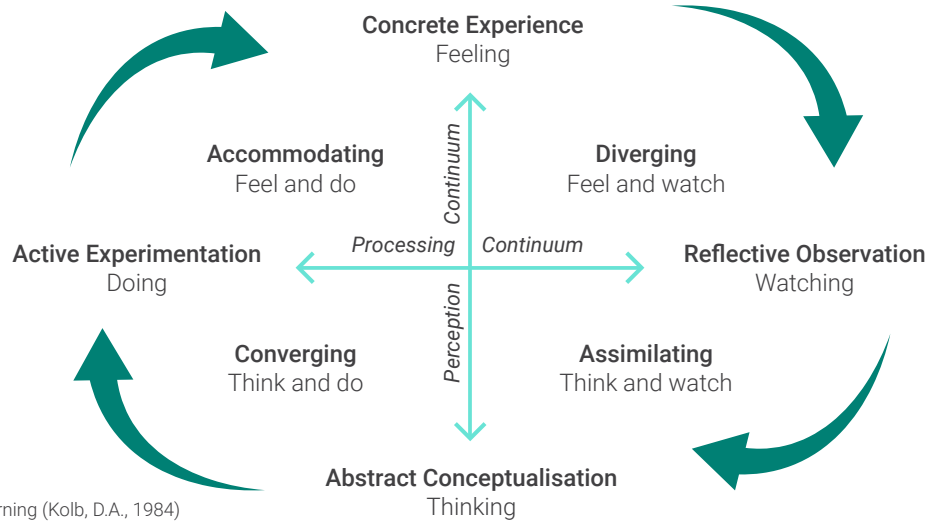
Knowledge application and behaviours are context specific. Being aware of the environment you are currently in enables you to store and use knowledge, skills, and behaviours relevant to that context. When someone has little awareness of their context, they do not have the ability to interpret and apply behaviours effectively for the current context and will have difficulty adapting that behaviour to different contexts. This impacts on their ability to apply knowledge and skills in an appropriate way. E.g. Sending off a tropinin blood test on a patient is appropriate in the Emergency Department where the patient can continue to be monitored, but is not appropriate in general practice where the patient goes home and the result is not available by the end of the work day.

d. Self-awareness

Self-awareness is a foundation for self-reflection. It is critical in effective interpersonal skills. Being aware of how you present, how you interact, the impact you have on others and how you can modify this is central to learning many skills. Awareness of when you have and do not have knowledge, and awareness of your own limitations is required for active learners to seek improvement.

e. Ability to learn from experiences

This combines self-awareness and 'awareness of context' to progress to the next step and be able to learn from experience. The process of having an experience, evaluating it, considering other options, and developing change, forms the basis of Kolb's (1984) cycle of learning. A registrar who lacks self-awareness and 'awareness of context' will be unlikely to effectively work through this cycle that is required for learning and progression. In theory, we should be confident that all pre-requisites for learning are present and managed in our registrars. However, experience shows that these are sometimes absent in someone who is underperforming. When the problem lies within these areas, it is likely to be a much greater challenge and have a lower probability of success. If they are not considered or addressed, then failure is guaranteed. This relationship is reflected in Kolb's Cycle of Learning.



Cycle of learning (Kolb, D.A., 1984)

2. Knowledge

There is a level of assumed knowledge for all doctors. There will be some registrars who have missed core knowledge areas that can influence their performance. Registrars may attempt to hide these knowledge gaps due to embarrassment, or they simply may not be aware of this, so knowledge gaps need to be looked for in those who are underperforming. When significant knowledge gaps are identified, reflection on pre-requisites for learning should occur. If no learning concerns are identified, and motivation is deemed to be adequate, it may be that either experience or actual study has been lacking. Identifying knowledge as the key deficit requires an understanding of the cause of the knowledge deficit. The only person who can gain knowledge is the registrar, so they are the ones who need to do the work in managing this area.

3. Skills

These are the individual behaviours that the registrar must perform to be able to act out their roles in a meaningful and effective way. These are not just physical skills such as suturing and taking a blood pressure, but also communication skills and clinical reasoning skills. These are best assessed by watching the registrar perform in their work, rather than from self-reporting. If they are deficient then we must decide:

- Is this because of a lack of knowledge about the skills?
- Are they aware of the skill but have never developed it?
- Have they not had a good role model to see how the skills are meant to work?
- Do they have the skill but are not using it because they do not perceive this as being valuable or part of their role, or are they not motivated to use it?
- Or do they not have the confidence to use the skill?

Both knowledge and skills are areas that can be taught and learnt for anyone who has the prerequisites for learning. Specific strategies are available for each of these.

