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A guide to performance management and support for general practitioners

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A guide to performance management and support for general practitioners

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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

Acknowledgements	*iii*
Introduction	*1*
Essential principles for managing performance concerns	*2*
Documentation	3
Engaging the GP	3
AHPRA and the Medical Board of Australia	4
Performance management	5
1. Problem identification	6
2. Investigation and assessment	10
3. Problem definition	12
4. Decision making	14
5. Management	14
6. Reassessment and evaluation of outcomes	17
7. Outcomes	17
8. Prevention	18
Roles and responsibilities	*20*
Resources	*23*
Bibliography	*24*
Appendix A. Case studies	*28*
Appendix B. Significant event reporting (pro forma)	*35*
Appendix C. Performance management policy for practice X (pro forma)	*38*

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Introduction

For most general practitioners (GPs) practising in Australia and who adhere to the Medical Board of Australia's (Medical Board's) code of conduct, there will not be any concerns regarding their safety to practise. It is inevitable, however, that there will be some GPs who are underperforming, where patient safety may be compromised, and who will require some form of support or assistance in order to address the performance concerns.

It is the individual GP's responsibility to ensure their safety to practise. Practices and employers of GPs also have a duty of care to the public (patient safety) as well as the GPs in their employ (GP safety). The practice, having knowledge of the GP and their work, is ideally placed to monitor performance and address concerns as they arise. If this is to be done effectively, it is important that appropriate practice policies and procedures are in place and are implemented with fairness and transparency, and that all GPs receive induction and are familiar with the policies and procedures.

Managing underperformance is also termed 'remediation'. It is a process that begins with identifying a concern, followed by investigation, assessment, decision making and, finally, implementing a management plan. A range of possible interventions, or remedial activities, may be implemented, from simple advice and support through to formal supervision and retraining. These interventions encompass:

- reskilling or retraining – the process of addressing deficits in knowledge, skills and/or behaviours to enable the GP to practise safely
- rehabilitation – the process of supporting the GP with any ongoing health issues and/or disability, to
  - surmount the difficulties that hinder them from practising safely
  - assist with making adjustments in the workplace to enable them to practise safely.

This guide makes recommendations only.

It relates to those GPs with performance concerns who are:

- post-Fellowship and in active practice
- working towards attaining Fellowship (but not in an Australian General Practice Training [AGPT] Program) and with performance concerns that are not related to the Fellowship exam.

It outlines a process for identifying and addressing the needs of underperforming GPs in order to facilitate their return to, and ensure their adherence to, safe practices.

It assists:

- practices and practice managers in having effective processes in place for identifying and managing underperformance
- medical educators, investigators, assessors and supervisors in managing performance concerns.

For remediation of general practice registrars in the AGPT program, refer to The Royal Australian College of General Practitioners' (RACGP's) *A guide to managing performance concerns in general practice registrars.*

For GPs re-entering practice, refer to the RACGP's *A guide to re-entry to general practice.*

A guide to performance management and support for general practitioners also outlines the role of the Australian Health Practitioner Regulation Agency (AHPRA) regarding performance concerns that have been brought to its attention. It is important to understand that AHPRA is the regulatory body with respect to doctors' conduct and any investigation by AHPRA does not preclude or impede an investigation by the practice in which the doctor in question works.

Essential principles for managing performance concerns

Managing performance concerns is not a simple process. For the underperforming GP, their identity is challenged and their livelihood threatened. Sometimes difficult decisions have to be made, decisions that can be strongly contested. For actions and decisions to be defensible, policies and processes for managing performance concerns at the practice level must be:

- documented
- clear and transparent
- fair, non-discriminatory and safeguarding of confidentiality
- supportive of the GP
- up-to-date
- instigated early, whenever possible.

Important aspects of the remediation process are:

- engaging the GP and maintaining communication with them at all times
- identifying the nature and range of all the concerns
- developing a detailed Remediation Plan tailored to the individual that includes
  - a learning plan
  - defined roles and responsibilities for those involved
  - a suitable time frame
  - clearly defined objectives
- always acting in a timely manner and not delaying with decision making
- monitoring progress
- evaluating performance after completion of the plan.

Processes for managing disputes in the workplace are not necessarily sufficient for managing performance concerns. Even if a practice has a remediation policy in place, there may be difficulties in implementing it. For example, it may be difficult to ensure fairness or to guard against discrimination when the person investigating or making decisions is also the employer. Individuals who are given the role of managing performance concerns may not always have the necessary skills. Consultation with an expert in the field would therefore be recommended in order to ensure that a performance concern is handled appropriately and effectively.

Documentation

There should be clear processes for documenting performance concerns. Documentation should include any firsthand evidence as to the concerns that have been raised, such as specific examples of problems that have arisen and patient complaints (whether formal or informal). All relevant discussions, decisions made, and action taken should be documented contemporaneously. Any such documentation should be kept separate from the patient file. Consideration should also be given to privacy and confidentiality and, consequently, to the levels of access to this documentation among 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 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 GP disputes the issues and is either reluctant or refuses to comply with a planned intervention or any decisions that are made.

Refer to Appendix B. Significant event reporting (pro forma). This pro forma outlines a framework for practices for reporting and documenting incidents that are concerning.

Engaging the GP

Complaints and performance concerns are not always easy to address at the local or practice level. Sensitivity is required because the GP in question may not accept criticism and they may react negatively, such as with anger or denial. It is not uncommon for GPs to question their self-worth and their abilities as a doctor.

While a GP cannot be compelled to undergo remediation, helpful strategies for enhancing engagement and their cooperation include:

- maintaining an open mind (eg not making assumptions, guarding against bias and prejudicial statements)
- seeking advice and/or assistance from someone more experienced in providing feedback on performance or managing difficult situations
- seeking advice and/or assistance from a colleague who the GP respects
- informing the GP that the issues are being raised out of concern not only for patient safety but also the practitioner's safety
- assisting the GP to better understand the concerns
- listening to the GP's perspective, allowing them to relate their story and what they perceive the issues to be
- advising the GP that they may need to seek support from their medical defence organisation (MDO) and allowing the GP to have a support person with them at meetings
- reassuring the GP that they will be supported through the remediation process and providing that support
- reinforcing the notion that better outcomes will be achieved by working together.

When a GP lacks insight or refuses to cooperate, consideration will have to be given to the action that should be taken. Possible actions for the practice to take include:

- issuing a warning to the GP and placing them on probation
- when there are health concerns, asking the GP to take sick leave or to present a certificate of fitness to practise from their treating health professional
- reporting the GP to AHPRA under the mandatory reporting regulations when there are serious performance concerns.

When a complaint or notification has been made to AHPRA, often the first that the GP hears of it is when they receive a request for further information or an explanation from AHPRA. In addition to the initial shock, the complaints process can be very long and costly, and therefore very stressful. The GP's welfare during this time is important and supportive initiatives, such as regular consultation with their GP and/or referral to a clinical psychologist, are helpful.

The practice may or may not be aware that a complaint has been made to AHPRA. If not, they should be informed by the GP because the practice itself will want to look into the matter and take appropriate actions (which may range from support for the GP through to measures to ensure patient safety).

AHPRA and the Medical Board of Australia

AHPRA supports the15 National Boards that are responsible for regulating the health professions with protected titles under the *Health Practitioner Regulation National Law Act 2009* (Cwlth). One of the National Boards is the Medical Board, the primary role of which is to protect the public and to set the standards and policies that all registered medical practitioners must meet.

In addition to supporting the National Boards, the role of AHPRA is to:

- manage the registration and renewal process for health practitioners and students around Australia
- on behalf of the Medical Board, manage investigations into the professional conduct and performance of medical practitioners, except in
  - New South Wales, where investigations are undertaken by co-regulators, the Medical Council of New South Wales and the Health Care Complaints Commission, via a formal consultation process designed to determine which agency is better placed to deal with a particular complaint or practitioner
  - Queensland, where it may be undertaken by the Queensland Health Ombudsman
- work with the Health Complaints Commission in each state and territory.

The Medical Board comprises medical practitioners and community members who are conversant with clinical practice and systems. All regulatory decisions that might affect a practitioner's registration are made by the Medical Board or by a Civil and Administrative Tribunal.

The roles of AHPRA and the Medical Board are complementary. AHPRA staff provide the administrative support that enables the Medical Board members to consider the available information and make decisions.