4. Professionalism

a. Roles

These are the clusters of behaviours that are expected to be learnt and used in the activity of being a GP. These include being a learner, a communicator, a diagnostician, an educator, and others. Difficulties arise when:

- There is conflict between expected roles within the job or between roles within the job and outside, e.g., when expected to do after-hours cover and manage the role as a parent.
- There is too much flexibility in the role. E.g. there may be inadequate guidance from the supervisor or practice about the way a registrar is expected to act or respond in the work situation.
- There is a lack of role commitment. The registrar does not believe that this is an appropriate role to take on. E.g. They may think that being a listener is not a valuable or reasonable role to perform as a GP.

b. Attitudes and motivation

This is based on the value placed on the activity and the subsequent behaviour by the registrar.
How interested are they in working and behaving in the way they are being directed to? This is influenced by their belief in the value of the activity as well as by their confidence in their ability to carry out the behaviour. A registrar who is unmotivated will either openly reject your approaches or accept information tacitly but with no intention of using the information.

5. Systems

This is the structure in which we practice as a doctor. The computers used, the PBS, the set-up of the surgery and the way a practice operates are examples of the working structure. There may be problems in this area that may be causing registrars to underperform. There may be a lack of understanding about how the system works in a particular practice, or the system itself may be inappropriate or broken, resulting in problems.

6. Health of the individual and family

This important aspect must always be considered. The physical and mental health of the registrar may have major ramifications in their ability to perform and to change. If the registrar is suffering from some significant underlying emotional or physical illness, then their performance will be significantly reduced. Similarly, if they have a significant family concern, then this will impact on their performance. External demands including financial concerns, travel, relocations, study and separation from family also have an impact on the registrar's wellbeing and performance. Acting on the other areas without identifying this as a contributor or priority area will result in sub-optimal interventions and change.

7. Inherent characteristics

These are the more inherent components of the person that influence their behaviour. They are things that we are born with or develop because of upbringing, family styles or cultural factors and which tend to be less amenable to change. However, this should not be a first label to apply. Other areas should be explored before attributing the difficulty to this area.

All the above factors interact to varying extents. There may be identified difficulties in several areas. The approach is to consider what are the principal areas and then the secondary areas. Also, it is important to note that what is perceived to be a primary area may change through the performance management process. Just as with patients when interventions are not working as we expect, a reassessment needs to be undertaken if satisfactory improvement does not occur.

Considering this framework is not meant to be an academic exercise. Identifying the point where the registrar may be having difficulty provides you with a significant point of leverage to act on. Acting at this point of difficulty is likely to produce the greatest gain in any learning intervention or remediation process. The most important outcome is that the registrar becomes a good GP with the reflective skills required to be a life-long learner. In addition, this assessment framework links to a range of interventions that could be implemented.

TIP: A registrar with performance concerns is already struggling to meet the requirements of the training program. When developing a performance management plan, focus on what is most critical to remediate, what resources will be most useful, and how success will be measured.

The remediation team

The remediation team is 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 team may consist of local and/or regional medical educators (MEs), supervisors, practice managers and operations team members such as Regional Operations Managers (ROMs), Training Coordinators (TCs) or Program Support Officers (PSOs) as applicable to your region.

The remediation team's role is to:

- explore 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 interventions, who should be involved, and formulate the plan.
- liaise with all relevant stakeholders (registrar, MEs, and supervisors), gain agreement and delegate responsibilities appropriately.
- monitor all general practice registrars with performance concerns.
- decide if the support/assistance being given to a general practice registrar needs to be continued.
- document and securely store all information (concerns, actions taken, decisions made) regarding identified general practice registrars.
- Facilitate the lines of communication between anyone directly involved in the general practice registrar's learning, and those who need to be informed.

The performance management process

The key elements of an effective performance management process are:

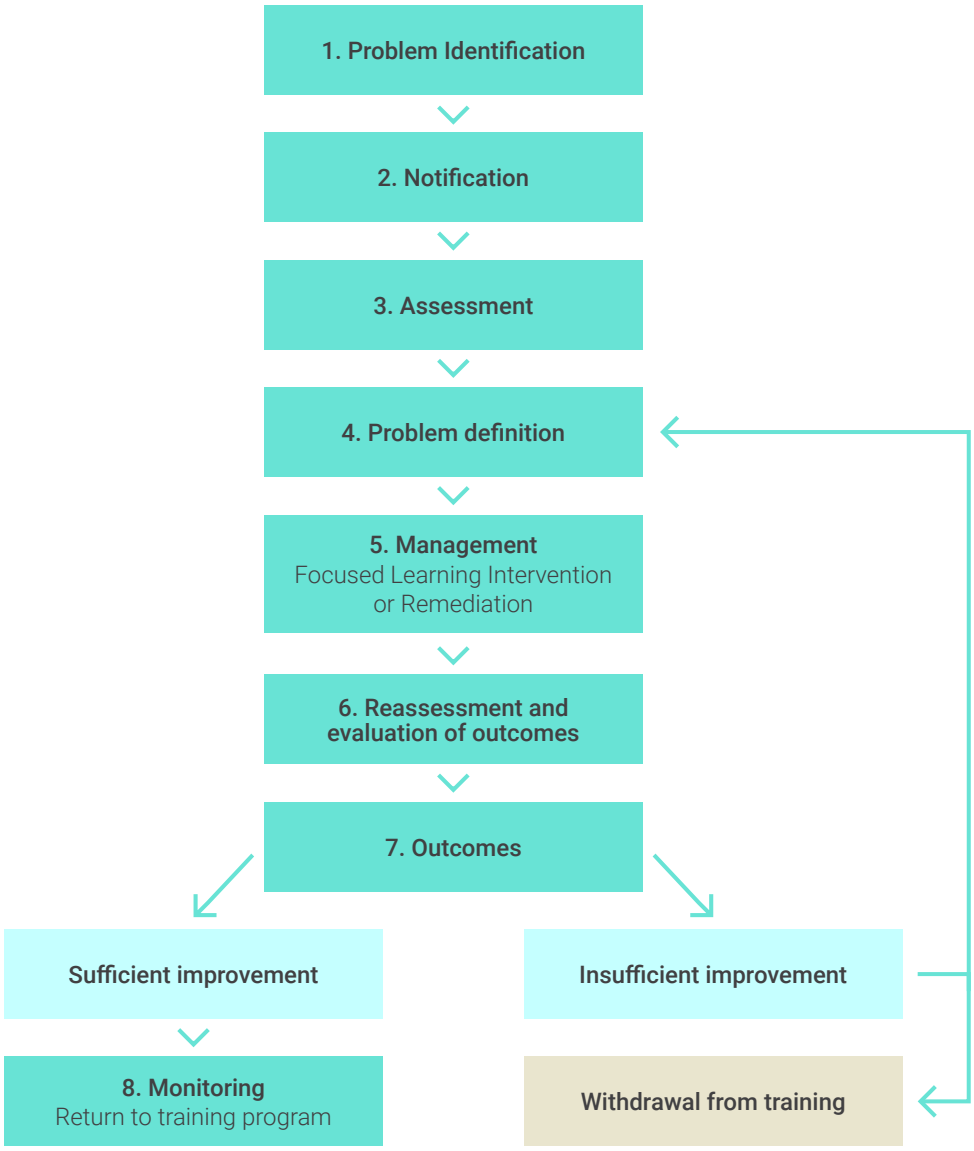
- adequate information from multiple sources
- effective communication with all involved, but particularly with the general practice registrar
- minimal delay with both notification and any action taken
- impartiality
- continuous support for the general practice registrar
- tailored management plans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

The key steps to addressing and managing performance concerns are:

1. Problem Identification
2. Notification
3. Assessment
4. Problem definition
5. Management
6. Reassessment and evaluation of outcomes
7. Outcomes
8. Monitoring

These elements are discussed in detail below.

Figure 1. Performance management process



1. Problem identification

There are several ways that performance concerns may be identified.

- In the practice: by the supervisor, external clinical (ECT) visitor, other doctors, practice staff and patients
- At the RACGP regional training level: by administration staff, medical educators, training coordinators and peers
- Self-identification: by the general practice registrar (rare), or by the AHPRA imposition of addenda on their registration

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, should intervention be required. Appendix B provides an outline of observations that indicate performance concerns.

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, 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 training team will determine the level of concern, the appropriate action and the urgency required.

Early identification and reporting of problems are 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 EASL (Early Assessment of Safety and Learning) at the commencement of training.
- directly observing the general practice registrar.

2. Notification

When a concern is raised or a problem identified, the registrar's medical educator (ME) and training coordinator (TC) should be notified. 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.

3. Assessment

When a performance issue or concern has been raised, there are 3 key questions to ask:

1. 'Does it matter?'