Performance management

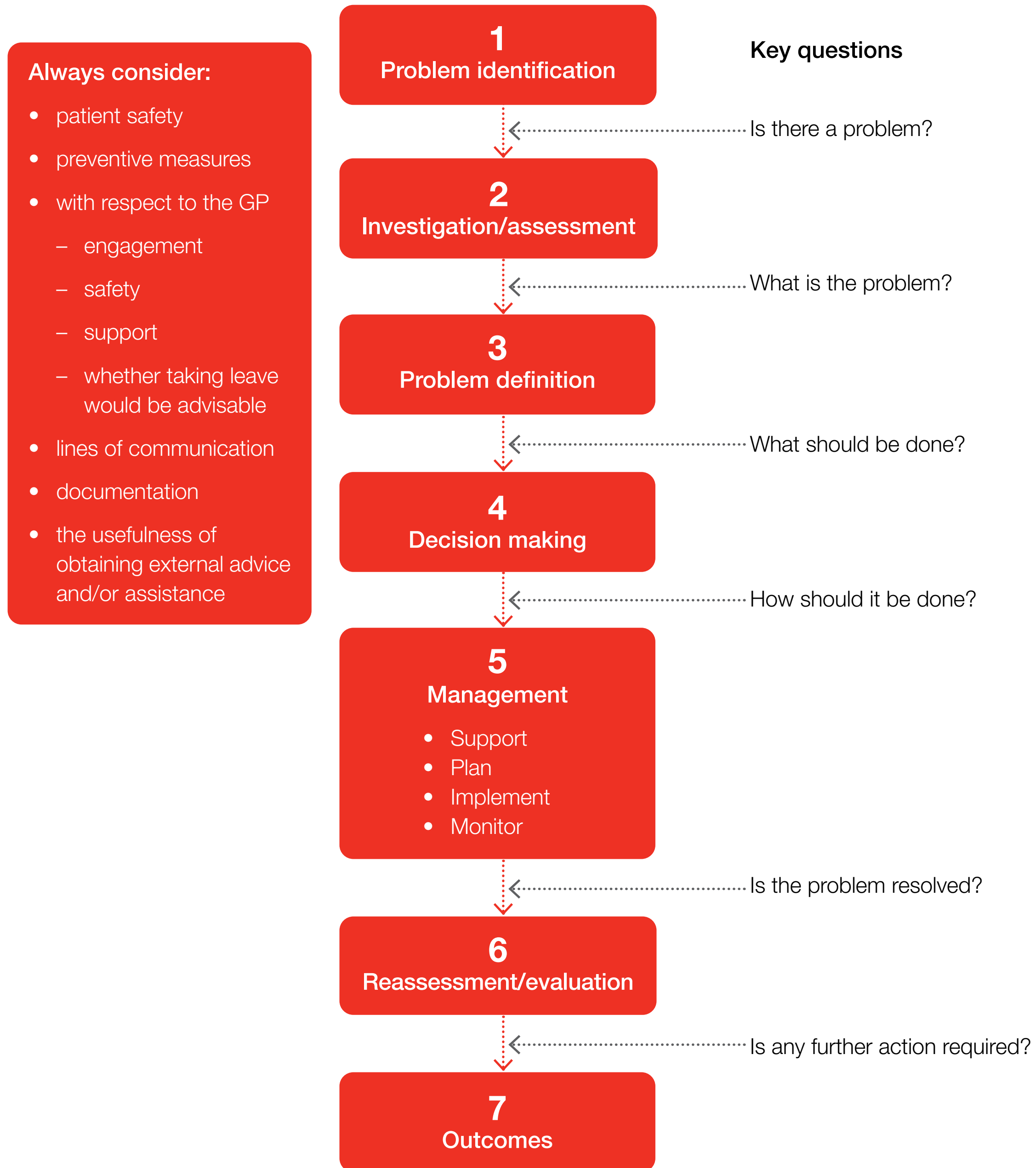

Figure 1. Performance management process

1. Problem identification

Performance concerns may be identified by:

- the GP concerned (self-appraisal)
- a colleague
- the practice employing the GP
- practice staff (eg nurse, reception staff)
- a complaint made by a patient or another individual
- the coroner.

Complaints against GPs may be made to:

- the GP concerned, who should then inform the practice to discuss what action should be taken
- the practice – in this instance, the GP in question should always be informed that a complaint has been made. Depending on the nature of the complaint, it may be
  - addressed directly by the practice. In some situations, where the complaints are of a serious nature, the practice may seek advice or assistance in the matter from someone having more experience, such as their MDO or the RACGP
  - referred to AHPRA or, in New South Wales, the Medical Council of New South Wales under the mandatory reporting regulations
- AHPRA (in all states except New South Wales) – all complaints, or notifications, to AHPRA are triaged and considered by the Medical Board soon after receipt. A significant proportion of notifications are closed with no regulatory action. The remainder are investigated and in that event, the GP can seek assistance with the complaints process from their MDO
- the Medical Council of New South Wales – complaints relating to the conduct, health or performance of a registered medical practitioner or registered medical student are dealt with by the co-regulators, the Medical Council of New South Wales and the Health Care Complaints Commission.

It is important to recognise that complaints against GPs are made for many different reasons and not solely because a clinical error has occurred. This is because the GP's task is not simply to manage a clinical problem but also to engage with the patient as a person. Interpersonal skills are just as important as clinical skills, with good communication skills and professional behaviour being fundamental to both.

Shortcomings, whether real or perceived, in any of these domains may result in a complaint. Complaints can be made not only by a patient but also by anyone connected to them (a relative, friend or carer), by any health professional involved in the patient's care or by a health professional that has direct knowledge of the GP in question.

Areas that give rise to complaints

There is very little in the Australian literature about the extent and management of performance concerns in general practice. What is known comes mainly from annual and other reports published by AHPRA. The following are the areas that more frequently give rise to complaints to AHPRA:

- clinical skills
  - communication skills (which are most frequently at issue)
  - prescribing (eg drugs of addiction, off-label prescribing)
  - appropriate documentation
  - informed consent
  - confidentiality
  - privacy
  - patient assessment
  - respect for patients
  - clinical decision making
  - keeping up to date
- professional boundaries, including sexual boundaries.

Possible barriers to identification and notification of a performance problem include:

- minimisation of the problem
- not acknowledging that a problem exists
- uncertainty as to whether there is a problem
- unwillingness to be seen as negative or critical of the GP
- unwillingness or reticence to report
- belief that the problem will resolve itself
- belief that the GP has sufficient insight to self-manage
- fear of repercussion from the GP.

Clinical reasoning

How doctors think and make decisions (clinical reasoning) is a complex process. It entails:

- information gathering
- analysis of the information
- input from the patient
- consideration for context and other pertinent factors
- judgements regarding elements of the gathered information
- decisions regarding diagnosis and management
- evaluation of the outcomes of the decision making.

Clinical reasoning ranges from the simple to the complex. With straight forward, familiar clinical problems, the degree of uncertainty is low and decision making relies primarily on heuristics (medical knowledge, simple actions, learnt schemas such as pattern matching and illness scripts). With problems of greater complexity and problems that are less familiar or new, the degree of uncertainty is greater. Reasoning is more complex, requiring deeper exploration and the use of a greater range of analytical skills. Judgements are also made with respect to probability (the likelihood of one disease occurring over another) and the relative value of individual pieces of information (how relevant it is to the decision making).

Clinical reasoning is facilitated by:

- the GP's level of clinical knowledge and experience
- the adequacy of the gathered information (history, physical examination, results of investigations and other pertinent information)
- an awareness for what might go wrong (red flags, masquerades, what should not be missed)
- the use of pertinent assessment tools
- advice or assistance from colleagues
- reference to relevant clinical guidelines and evidence-based practice.

Problems with any of the steps in the reasoning process, such as the adequacy of the gathered information, can certainly lead to errors. However, other factors can impact on the reasoning process and must also be considered (refer to 'Problem definition', later in this document).

Profiling

The issue of whether it possible to identify doctors who are more likely to make errors is contentious. A particular risk profile has been put forward (Spittal, Bismarck and Studdert 2015 – for full details refer to the bibliography); however, it provides predictability only with doctors for whom a prior complaint exists. According to the profile, the factors associated with increased risk of a complaint being made are:

- type of doctor (GPs followed by surgeons being at highest risk)
- location of practice (rural practice being at higher risk)
- the number of previous complaints (risk increases proportionately to the number of prior complaints)
- the amount of time that has elapsed since the last complaint (short time periods between complaints are probably indicative of a doctor who is risk prone)
- the gender of the doctor (males being at greater risk)
- age greater than 35 years (the risk increases with age).