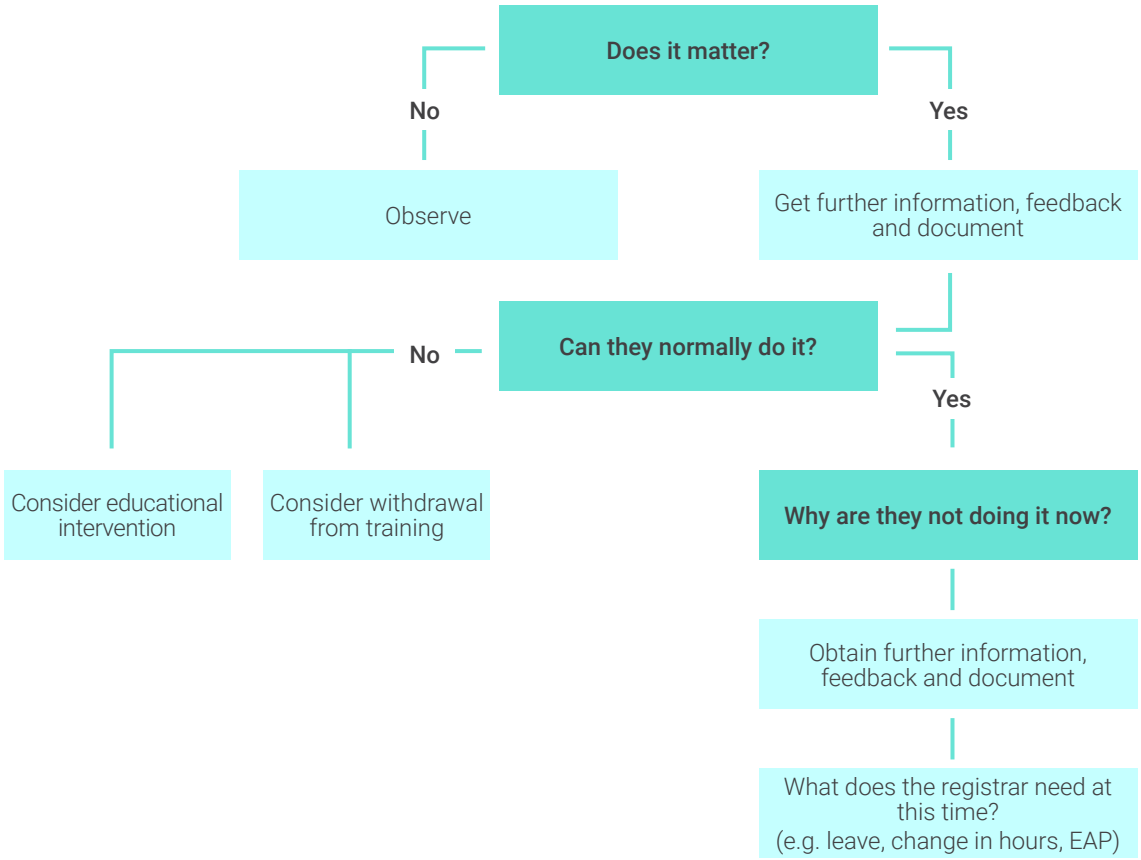
E.g. the registrar has a knowledge gap but is aware of limitations and is appropriately help seeking-no further intervention required.

2. 'Can they normally do it?'

E.g. The registrar normally checks all results at the end of the day but missed doing this when they went home sick mid-afternoon-this is a one-off situation.

3. 'Why are they not doing it now?'

E.g. the registrar is calling in sick at least once a week for the last month-this requires discussion to understand what has changed for the registrar.



Performance concerns will often arise from Workplace Based Assessments (WBAs), performance in education sessions (in and out of practice), and interactions with other training or practice staff. Following an assessment, feedback (verbal at the 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 have been discussed. If the concern is serious (especially when there are patient safety concerns) then the registrar may also be asked to take Category 2 leave while the performance management interventions are determined.

Registrars with performance-based concerns that require intervention will be discussed at the Progression Review Committee (PRC).

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 may be at the root of the presenting concern. This is where the assessment framework may be helpful.

Serious concerns ('red flags')

It may be that serious concerns have already been identified as part of the assessment framework. How these concerns will be addressed will depend on the context and can include placing the registrar on Category 2 leave and/or instituting a performance management intervention (Focused Learning Intervention or remediation). 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. Red flags or serious concerns may include, but are not limited to:

- Unprofessional behaviour
- Overt signs of impairment
- Serious complaints from patients and/or staff
- Unorthodox or dangerous prescribing
- Serious clinical errors and safety concerns

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 outline of the objectives, requirements, roles, and responsibilities of each party of the agreement, and potential outcomes.
- have a set timeline, with regular reviews and a clear end point.
- indicate how the outcomes will be evaluated.
- have provision for reassessment and evaluation of the outcomes.
- have defined actions with respect to the outcomes.

Considerations for developing a management plan:

- The type of intervention will depend on the cause of the performance concern. If the root cause is not addressed, the general practice registrar is unlikely to progress.
- A well-considered, tailored management plan that addresses the key issues at play is more likely to be successful.
- The learning environment must be psychologically and culturally safe and supportive.
- The general practice registrar needs to be fully engaged.

As already discussed, there are two types of RACGP supported management plans: Focused Learning Interventions (FLIs) and Remediations. Plans for either of these must be developed by the training team in consultation with the general practice registrar and supervisor/s. The plan should be documented in a formal agreement.

Regional processes should be in place to identify local practices and supervisors that are suitable and willing to take the general practice registrar for remediation training.

In circumstances where the training region cannot accommodate remediation within its region, a transfer to another location may be appropriate as per the guidelines in the RACGP Training Transfer Policy.

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

Formal progress reporting to the National Clinical Lead-Performance Management is required at the mid and end points of a remediation term.

Interventions and assessments to consider including within a management plan

Prerequisites for learning	**Awareness of context**	Mindfulness activities - Think out loud; 5 things I see; Stop, look, and listen
	Self-awareness	Mindfulness training
	Ability to learn from experience	Case review Video review Think out loud Micro-step analysis of process What if? (Random Case Analysis process) Investigate specific learning difficulties – e.g. dyslexia, auditory processing problems through Educational Psychologist or similar
	Interpersonal skills	See communication skills below

Knowledge		Audit and reflection Learning plan/program Self-Assessment grid - Community GP terms Discomfort log Reading, reflection, study groups, web-based activities Workshop/ tutorial attendance Self-assessment Progress testing (SAPTs) Post Exam Support Intensive Program (PESIP) Teaching others Learning style evaluation and planning Investigate specific learning difficulties – e.g. dyslexia, auditory processing problems through Educational Psychologist or similar
Skills	**Communication Skills**	Direct observation and feedback e.g. supervisor, ME or ECTV Reverse direct observation Video deconstruction Standardised patient Simulation/ Role play Intensive communication workshop RACGP Communication Skills Specialist (CSS) support
	Specific Skills development	Procedural skills training Direct observation of procedures (DOPS) Specific skills courses- Emergency, skin cancer, family planning, implanon/mirena courses Physical examination practice Observation and feedback Error reporting and review
	Clinical reasoning skills	Random case Analysis (consultations/pathology inbox/referral letters) Adequate case numbers and diversity of exposure Case based discussion including review of • Consult structure. • Understanding of context • Framing presenting problem • Hypothetic-deductive approach • Challenge cognitive bias • Targeted vs scattergun information gathering • Prioritise decision making • Talk out loud decision process • Ensure adequate knowledge base • Creating illness scripts • Socratic questioning • Taking patient perspective

Professionalism		"Difficult" discussion e.g. GPSA Shades of Grey cards Specific instruction e.g. Good Medical Practice: a code of conduct for doctors in Australia Mentoring Role modelling Peer benchmarking e.g. Multi source feedback (MSF) Video deconstruction taking the patient perspective (real or simulated) Self-assessment and reflection
	Role	Role clarification Role modification Managing role conflicts both internally and externally
	Motivation	Motivational interviewing • Enhance confidence • Enhance conviction • Values hierarchy • Cognitive dissonance • Doable steps
System		System analysis System redesign – targeted at specific challenges Education of systems
Health of the individual		Psychological intervention • Mindfulness • CBT GP referral Treating doctor reports e.g. Fitness to work certification Home situation assessment and adjustment Workplace modifications – time, consulting hours and rate, etc.

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.

Measuring progress or change can be difficult but should be as objective as possible and have consideration for benchmarking against the Progressive Capability Profile of the General Practitioner for the registrar's level of training.

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 (e.g. poor engagement, learning difficulties, inability to progress because of unresolved personal or health issues)
- The practice (e.g. insufficient support in scheduling appointments, work hours)
- the general practice supervisor or medical educator (e.g. inadequate/insufficient support)
- the management plan used (not well formulated, inadequate resources, insufficient time).

After an evaluation has been made, the general practice registrar may:

- be allowed to resume training without additional support.
- be allowed to resume training with a focused learning intervention in place which will enable them to reach the required level of training.
- be placed on a further remediation term to a maximum of 26 weeks total.
- may 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..

Reconsiderations and appeals

General practice registrars who oppose the need for remediation as determined by their regional training team may access the RACGP's disputes, reconsiderations, and appeals process to review the matter.

Where the regional training team determines that remediation has failed and further remediation is unlikely to be successful, and where the general practice registrar disputes the regional training team's decision, the general practice registrar may access the RACGP's disputes, reconsideration, and appeals process to review the matter.