It should be noted that this profile doesn't take into consideration a number of other factors that have an impact on errors and complaints. These other factors also highlight the complexity that underlies how errors occur and complaints arise. They include:

- individual as opposed to systemic factors
- multiple co-existing factors
- patient factors such as patient demographics and the complexity of presentations

- solo as opposed to group practice
- doctors who are 'isolated' (and not necessarily in the geographic sense).

With regard to the crossing of sexual boundaries – which can cover a range of behaviours – doctor groups that are more likely to offend are obstetricians/ gynaecologists and GPs. The risk of offending increases with age, and the doctor who is more likely to offend tends to be:

- a socially isolated, middle-aged man experiencing a mid-life crisis
- well functioning, perhaps even eminent in their field
- someone having unmet emotional needs
- someone who over-identifies with the patient (significant counter transference).

The triggers are generally:

- marital/partner discord
- loss of an important relationship (separation, divorce, death)
- professional crisis
- significant stress
- depression.

The ageing GP has also drawn attention as being more prone to making errors. The following factors have been identified as contributing to increased risk in the older doctor:

- age greater than 70 years
- more than 40 years in practice
- the type of practice (the walk-in practice carries higher risk)
- the percentage of billing outside one's specialty (greater than 30% is suggestive)
- unusual prescribing habits (eg excessive prescribing of drugs of addiction)
- solo practitioner
- concurrent health issues and the nature of the impairment (physical or cognitive)
- processes of clinical reasoning that are not well considered (insufficient use of analytical processes carries higher risk).

Physical and cognitive decline occurs with age and doctors are certainly not immune to this. Memory and thinking processes are affected and they may not be as sharp as previously. Knowledge may not be as up to date as it might and generally, there is greater reliance on experience. While experience does facilitate clinical reasoning substantially, reliance on this, at the expense of analytical skills and higher-order thinking, will increase the risk of errors. The ageing GP cannot afford to ignore signs of cognitive or any other impairment. Concerns that are raised by family, friends or colleagues should be taken seriously and acted on appropriately.

Profiles have their uses but they are not absolute, and caution should be exercised in using them. A profile is essentially a set of characteristics and behaviours. It is far more useful for every GP to reflect on the items in each of the profiles and to consider whether any one of those factors might be placing them or their patients at risk. If that is the case, it is imperative to implement corrective and/or preventive measures. There is nothing to be gained by labelling someone purely because they 'fit the profile'.

2. Investigation and assessment

With respect to notifications to AHPRA, and as deemed necessary, AHPRA will conduct an investigation, after which the Medical Board will make a determination. This determination includes:

- the reasons for its decision
- the areas of concern
- any undertaking that the GP has voluntarily agreed to enter into
- the conditions imposed on their practice.

In the case of serious offences, the imposed conditions may entail suspension of practice or deregistration or referral to a criminal court. Conditions on registration are imposed by the Medical Board; however, the Medical Board does not have the powers to de-register a practitioner. Only the relevant Civil and Administrative Tribunal has that power. Most issues do not require such serious measures and will generally entail either one or a combination of:

- completion of an educational program
- undergoing an audit of medical records
- undergoing a period of mentoring or supervision.

The Medical Board may sometimes require the practitioner to undergo a performance assessment when there is significant concern for patient safety. The aim of a performance assessment is to identify any deficits in a practitioner's performance, so that a plan can be developed to ensure that the practitioner meets the expected standards as well as to protect the public. It is usually conducted by one or more GPs who are not Medical Board members, but who have been approved by the Medical Board and who have the necessary expertise to assess. As a result of a performance assessment the Medical Board may decide to:

- take no further action
- investigate the practitioner further
- refer the matter to a performance and professional standards panel
- impose conditions on and/or accept an undertaking from the practitioner
- require the practitioner to undergo a health assessment
- caution the practitioner
- refer the matter to a tribunal
- refer the matter to another entity (such as a health complaints entity).

While a GP may self-identify, generally, information regarding a performance problem will come from colleagues in the practice, the practice manager, reception staff and patients. The quality of this information can vary. Seeking the GP's perspective is helpful but will not necessarily answer the question of whether there are performance issues of significance. In this instance, further investigation and perhaps even formal assessment of clinical skills may be required, particularly where there is uncertainty with regard to:

- the issues affecting performance
- the extent/seriousness of the problem(s)
- whether action needs to be taken
- the required action and support.

The individual GP or the practice may be assisted by someone capable of conducting workplace-based assessments to investigate concerns further, adequately define the issues and make recommendations with respect to a Remediation Plan. Assistance from the RACGP may be sought in this respect.

Investigations and assessments should:

- be done in a timely manner
- be done with sensitivity
- be supportive of the GP and the practice
- be fair and reasonable
- use up-to-date procedures
- safeguard confidentiality
- be non-discriminatory.

Assessing professionalism

Professionalism can be difficult to define, especially when individuals and organisations have different notions about what constitutes professionalism. Nevertheless, the Medical Board's *Good medical practice: A code of conduct for doctors in Australia* describes the expected behaviour for all doctors practising medicine in Australia. It sets out the standards against which judgements are made when complaints are made about doctors. Every GP has a duty to adhere to these standards and to comply with the professional behaviour policy of their workplace.

When assessing professionalism, it is easier to consider attitudes and behaviours and whether they are in keeping with workplace policy and/or the Medical Board's *Good medical practice: A code of conduct for doctors in Australia*. Information about professional behaviour can come from various sources in the workplace such as colleagues (eg doctors, other health professionals), the practice manager, reception staff, patients and critical incident reports. Questionnaires to patients and key individuals, formal multi-source feedback or 360-degree evaluations are useful tools.

Performance appraisals

Performance appraisals and peer reviews are currently not mandated in Australia. They are useful for identifying issues at an early stage. Appraisals can be conducted informally by:

- in-practice tutorials
- case discussion
- random case analysis
- direct observation of consultations
- review of videotaped consults.

These educational tools are very useful for identifying gaps in knowledge and skills and for providing formative feedback. Audits are another useful tool.

3. Problem definition

Performance concerns may occur in isolation but often occur in combination with other issues. When a concern is raised, it is important to look beyond the overt problem and to identify all issues that are associated and/or contributory. For example, it is not uncommon to find an underlying physical or mental health concern. It is also not uncommon to find a number of co-existing issues culminating in a significant error. Identifying the issues is not always easy because they can be subtle or disguised; in some situations, the GP in question may not want to divulge personal information.

Some concerns will call for more urgent responses than others. Low-level concerns in isolation may seem insignificant but when considered together, they may indicate a problem requiring action. In a team context it is important to consider whether the individual performance problem might be a manifestation of broader team dysfunction.

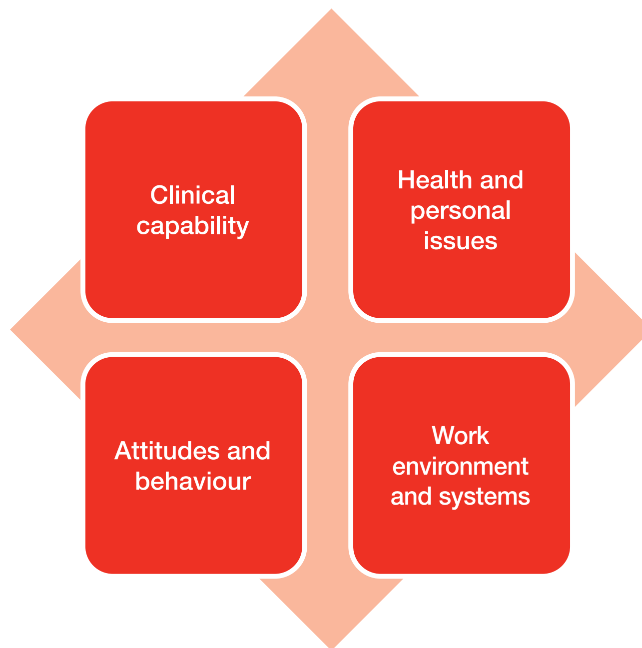

Figure 2. The four broad areas for performance concerns

Performance concerns fall into four broad categories.

1. **Clinical capability (knowledge and skills), for example:**

- inadequate training
- lack of engagement with continuing professional development and/or maintenance of clinical skills
- a lapse in clinical skills (eg taking short cuts, overconfidence, prescribing errors)
- not following guidelines
- poor awareness of limitations (eg doing clinical work that is beyond the GP's level of skill and experience)
- poor communication skills
- clinical reasoning
- patient factors (eg higher needs, greater complexity of medical problems, challenging behaviour).