8. Monitoring

Monitoring is an important aspect of managing performance concerns. This occurs at all levels of the performance management process and for the remainder of the registrars training time. The training team 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.

Potential barriers or errors when addressing performance concerns

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.

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.

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.

Resources

Policies and standards

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)

- Dispute reconsideration and appeals guide
- Dispute reconsideration and appeals policy
- Registrar Remediation Policy
- Training Transfer Policy
- Standards for general practice training
- Progressive capability profile of the general practitioner
- Leave Policy
- Withdrawal policy
- Academic Misconduct policy

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

RACGP AGPT documents

- Application for registrar remediation funding
- Progress report – registrar remediation
- Final report – Outcomes of registrar remediation
- Focused learning interventions application and report
- A guide to understanding and managing performance concerns in international medical graduates
- RACGP AGPT Registrar Handbook

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Appendix

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 practical 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 – 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 ME 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?

Thank Evan for discussing this with you.

Check what he needs immediately: facilitated discussion with practice, time to see GP, engagement with a psychologist, leave, opportunity to debrief in a safe environment, increased access to supervisor, reduced hours, or patient load, Establish a close follow up plan.

How would you explore Evan's anxiety?

Cautiously and with a clear understanding of role. In this space the role of the ME or TC is to explore all the issues and encourage/assist the registrar to seek appropriate help from their GP or psychologist. The opportunity to discuss his anxiety should be offered, but it should be respected if Evan chooses not to share.

Do you require any other information?

Review of Evan's WBA's, engagement with the training program and performance in 'out of practice' education.

Supervisor feedback about Evan's in practice performance.

Any other social, health or cultural factors that may be impacting Evan if he is willing to share them.

Evan describes always feeling a little anxious and tending 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?

Thank Evan for trusting you and sharing this information.

Acknowledge how all these issues are likely to affect his anxiety and confidence.

Reassure him that you are there to help and ask him what he thinks could be helpful.

Offer other suggestions as appropriate once Evan's ideas have been explored.

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

Taking time off may exacerbate Evan's anxiety particularly about financial issues. It is reasonable to ask Evan for a clearance letter from his GP stating that he is fit to continue working with his current level of anxiety. Despite this Evan should be made aware that taking time off to manage his anxiety is an option for him.

Evan's supervisor reports that Evan is asking questions for almost 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?

Acknowledge the supervisor's concerns and current overload.

Identify that Evan's wellbeing and safe learning is the primary concern.

Seek viable solutions from the supervisor/practice manager to reduce the load on Evan.

Consider reviewing the supervisors informal teaching skills e.g. 1 minute preceptor.

Check in with Evan to check on how supported he feels.

Facilitate discussions between the supervisor and Evan to address the current issues if possible.

Continue to support Evan and the supervisor.

Case 2 – 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 explanations for Marion's repeated exam failure? Could these exam failures have been prevented?

- Inadequate preparation
- Time management issues
- Knowledge gaps
- Reading and question interpretation issues
- Clinical reasoning difficulties
- Not changing approach to study in each exam cycle
- Performance anxiety
- Personal issues
- Lack of exposure to common presentations

Intervening after the first exam fail may have been helpful.

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

Perform Post Exam Reflection Training Advice Meeting.

Identify issues.

Consider specific feedback from assessment team as has failed exam 3 times.

Consider practice and work hour adjustments.

Involve in RACGP exam prep and exam support resources-e.g. SAPT (Self-Assessment Progress Test), PESIP (Post Exam Support Intensive Program).

Consider FLI or remediation term.

Consider Communication Skills Specialist input.

Consider learning disorder/ADHD/ASD assessment and special arrangements that may assist Marion to perform in the exam.

Consider psychological/pastoral support.

Case 3 – 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?

Cultural mismatch - Mikhail may be used to a more transactional approach than a patient centred approach.

Difficulties receiving feedback - Mikhail may interpret feedback as criticism.

Role conflict or uncertainty - Mikhail may have difficulty understanding the GP registrar role.

Professional communication concerns.

Supervisor may not be giving feedback about what Mikhail is doing well.

Supervisor hasn't asked for help with his communication with Mikhail earlier.

Practice processes and/or patient demographics may be poorly suited to Mikhail's consulting style.

Is Mikhail in the right specialty - might he be more suited to Emergency Medicine or ICU.

The comments about racism must be explored and taken seriously.

How should the situation be managed?

Further information needs to be gathered from the supervisor and Mikhail.

If possible, a mediated discussion should take place to identify whether this working relationship can be salvaged.