2. Health and personal issues, for example:

- physical conditions (eg misuse of drugs and alcohol)
- psychological conditions (eg stress, depression, disillusionment, burnout)
- cognitive impairment/deterioration
- personal stresses (eg marriage/partnership break-up and other significant life events)
- financial difficulties.

3. Attitudes and behaviour, for example:

- loss of motivation, interest or commitment to medicine and/or the practice
- poor interpersonal relationships with colleagues and staff
- poor leadership/teamwork skills
- not adhering to regulations (eg AHPRA, the practice)
- probity (eg boundary issues, bullying and harassment, altering clinical records, conflicts of interest)
- criminal behaviour (eg Medicare fraud, theft, assault).

4. Work environment, for example:

- team dysfunction and lack of support
- poor managerial relationships
- interpersonal problems with colleagues and staff (eg harassment, bullying)
- work stresses (eg time pressure, interruptions, inadequate resources, poor working conditions)
- employment and contractual issues
- poor or absent systems and processes.

Possible errors with problem definition include:

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

4. Decision making

When a performance concern arises in practice, information will be gathered and considered and decisions made at each stage of the performance management process. It is important to follow practice procedure and not to make decisions hastily. For example, decisions about management should not be made before all the relevant information is available or the problems have been adequately defined. Decisions should also be made with due consideration and fairness. Poor decisions have negative flow-on effects, with potentially disastrous end results. Particular care should be exercised with decision making in instances relating to whether:

- a problem exists
- patients need to be protected
- anything needs to be done about the performance problem
- the concern should be reported to a higher authority (eg AHPRA, the police).

While decision making should not be done hastily, it is also important to act in a timely manner because delays will cause unnecessary distress for the GP in question and uncertainty within the practice. Good documentation is also important.

5. Management

Once all the issues have been defined, a management or Remediation Plan should be drawn up. All issues, whether relating to clinical skills or otherwise, should be included in the plan. Most Remediation Plans will relate to clinical capability and most will be of short duration. Longer plans and those that relate to serious concerns should generally be prepared and implemented with the assistance of an external expert.

Remediation Plans should:

- be developed in consultation with the GP and any important stakeholders, such as AHPRA or the practice
- be tailored to the GP's needs
- address all the concerns
- have clear objectives
- have a set time frame
- have provision for evaluation of the outcomes
- have defined actions with respect to the outcomes.

Employers and practices may not have the requisite resources and skills to appropriately manage performance concerns. In that event, advice and/or assistance should be sought from an expert in the field of performance management or the RACGP.

Clinical capability (clinical knowledge and skills)

Various clinical skills interventions are available; however, the following points require highlighting:

- The type of intervention will depend on the cause of the performance problem. If the root cause is not addressed, change is unlikely to occur.
- A well-considered, practically oriented and tailored management plan that addresses all the issues is more likely to be successful.
- The learning environment must be supportive.

- The GP needs to be fully engaged. Possible interventions include:
  - tutorials to address knowledge and clinical skills deficits
  - case discussion, including random case analysis
  - audit of clinical notes and prescribing
  - role-play of clinical scenarios
  - direct observation of consultations with feedback.

Rural and remote locations present their own particular challenges with respect to suitable interventions, how they are to be implemented and the provision of mentorship and/or supervision for the GP.

Health and personal issues

When a clinical capability problem has been identified, consider whether a concurrent health issue exists. It is not unusual for a health problem to be either the cause of the performance problem or the result of it.

Any significant illness, whether physical or mental, acute or ongoing, has the potential to:

- affect judgement or performance
- impact on patient care
- impact (to varying degrees) on self, family and friends, colleagues and work capability.

The health problems that affect performance more frequently are:

- psychological disturbances (eg depression, anxiety)
- substance misuse (eg drug and alcohol misuse)
- physical ill health as a result of stress
- fatigue, jadedness and burnout.

Burnout is a complex syndrome that results from the stresses of daily practice, with heavy workload and time pressures being the predominant factors. Burnout consists of emotional exhaustion, cynicism towards patients and low personal accomplishment (encompassing poor motivation, loss of self-confidence and self-deprecation). Burnout can lead to psychological disturbances and substance misuse. Signs of burnout should immediately raise concerns for patient safety as well as the safety of the affected GP.

Doctors are often reluctant to admit that they have a problem and engaging them is not always easy. In the first instance, concerns regarding a GP's health and wellbeing should be addressed with the GP, either by the practice or a respected colleague. The GP should be encouraged to seek the necessary help from a doctor and/or psychologist. If they do not have their own GP, they should be encouraged to find one or to contact one of the organisations that provide timely access to medical care for doctors.

It is not appropriate for a GP to have as their treating doctor a friend, colleague, counsellor or psychologist in the practice that they work in.

It may be appropriate for the GP to take time off in order to address their problems, even though they may be reluctant to do so. Rural and remote locations can present particular challenges with respect to taking time off. Referral to AHPRA may be necessary when there is concern for patient safety and the GP does not comply with advice and when the concerns are not addressed.

Rehabilitation

Chronic illness and disability are not contraindications to clinical practice. Once again, patient safety is paramount. Allowances and adjustments can be made so that the GP may function to the best of their ability. Advice and/or assistance in achieving this may be sought from:

- the GP's treating doctor(s)
- a rehabilitation physician
- an occupational physician
- an allied health professional, such as an occupational therapist or physiotherapist, who has knowledge of the GP's health issues and is in a position to advise.

While there is significant overlap between the roles of the rehabilitation physician and the occupational physician, the occupational physician is possibly better positioned to provide independent advice and support for the GP and the practice.

Attitudes and behaviour

Unprofessional behaviour, such as personal grievances and personality clashes, can have a significant impact on the GP's functioning in the workplace, as well as on the functioning of that workplace. Practices 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 practice
- 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.

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

Work environment and systems

It is not in the scope of this document to provide recommendations for managing issues relating to the work environment; process, systems and other organisational factors; and industrial relations matters, such as employment contract disputes. However, all these issues have the potential to indirectly precipitate a deterioration in performance (either on their own or in conjunction with other problems) and resolution will generally occur by:

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

6. Reassessment and evaluation of outcomes

Most Remediation Plans will be of short duration (less than two months). Those that are of longer duration should have provision for periodic assessment of progress during their execution. Once the plan has been completed, the outcomes should be evaluated to determine whether they have been achieved and what this means regarding the GP's continued safety to practise.

Measuring progress or change can be difficult but should be as objective as possible and have consideration for the expected standards of general practice, as well as the scope of practice that the GP is engaged in.

Possible evaluation methods include:

- case discussion
- role-play of clinical scenarios
- direct observation of consultations
- audit of clinical notes and prescribing
- feedback from other doctors in the clinic, the practice manager, reception staff and/or patients
- medical reports from treating doctors and/or psychologists.

7. Outcomes

When evaluating a remedial intervention, the key questions to ask are:

- Is the GP progressing?
- Is progress sufficient?
- Is the GP capable of achieving the required objectives?
- What further resources are required to assist the GP to achieve the required outcomes?
- Should the GP continue to be monitored and/or supported?

In answering these questions, consideration should also be given to the GP's:

- level of engagement in the remediation and with the remediator (including such things as attendance on time and acceptance of responsibility)
- ability and willingness to reflect and accept feedback
- degree of insight into the concerns
- ability to apply learnt skills to their work.

Possible outcomes following the evaluation of progress or reassessment of the GP include:

- resolution of the problems/concerns
- the problems/concerns remain the same
- the problems/concerns have worsened.

In the latter two instances, the situation has to be reassessed and decisions made about any further action. If the GP continues to work in the practice, monitoring for possible recurrence of the concerns may also be required.

8. Prevention

Prevention is an individual as well as a collective responsibility. It is about maintaining:

- a level of knowledge and skills that ensure safety to practise
- an awareness for situations where things can go wrong
- attitudes and behaviour consistent with professional practice.

The situation is not helped when the GP:

- is defensive, either rationalising or minimising the problem
- doesn't accept that a problem has occurred
- believes that they have the problem under control (when they don't).

Having insight is important, as is the willingness to change and improve. Insight is developed by reflecting honestly on one's practice, objectively evaluating consultations that have not gone as expected, and considering what can be improved and how and what preventive measures can be put in place. Attention to self-care must not be ignored. Anything that impacts negatively on the self only increases the propensity for distraction from what matters, thus increasing the likelihood of errors occurring.

The following are early warning signs to a performance problem. When noted, they should be taken seriously and action taken before the issues escalate and more serious situations arise.

- Behaviour:
  - frequently arriving late and/or leaving early
  - absences from work, frequent and/or unjustified
  - negative interactions with colleagues and practice staff (eg poor interpersonal skills, rigidity of opinions, difficulty reflecting, defensiveness, inability to compromise, counter-arguing, anger outbursts)
  - paucity of interactions with colleagues and staff
  - signs of impairment (eg mental illness, alcohol and substance misuse).
- Clinical practice:
  - significant knowledge deficiencies
  - significant clinical skills deficiencies
  - serious clinical errors (eg diagnosis, management)
  - deficiencies in ethical behaviour.
- Complaints from staff, patients and others (whether formal or informal and particularly when repeated).

Clearly, these are areas for every GP to routinely reflect on and for practices to assist their GPs with. Early problem identification and intervention is to be encouraged because concerns can be dealt with:

- more readily and with simpler interventions
- potentially before patient safety is compromised.

The profiles that were presented under 'Problem identification' are useful as checklists for identifying problematic situations requiring corrective and/or preventive measures. While age-related impairment is a particular problem for a GP to be mindful of, it is not the only one. Stress, in its many forms, impacts on behaviour and cognition, which in turn increases the potential for errors and complaints.

The supportive measures listed here have been identified as being useful for the ageing doctor to reduce stress and enable analytical thinking. They are useful to any doctor at any stage in their life.

- Working hours:
  - reducing working hours, including after hours work
  - more flexible working hours
  - later starting time and earlier finishing time.
- Work stresses:
  - allocating more time for the patient (to be able to think through the problem without feeling pressured)
  - no double booking of patients
  - taking regular breaks through the day (so that stresses don't mount up but also allowing time for reflection)
  - scheduling administrative breaks (to catch up with paperwork, make phone calls)
  - using memory aids, checklists and guidelines more readily.
- Extra support:
  - seeking opinions, advice and assistance more readily, particularly with presentations that are new or unusual or outside of one's expertise and what one is familiar with
  - working with others (group rather than solo practice; team work).
- Self-care:
  - attention to health problems
  - addressing constraints that come with age
  - managing stresses outside of work
  - developing non-medical interests
  - having retirement in mind and planning for and transitioning to new roles (education, mentoring, consultancy).

While GPs individually have a responsibility to ensure their safety to practise, practices may decide to develop policies and processes for monitoring and managing the performance of their GPs (eg peer review, performance appraisal). It is important that these policies and processes are:

- fair and transparent
- developed in consultation with the GPs of the practice
- implemented, as far as possible, with the cooperation of the GP about whom a concern exists.

A pro forma for a practice remediation policy is available in Appendix C.

The cases found in Appendix A are commonly occurring scenarios that would raise concern, necessitating investigation and requiring the GP to undergo some form of remedial intervention. They are scenarios for reflection from both a personal and a practice perspective. They may also be used in clinical meetings to facilitate discussion on a range of topics having medico-legal repercussions, to encourage reflective practice, and to improve capability and effectiveness at the individual and practice level.

Roles and responsibilities

The underperforming GP

It is the individual GP's responsibility to ensure their safety to practise. The onus is therefore on the GP to:

- continually reflect on their practice and maintain the required level of knowledge and clinical skills appropriate to that practice (prevention)
- demonstrate that any identified performance concerns are addressed and resolved.

Assessors/investigators

Assessors and investigators:

- investigate performance concerns
- assess the clinical skills of the GP and identify deficiencies
- make a determination as to the GP's safety to practise
- make recommendations addressing performance issues
- evaluate the outcomes of the Remediation Plan
- ensure they (ie the assessors/investigators) have adequate training and support (including appropriate indemnity) to undertake their role
- ensure they are clear about their decision making and any recommendations they make regarding a Remediation Plan.

Medical educators

Medical educators:

- assist in investigating and assessing performance concerns
- deliver and monitor Remediation Plans
- assist in evaluating the outcomes of Remediation Plans
- ensure they have adequate training and support (including appropriate indemnity) to undertake their role and be aware of the scope of their decision making.

AHPRA has requirements with regards to educators delivering interventions to GPs who have to comply with conditions imposed by the Medical Board. The requirements are that the educator must:

- be approved by the Medical Board
- be a registered medical practitioner holding unrestricted registration
- be senior to the GP in question by either years of experience or position, or with additional training, experience and/or qualifications to deliver the education
- not be in a close collegiate, social or financial relationship with the GP in question

- agree to
  - deliver the required intervention (education, audit of medical records, mentoring or supervision)
  - provide a plan for the proposed intervention
  - provide a report to the Medical Board at the completion of the intervention
  - report immediately to AHPRA any unsafe practice or inappropriate conduct of the GP in question.

Clinical supervisors

A colleague in the practice may be asked to supervise a GP about whom there are performance concerns. Supervision may be formal or informal and will depend on the context (eg formal supervision is more likely to be required following an extended period of absence from practice or when significant performance issues have been identified).

Mentors

Mentoring is a developmental process whereby a more experienced GP ('mentor') helps a less experienced GP ('mentee') in their personal and professional development.

Mentors:

- provide personal support
- challenge thinking and promote the development of reflective skills.

Employers/practices

Employers/practices:

- have a duty of care to the public (patient safety) as well as the GPs in their employ (GP safety)
- develop and maintain policies and procedures that identify and address performance concerns as early as possible (prevention)
- ensure that performance management is done, as much as is possible, with the cooperation of the GP about whom a concern exists
- provide a supportive environment that allows remediation to take place without putting patients or the GP at risk.

Employers and practices may not have the requisite resources and skills to appropriately investigate and manage performance concerns. In that event, advice and/or assistance should be sought from an expert in the field of performance management or the RACGP.

The RACGP

The RACGP:

- sets standards for general practice
- provides suitable educational resources
- advises and supports the GP, practice, investigator, assessor, educator, mentor and/or supervisor
- provides suitable professional development programs for investigators, assessors, educators, mentors and supervisors.

Additionally, there is scope for the RACGP to:

- work closer with AHPRA to facilitate the investigation processes
- advocate for the GP under investigation.

AHPRA

AHPRA manages investigations into the professional conduct and performance of medical practitioners, on behalf of the Medical Board (except in New South Wales and Queensland).

The Medical Board

The Medical Board:

- sets and maintains standards of medical practice against which a doctor's professional conduct can be evaluated
- makes decisions and imposes conditions on the doctor under investigation.

The relevant Civil and Administrative Tribunal

The tribunal has the power to de-register a doctor.

New South Wales regulatory bodies

The Health Care Complaints Commission:

- can investigate and prosecute complaints about the conduct of medical professionals and unregistered health practitioners
- can also investigate health service providers.

The Medical Council of New South Wales:

- works in collaboration with the Health Care Complaints Commission to receive and manage complaints about registered doctors and registered medical students in New South Wales
- can place conditions on a doctor's registrations and/or use urgent action powers to suspend a doctor's registration as an interim measure to protect the health or safety of the public while proceedings by the Health Care Complaints Commission or the courts are underway
- does not have the legal power to cancel the registration of a New South Wales medical practitioner. This can only be ordered by the NSW Civil and Administrative Tribunal following successful prosecution conducted by the New South Wales Health Care Complaints Commission.

Medical defence organisations

MDOs:

- assist GPs and practices with risk identification
- provide medico-legal advice and support to GPs and practices
- make available a variety of medico-legal educational resources.