Consider ME direct observation of Mikhail's consulting.

Consider career counselling.

Consider whether a change of practice is beneficial for all concerned.

Consider FLI or remediation for professionalism issues.

Provide support to both the supervisor and Mikhail.

Consider whether the practice/supervisor needs remediating.

Consider whether the practice/supervisor and Mikhail require cultural safety training.

Case 4 – Sandrine

Sandrine is a general practice registrar in her second general practice term. Midway through the term, the supervisor reports several concerns to the ME 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
- Several patient complaints.

Is this information sufficient to act on?

Several significant concerns have been raised. Further exploration of the situation is required.

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?

Judgements

Cultural issues are causing difficulties in the consultation.

The practice nurse has been covering for Sandrine.

Sandrine asking lots of questions means she has knowledge gaps.

The next step would be to check in on Sandrine and get her version of events.

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

How should this situation be addressed?

Check with Sandrine whether it would be okay to meet with her now or whether the meeting should be rescheduled.

Meet with Sandrine by herself initially.

Outline the purpose of the meeting and identify that the goal is to support Sandrine's training and wellbeing.

Sandrine is reassured by the ME 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?

This needs to be taken seriously and explored further.

How should Sandrine's claim be addressed?

Ask Sandrine to explain her concerns further.

Ask Sandrine whether there are any other explanations for the behaviours she is experiencing.

Explore whether these issues also occurred in Sandrine's 1st GP term.

Review available WBA to see if any concerns have been previously identified.

Check on Sandrine's wellbeing and whether she is safe to continue at the practice while the issues are further explored.

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 ME decides that she would benefit from a remediation term.

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

This should be discussed with Sandrine initially.

If she does not feel culturally safe within the practice, then she should be moved.

The ME 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 remediation 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 if Sandrine had not progressed in her clinical skills?

Consider any factors that may have hindered her progress e.g. settling into new practice, personal or health issues.

Discuss with Sandrine whether general practice is the career she wants and offer career counselling if appropriate.

Consider whether a further learning intervention is warranted.

Consider whether patient safety concerns necessitate a withdrawal from training.

Case 5 – 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 concerns regarding his progress had been noted in his record. The administration staff handling the transfer report that Hans 'has attitude.'

Does it matter that no past reports are available?

Yes-it is in Hans best interests that all information about his training journey to date is available to his current training team.

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

It is a subjective statement without supporting evidence and needs to be disregarded for now.

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 ME, 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'?

There are now 3-4 sources reporting that Hans has 'attitude'. It is reasonable to ask the supervisor and MEs to explain their concerns in more detail. An ME ECT visit would be reasonable to consider.

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 ME 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?

A decision needs to be made immediately regarding whether it is safe for Hans to continue seeing patients while the situation is further explored.

The ME needs to meet with Hans to discuss these concerns as a priority.

The supervisor should discuss the situation with his MDO to determine whether there is mandatory reporting requirements.

The ME 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 takes opioids for pain sometimes, but never when he is at work. When his pain is 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 ME? Should Hans be compelled to take time off to address his medical concerns?

The ME should request that Hans not work until he sees his GP and has a clearance to continue working from his GP.

Options for his ongoing training should be discussed if he is medically cleared.

- Reduced hours or days
- Further Category 1 leave
- Educational intervention with increased supervision while he returns to work.

The information that Hans has shared should be treated confidentially unless there is concern that Hans is a risk to himself or others in which case confidentiality can be breached to ensure safety.

The ME decides to observe Hans' consulting. With the first few patients, the ME 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 patient should be handed over to the supervisor.

The ME should debrief with Hans, clearly outlining the concerns they have observed with Hans' consulting today.

The ME 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. Considering this, has the ME been overcritical of Hans?

The explanation that Hans has provided does not negate that there was clearly a significant patient safety issue in the consultation. Whether due to performance anxiety, knowledge gaps or medication side effects the patient safety issue is paramount.

What should be done with Hans now?

Hans needs to be put on leave immediately.

Ongoing support for Hans must be provided while the next steps are sorted e.g. regular welfare checks from the training team, RLO support, EAP support.

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

With respect to the concerns about patient safety and Hans's work impairment, is there a requirement for the ME/RACGP to report the concerns to AHPRA?

The ME should seek legal advice from their MDO regarding the need to mandatorily report. If the ME is advised that a mandatory report is not needed and the training team is considering a voluntary AHPRA report this must be discussed with the legal team at the RACGP.

Hans should be encouraged 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?

Yes - this is essential.

Hans undergoes the clinical skills assessment. He completes a multiple-choice paper and role-plays several 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?