Resources

AHPRA

- Complaints process, www.ahpra.gov.au/Notifications/Find-out-about-the-complaints-process.aspx
- *Good medical practice: A code of conduct for doctors*, www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx
- Guidelines for mandatory notifications, www.medicalboard.gov.au/codes-guidelines-policies/guidelines-for-mandatory-notifications.aspx
- Guides and fact sheets about the complaints process, www.ahpra.gov.au/Notifications/Further-information/Guides-and-fact-sheets.aspx
- Monitoring and compliance, www.ahpra.gov.au/Notifications/Further-information/Guides-and-fact-sheets/Monitoring-and-compliance.aspx
- Performance assessment (fact sheet), www.ahpra.gov.au/Notifications/Find-out-about-the-complaints-process/Performance-assessment.aspx
- Sexual boundaries in the doctor–patient relationship, www.medicalboard.gov.au/Codes-Guidelines-Policies/Sexual- boundaries-guidelines.aspx
- Supervision of international medical graduates (FAQ), www.medicalboard.gov.au/Codes-Guidelines-Policies/FAQ/FAQ-Supervision.aspx

The RACGP

- *A guide to managing performance concerns in general practice registrars*
- *A guide to re-entry to general practice*
- Competency profile of the Australian general practitioner at the point of Fellowship, www.racgp.org.au/getmedia/9e15fd65-77f5-466a-9010-3f8e3f3245f2/Competency-profile-2019.pdf.aspx
- Curriculum for Australian General Practice 2016, www.racgp.org.au/education/curriculum
- GP Support Program, www.racgp.org.au/running-a-practice/practice-management/gp-wellbeing
- PLAN activity, www.racgp.org.au/education/professional-development/qi-cpd/qi-cpd-requirements/plan
- *Standards for general practices*, 5th edition, www.racgp.org.au/your-practice/standards/standards-for-general-practices-(5th-edition)

Other

- American Medical Association, Physician burnout (online learning module that takes an ‘all practice’ approach), https://edhub.ama-assn.org/steps-forward/module/2702509
- doctorportal learning, www.doctorportal.com.au/doctorshealth
- Doctors’ Health Advisory Service, www.dhas.org.au
- Fit for Work, Fit for Life (New Zealand) (services offered: occupational health, vocational rehabilitation, pain management, career services), www.fitforwork.co.nz
- Royal Australasian College of Physicians, eLearning (wellbeing module), https://elearning.racp.edu.au

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Appendix A. Case studies

The following cases are commonly occurring scenarios that would raise concern, necessitating investigation and requiring the GP to undergo some form of remedial intervention. They are scenarios for reflection from a personal and a practice perspective. They may also be used in clinical meetings to facilitate discussion on a range of topics having medico-legal repercussions, to encourage reflective practice and to improve capability and effectiveness at both the individual and practice level.

Clinical skills

Case 1 – Dr GA

PA, the practice manager at practice X, has received several complaints from patients about Dr GA, one of their GPs. The complaints are that Dr GA does not listen, his practice is different from that of the other GPs in the clinic, and the patients do not want to see him again. PA decides to speak to SA, the practice principal. SA is surprised to hear these complaints because he believes Dr GA is a good doctor. SA wonders whether the problem may be due to language and communication skills because Dr GA is overseas-trained and speaks with an accent. PA mentions that patient bookings with Dr GA remain consistently low, even though he has been at the clinic for several years. SA and PA arrange a meeting with Dr GA, who is taken aback when he hears the complaints. He says that he is an experienced GP, has enjoyed working at practice X, has many regular patients who are happy with him and no one has ever complained about him before. He blames his colleagues' patients who question him and make it difficult for him to do his job properly.

After some consideration, SA speaks to RM, a remediation expert, and requests a formal assessment of Dr GA's communication skills. SA informs Dr GA of this decision and Dr GA agrees to the assessment.

On the day of the assessment, RM speaks first with Dr GA to obtain his perspective. RM then observes several of Dr GA's consultations. RM identifies that Dr GA has no difficulties with use of language, reasonably good clinical skills, some knowledge deficits, and difficulty with being assertive and communicating effectively (understanding the patient agenda and providing information clearly). RM makes recommendations to Dr GA and the practice for addressing these issues.

Questions

- *Have assumptions been made? How does SA know that Dr GA is a good doctor? Is there bias in attributing the problem to language and communication skills?*
- *What do others in the practice (colleagues and staff) know about the concerns?*
- *Are the patient complaints new? If so, what has happened? If not, why weren't they addressed earlier? How long has the practice known about these complaints?*
- *What if Dr GA had refused to undergo the assessment? Can the practice compel him?*

- *How is Dr GA being supported through this process? How does he continue working in light of what has happened?*
- *What if Dr GA does not follow through on the recommendations? Is there anything else that can be done by the practice?*
- *Would a period of supervision be helpful? If so, how would it be conducted?*

Case 2 – Dr GB

Dr GB has been a GP for more than 20 years and runs a busy solo practice. He has not been accepting new patients for some time and he knows his patients quite well. Following a patient complaint that triggered an investigation by AHPRA, Dr GB's standard of practice is found to be below what would be expected of his peers because he is not keeping up to date with current medical information and treatment guidelines.

While Dr GB has been maintaining his CPD requirements, specific concerns are identified regarding his clinical skills.

Observations and questions

Most, if not all, GPs attract a particular patient base over time and settle into a mode of practice that suits them. Familiarity, however, can be a double-edged sword.

- *What processes do individual GPs and practices have in place for ensuring the adequacy of their clinical skills? How can a GP:*
  - be truly reflective as regards their clinical practice and identify their real learning needs?
  - keep abreast of change and maintain their general skills when they are working in an area of special interest or a specific patient base?
- *Would Dr GB benefit from having a mentor on an ongoing basis?*

Dr GB is required by AHPRA to undertake an educational program on 'staying up to date'. At the conclusion of the education, Dr GB says to the medical educator that he intends working as a solo GP until the day he dies. His father, he says, died while consulting at the age of 90.

- *What do you think of Dr GB's plans to continue working for so long?*
- *What advice would you give him?*
- *Should Dr GB be encouraged not to continue working for so long? If so, at what age do you think he should stop and should he commence planning for retirement from now?*

Medical records

Case 3 – Dr GC (professional behaviour)

Dr GC was investigated by AHPRA following a patient complaint regarding his professional behaviour. In the process, Dr GC's medical record keeping was found to be inadequate. He was ordered to undertake education in medical record keeping and undergo six-monthly audits of his medical records.

Case 4 – Dr GD (informed consent)

Dr GD was investigated by AHPRA following a patient complaint about a skin procedure that Dr GD had performed. The patient was unhappy with the outcome of the procedure and claimed that Dr GD had not informed her of the risks. The investigation found that Dr GD's record keeping and processes for obtaining informed consent were inadequate. Dr GD was ordered to undertake education about informed consent and medical record keeping.

Case 5 – Dr GE (certificates)

Dr GE was investigated by AHPRA following a complaint by an educational institution that Dr GE was issuing inappropriate sickness certificates to students at examination times. Dr GE was ordered by AHPRA to undergo an audit of his medical records. Fortunately, Dr GE maintained good medical records from which it was possible to verify the appropriateness of the certificates.

Case 6 – Dr GF (prescribing)

Dr GF was investigated for inappropriately prescribing narcotics. During the investigation, Dr GF's medical record keeping was found to be inadequate. Specifically, her medical records lacked considerable detail regarding the reasons for prescribing narcotic medication to several patients; the need for the ongoing use of narcotics; why doses were increased and multiple narcotics prescribed; and what other treatment measures were being used. Dr GF was ordered to undergo education about narcotic prescribing, drug-seeking behaviour and medical record keeping.

Observation and questions

These are not uncommon scenarios where, as part of an investigation, medical records are examined and documentation found to be inadequate.

- *What processes do individual GPs and practices have in place for assessing and ensuring the appropriateness of:*
  - documentation?
  - certification?
  - informed consent?
  - prescribing practices?
  - billing practices?
- *Would consultation with an MDO, by the individual GP and the practice, be helpful in assessing risk?*

Professional boundaries

Case 7 – Dr GG

Dr GG was investigated by AHPRA following a patient complaint. The patient had stated that Dr GG did not close the curtain around her while she undressed for a physical examination. This distressed her greatly and it was made worse when Dr GG made jokes while examining her. In reply, Dr GG said that he had not intended to be disrespectful towards the patient. He said he was on the computer recording notes and he had his back to the patient while she was undressing.

He also said that he had made some lighthearted comments while examining the patient because she appeared very tense. Dr GG was ordered to undergo education about professional boundaries and working ethically with female and vulnerable patients. Dr GG was also required to participate in a mentoring program to reinforce what he had learnt in the education program. This entailed direct observation of Dr GG's consultations, over several sessions, by a medical educator.

Observations and questions

Among other things, this case highlights the importance of good communication skills: what was said and what was not said by the doctor, his intent and the patient's perceptions.

- *How often are patient complaints either partly or entirely about poor communication on the doctor's part?*
- *How do GPs know whether their communication skills are appropriate and effective?*
- *How do practices address poor or ineffective communication by their GPs?*

Case 8 – Dr GH

Dr GH was investigated by AHPRA for professional misconduct in examining female patients. He was ordered to have a chaperone in attendance when consulting with and examining female patients. He was also ordered to display a sign to this effect in his waiting room. Dr GH did put up a sign, but it was in such a position that it was obscured from view. This came to the attention of AHPRA and Dr GH was reprimanded. He was required to undergo education not only on professional boundaries, but also on professional behaviour and responsibilities.