Yes, Hans is at considerable risk of further patient safety incidents and is not performing at an acceptable level for a registrar in GP training.

Case 6 – 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 ME, expressing his concerns about Maryse's clinical skills. He says that she is requiring a lot of assistance with most patients 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 ME attends the practice, observes Maryse's consulting and confirms the supervisor's concerns. The ME'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 ME that Maryse has conditions on her registration because of a medical condition. For reasons of confidentiality however, he is unable to tell the ME what the medical condition is.

Should the ME be told what Maryse's medical condition is?

Maryse must disclose her publicly available AHPRA conditions to the training team. This is non-negotiable and the failure to disclose can be grounds for Academic Misconduct. She is entitled to privacy about her medical condition however the training team may be able to better support her through training if they are aware of the health issues and how they impact Maryse.

Regardless of whether the diagnosis is disclosed, an assessment of Maryse's ability to meet training program requirements with her current conditions must be undertaken and training halted if her conditions are incompatible with her being able to meet training program requirements e.g. unable to work more than 14.5hrs a week (minimum training requirement 14.5hrs a week) or gender restrictions or unable to see children.

A medical clearance for Maryse to return to work is required from her treating team.

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

Not knowing her diagnosis may limit the support that can be offered to Maryse by the training team. Appropriate adjustments to training may not be suggested or offered.

The ME 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?

It is possible, particularly if Maryse has not kept up with any reading/study in the previous 18 months. However other potential causes should also be considered and explored.

Maryse says that she recognises that there is room for improvement in her skills and she is quite happy to receive assistance. The ME 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 ME to be asking Maryse about her medical condition?

It is appropriate to ask as part of an assessment to support Maryse's return to practice. Maryse may or may not choose to share and this must be respected. However, Maryse must be asked about her registration conditions and how they impact her ability to practice. She should be informed that it is a requirement to inform the training program about any addenda on her registration and any changes to those addenda.

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 ME ask Maryse for more information about her medical condition?

The ME could let Maryse know that sharing more about her medical condition may help the team support Maryse better, but that she is entitled to her confidentiality. It is reasonable for the ME to ask for a medical clearance to say that Maryse is fit to be at work.

Maryse commences her remediation term. Four weeks into the term, her supervisor and the medical educator providing her with educational support report to the ME that Maryse has made minimal improvement.
The ME 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 ME act now?

The ME needs to clearly outline the areas of concern with Maryse's performance and the interventions already instituted.

They should further outline the changes that need to be seen within a given time limit for the remediation to continue.

Maryse need to be made aware of the consequences of not meeting these milestones which may include.

- Further Category 1 or 2 leave.
- Review of the current remediation plan and adjustment if new concerns are identified.
- Withdrawal from training.

Maryse should be offered career counselling to see if another aspect of medicine is more suited to her interests and skills.

Maryse should be offered pastoral support e.g. ME, RLO, EAP

Appendix B - Observations indicating performance concerns

Area of competency	Skills and behaviours	Observations Raising concerns
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) • Comprehension issues (hearing, understanding)
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 (e.g. excessive closed questioning) of the presenting problem with an appropriate system 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 – crucial 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

Area of competency	Skills and behaviours	Observations Raising concerns
Clinical skills (continued)	**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 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 regarding decision making (particularly with 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
	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

Area of competency	Skills and behaviours	Observations Raising concerns
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. • Rigidity in their role and opinions (poor tolerance of ambiguity, difficulty prioritising, inability to compromise)
	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) • Difficulty in accepting feedback, defensiveness. • Not seeking advice or asking questions as expected for their level of training • Seeking assistance excessively and/or for minor things
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)

Area of competency	Skills and behaviours	Observations Raising concerns
Organisational, integrative, and collaborative skills (continued)	Collaborative skills	• Inability to work in a team (with colleagues, staff, other health professionals in the practice) • Lack of involvement in practice activities (e.g. meetings, social activities) • Poor interpersonal skills • 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) • Absenteeism (frequent and/or unjustified) • Serious complaints from staff, patients, and others
	Ethical, moral, and legal stance	• With respect to patients/colleagues/other health professionals/staff/assessors, not behaving professionally (respect, boundaries, teamwork) 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 • Unprofessional behaviour • Deliberate overbooking of patients • Financial focus rather than learning focus?
	Continuing professional development	• Unwillingness to extend oneself, accept feedback and be challenged (i.e. reacts unprofessionally) • Inability or difficulty with identifying and addressing learning needs • Late submission of tasks • Lack of proactivity with respect to their learning
Other	Health	• Overt signs of impairment (mental illness, substance misuse) • Absenteeism

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