Observation and questions

Dr GH was clearly embarrassed to display the sign and saw it as a significant blow to his professional standing. He was also very upset that AHPRA had not taken into consideration that he was a hard-working GP, often going beyond the call of duty for his patients. While his commitment might be laudable, his repeated protestations suggested some denial of wrongdoing. AHPRA investigations take their toll both professionally and personally, and it is also not unusual for GPs to react in anger and to believe that the system is against them.

- *How can the medical educator delivering the education engage with Dr GH and enable him to understand the issues?*
- *How can Dr GH regain his self-respect and sense of commitment?*
- *Does the medical educator have a role in counselling and supporting Dr GH?*

Postscript

Dr GH completed the education on professional boundaries, behaviour and responsibilities. Not long after, he was under investigation again by AHPRA for professional misconduct over the same issues ('inappropriate and unwanted physical contact of a sexual nature' and 'placing pressure on the patient not to complain about his behaviour'). Dr GH's medical registration was cancelled. The basis for this decision was that Dr GH had not shown any insight into his behaviour and even though he had expressed remorse with the first patient, he had gone on to reoffend.

Case 9 – Dr GI

Dr GI was found by AHPRA to have engaged in professional misconduct in that he had entered into a personal and sexual relationship with a patient. His registration was suspended and he was ordered to first undertake an educational program on 'the importance of professional and sexual boundaries', followed by a mentoring program to 'reinforce the importance of maintaining professional boundaries'.

Observation and questions

The mentoring task presents challenges for the mentor, namely:

- engaging Dr GI in the mentoring, especially because this is a very sensitive and personal area
- what to cover in each session
- AHPRA's concern that Dr GI does not reoffend, which would entail a behaviour change on Dr GI's part
- addressing issues of self-care and the development of resilience
- assisting Dr GI with re-entry to practice.

Questions to consider:

- *Where should the line be drawn regarding relationships with patients?*
- *What about patients who become friends? Can friends become patients?*
- *What action can be taken when intimacy with a patient has developed? What are the early warning signs to developing intimacy with a patient?*

Team work and practice systems

Case 10 – Dr GJ, Mr SB, Mr SC

Dr GJ, a GP, and surgeons Mr SB and Mr SC were found by the coroner to have been negligent when a patient under their care died from complications of cosmetic surgery that had been performed by Mr SB. All three doctors were either directly or indirectly involved in this patient's post-operative care. The coroner determined that there had been poor communication and cooperation between the doctors as well as a failure in their duty of care. Following this unfortunate incident, the practice updated its management protocols, including having delineated responsibilities and clear lines of communication. Dr GJ decided to cease clinical practice because AHPRA's investigation, the civil court case and the attendant media scrutiny had taken their toll on him and his family.

Questions

- *How do these doctors recover personally from such an incident?*
- *How do these doctors retain their professional standing and continue working, especially when the incident and ensuing court case were widely reported in the media?*
- *Can MDOs be of assistance to practices in preventing similar incidents from occurring?*

Prescribing

Case 11 – Dr GK

Dr GK was investigated by AHPRA for inappropriate prescribing of drugs of addiction. The investigation was instigated when a patient made a complaint to AHPRA that Dr GK had turned him into a drug addict.

During the investigation it came to light that Dr GK had:

- been prescribing drugs of addiction inappropriately to several patients
- been inappropriately prescribing human growth hormone to patients and family members
- a chronic medical condition for which he was self-prescribing.

Observations and questions

The patient who made the complaint to AHPRA was a drug-seeker and didn't become drug addicted because of Dr GK's prescribing. While this was a vexatious complaint, Dr GK did breach several prescribing regulations (regulations regarding drugs of addiction, self-prescribing, unsanctioned off-label prescribing).

- *Why do GPs self-treat? Why do GPs find it difficult to seek help?*
- *Is 'I'm just too busy' a valid excuse when problems arise?*
- *When a GP is experiencing health or personal problems, what duty of care is owed to that GP by their colleagues and the practice?*

Drug-seeking behaviour has become more difficult to manage and requires a higher level of communication skills as well as behaviour management skills. When faced with problems that are outside one's level of expertise, it is important to ask for help. The next step is to decide whether to continue managing these problems and if so, to obtain the required skill set.

- *What processes do practices have in place to assist GPs in managing difficult patient behaviour, including drug-seeking behaviour?*

Off-label prescribing and medical practices that are not recognised as mainstream are fraught with medico-legal issues.

- *How do individual GPs monitor their practice, including prescribing, to ensure that they are practising safely?*
- *What processes do practices have in place for supporting and ensuring that their GPs are practising safely?*
- *How can a GP be more mindful of potential medico-legal issues?*
- *Would a period of supervision be helpful for Dr GK? If so, how would it be conducted?*

Behaviour

Case 12 – Dr GL

Dr GL is a GP of many years and well regarded by his colleagues. Lately, Dr GL has been having outbursts of anger, often directed at the practice nurse, NA. Last week, after yet another altercation with NA, he smashed her mobile phone on the floor. NA demands of PB, the practice manager, that something be done about Dr GL immediately, otherwise she will resign.

PB discusses the situation with the practice principal, SD. They arrange a meeting with Dr GL. Initially Dr GL denies that he is at fault but then becomes apologetic. He says that he is under a lot of stress and not coping because his marriage is breaking down. He requests time off so that he can get his life in order.

Dr GL returns after three weeks. At first, he appears to be much more settled, but before long the anger outbursts recommence. He is often late for work. There are occasions when he leaves part way through a session, without telling anyone, and doesn't return. When questioned, he apologises and says that he is experiencing 'horrendous migraines'. Some of his patients complain that he smells of alcohol and appears very detached. PB and SD are discussing what to do when one of the receptionists interrupts them. She says that there is a very angry woman at the front desk claiming that Dr GL groped her and tried to kiss her. At the same time, she saw Dr GL hurriedly leave the building and she is concerned that he might harm himself. She says that Dr GL has been confiding in her about his marital problems and how life is not worth living.

Observation and questions

This case highlights the importance of looking beyond the behavioural problem and exploring what underlies the behavioural change.

- *What should be done now?*
- *Dr GL has not made any clinical errors. Should he be reported to AHPRA? What are the issues for Dr GL? For the practice?*
- *What support/assistance might Dr GL need?*
- *What issues need to be considered, by Dr GL and by the practice, when Dr GL returns to work? What is Dr GL's responsibility with respect to self-care?*
- *What would be an appropriate Remediation Plan for Dr GL?*
- *Could this have been better dealt with earlier? When Dr GL requested time off 'to get his life in order', should he have been required to take longer time off?*

There are individuals whose behaviour is more ingrained.

- *Does that mean that their behaviour can never change and that it shouldn't be addressed?*

Appendix B. Significant event reporting (pro forma)

Policy

Practice X has designated person Y with primary responsibility for clinical risk management including following up on incidents, injuries, adverse patient events and near misses.

It is a legal requirement under the Occupational Health and Safety legislation, and for insurance purposes, to report any injury sustained, or believed to have been sustained, in the workplace, recognising that good reporting also leads to effective prevention.

Practice X encourages reporting and appropriate management of significant events. Analysis of significant events is also encouraged in order to develop and improve risk management strategies for minimising risks to personal and/or patient safety.

Regardless of whether harm has occurred, the significant events that should be reported include:

- non-clinical events
  - slip, fall or other injury
  - theft, assault, gas leak, bomb hoax, security breach
- clinical events
  - needlestick injury or mucous membrane exposure to blood or bodily fluids
  - drug or vaccine incident (eg loss, misplacement or other)
  - adverse patient outcome
  - failure to complete or inadequate completion of the handover or identification of a patient at the point of transfer of care
  - delayed treatment, delayed or failed follow-up, or an unnecessary repeat of tests
  - medication errors
  - any deviations from standard clinical practice, or where a near miss has occurred
- patient complaints.

Significant events may involve:

- staff (either employed directly by this practice or contractors)
- non-staff (eg patients, visitors).

Actual and potential risks are identified and actions are taken to increase the safety and improve quality of care. The privacy of individuals involved is maintained.

Procedure

Reporting

The 'Significant event reporting and analysis form' is used to report any significant events. The practice's MDO is contacted for events that might give rise to a claim.

The 'Significant event reporting and analysis form' is:

- completed as soon as possible after an incident has occurred, preferably within 24 hours
- filed in the 'significant event register' folder.

Any additional documentation (eg medical or other certificates, reports, pathology results related to the accident/incident) is dealt with as soon as possible and copies of original documents are appended to the 'Significant event reporting and analysis form'.

For injury occurring in the practice or course of work, WorkCover reporting protocols must also be followed. It is a legal requirement to report all injuries sustained in the workplace.

In situations of potential conflict of interest, for example, a staff WorkCover claim being managed by a GP who is also the employer, it is preferable for that claim to be managed by a doctor outside of that practice.

Risk assessment

The designated risk assessment officer conducts a thorough review of the significant event with a view to identifying appropriate corrective measures for future implementation.

Risk control

This involves identifying and implementing all practicable strategies to reduce or eliminate any potentiating factors, therefore minimising the occurrence of similar incidents, including:

- informing relevant staff (eg at staff meetings, through bulletins) about systems changes and why they have been implemented
- conducting subsequent review/s to ascertain whether the changes that were implemented were successful
- conducting three-monthly reviews of all events involving medical practitioners, nursing and clerical staff
- conducting regular meetings for all doctors so that learning from these events can occur in a non-judgemental way
- conducting regular meetings for all nursing and clerical staff so that learning from these events can occur in a non-judgemental way
- incorporating this process into general practice registrar training (both individually and in group tutorials).

Documentation

Retain documentation of the investigation process and any agreed actions implemented to minimise the re-occurrence of the incident and to log trends.

Source: RACGP *Standards for general practices*, 5th edition. Criterion QI3.1 – Managing clinical risks, Criterion C5.3 – Clinical handover, Criterion C6.1 – Patient identification.

Significant event reporting and analysis form

Name Date of report

Date event occurred Event reported to

Description of significant event: (Attach additional information where necessary)

Why was the event significant?

Who was involved?

What factors led to this event? How was the event handled?

How could it have been handled differently?

What actions need to be taken as a result of this event?

What lessons can be learnt for future reference?

Signature of reporting staff member Date

Person/s concerned advised

Yes No N/A Advised by Date

Complainant advised of action taken

Yes No N/A Advised by Date

Insurer advised

Yes No N/A Advised by Date

Advice sought from peer/senior partner(s)

Yes No N/A Peer or senior partner's name Date

Further action required?

Appendix C. Performance management policy for practice X (pro forma)

Preamble

Practice X has a duty of care to the public (patient safety) as well as the GPs working in practice X (GP safety). Consequently, practice X has a responsibility to:

- the standard of performance and behaviour of its GPs
- ensure that every GP understands and complies with their responsibilities
- manage performance concerns regarding its GPs.

With respect to managing performance concerns, practice X's role is to:

- ensure that processes for performance management are transparent, fair and equitable
- provide a supportive environment that allows performance management to take place without putting patients or the identified GP at risk.

Purpose

To outline the process for managing performance concerns of GPs at practice X.

Scope

This policy:

- applies to all GPs at practice X, regardless of the terms of their employment
- provides a framework for addressing performance concerns.

Note: With general practice registrars, performance concerns are managed, in the first instance, by their supervisor. Significant performance concerns will be referred to the registrar's Regional Training Organisation (RTO), but may also require involvement from practice X.

Guiding principles

This policy is guided by the following principles:

- the safety of patients and the public
- the needs and wellbeing of the GP
- the integrity of practice X
- the requirement to take a comprehensive approach
- processes that are fair and transparent
- confidentiality for the GP (this need for confidentiality will, however, be balanced against the need to ensure that information is passed to colleagues where appropriate, and patients are properly informed before giving consent to care from a practitioner who has restrictions placed on their practice)

- personal and professional support for the GP and the team that they are working in
- drawing on external expertise to facilitate processes and ensure better outcomes for all.

Definitions

Managing underperformance is also termed 'remediation'. It is a process that begins with identifying a concern, followed by investigation, assessment, decision making and, finally, implementing a management plan. A range of possible interventions, or remedial activities, may be implemented, from simple advice and support through to formal supervision and retraining. These interventions encompass:

- reskilling or retraining: the process of addressing deficits in knowledge, skills and/or behaviours to enable the GP to practise safely
- rehabilitation: the process of supporting the GP with ongoing health issues and/or disability to
    - surmount the difficulties that hinder them from practising safely
    - assist with making adjustments in the workplace to enable them to practise safely.

Roles

Once a performance concern is identified, assistance from various individuals or agencies may be necessary at any or all stages of the performance management process. Those who may be involved in the performance management process include the following.

The **governing body of practice X** (practice principal/chief executive/board of directors):

- has overall responsibility for ensuring that identified cases of underperformance are properly managed
- leads the performance management panel, but delegates these responsibilities to an appropriate person when there is a conflict of interest
- nominates the members of the performance management panel
- convenes discussions regarding performance concerns with the performance management panel
- obtains advice and/or assistance, as relevant, from AHPRA, the RACGP, practice X's MDO and experts in performance management.

The **performance management panel**:

- is responsible for managing identified performance concerns
- makes decisions regarding performance concerns
- comprises the governing body (or their representative), the practice manager and a GP of the clinic.

The **practice manager**:

- is responsible for ensuring policy implementation and compliance
- is responsible for enabling the early identification of performance concerns
- refers concerns about patient safety directly to the governing body
- participates in discussions regarding performance concerns
- may participate as a member of the performance management panel.

The **GP** is responsible for ensuring their safety to practise. The onus is therefore on the GP to:

- continually reflect on their practice
- maintain the required level of knowledge and clinical skills appropriate to that practice (prevention)
- demonstrate that any identified performance concerns are addressed and resolved.

The GP may also be called on to assist:

- as a member of a performance management panel
- the identified GP in a supervisory, mentoring and/or educational role.

The **clinical supervisor** (a suitably experienced GP from within the practice):

- is a doctor in the practice who may be asked to supervise a GP about whom there are performance concerns. Supervision may be formal or informal and will depend on the context that assists the GP with their learning plan (development and execution)
- monitors the GP's progress
- reports to the governing body and makes recommendations about the GP's progress and any concerns they may have
- evaluates the outcomes of the Remediation Plan.

The **mentor**:

- provides personal support
- challenges and promotes the development of reflective skills.

Mentoring is a developmental process whereby a more experienced GP ('mentor') helps a less experienced GP ('mentee') in their personal and professional development.

The mentor does not have to be from practice X and may be of the identified GP's choosing.

The **assessor/investigator** (an external expert having experience with remediation and assessment of clinical skills):

- ensures they are clear about their decision making and any recommendations they make with respect to a Remediation Plan
- assists practice X to
  - investigate performance concerns
  - assess the clinical skills of GPs and identify deficiencies
  - make a determination as to the GP's safety to practise
  - make recommendations for addressing the performance issues
  - evaluate the outcomes of the Remediation Plan.

The **medical educator** (has experience in medical education and remediation):

- assists in the investigation and assessment of performance concerns
- delivers and monitors Remediation Plans
- assists in evaluating the outcomes of Remediation Plans.

Occupational health and rehabilitation services assist when there are concerns regarding the identified GP's health. Referral to such specialist services may be necessary when adjustments or modifications need to be made in the workplace to assist the identified GP in their practice.

AHPRA must be notified (under legislation) when there is serious concern regarding patient safety. Practice X may have a role in supporting the GP with respect to any determination made by AHPRA.

Practice X's performance management process

1. Problem identification

A GP's clinical capability may be brought into question in the following circumstances:

- concerns expressed by colleagues, staff or students
- complaints made by patients, relatives or carers
- anonymous complaints/allegations
- investigation into a critical incident
- information provided by AHPRA
- information provided by the police
- court decisions
- self-identification
- information provided from other sources regarding clinical capability
- the GP seeks to return to work after a sustained period of absence (from either illness, disability, suspension or deregistration).

2. Investigation

All allegations or concerns will be investigated and appropriate action taken; this includes action with respect to vexatious complaints.

Concerns about the capability of general practice registrars are primarily a training issue involving the registrar's supervisor and the RTO. However, practice X may also be involved in managing the performance concern.

The governing body will decide the appropriate course of action in the first instance for each case. The governing body may delegate authority, as appropriate, after considering the details of a particular case and any conflicts of interest. All concerns will be investigated by the performance management panel, as appointed by the governing body, in a timely manner.

Advice and/or assistance may be sought from external parties, such as the RACGP or an expert in the field of remediation.

A meeting will be convened, as soon as practicable between the performance management panel and the GP about whom the performance concerns have been raised, to discuss the concerns and the appropriate course of action. The GP may nominate a support person to attend that meeting.

Possible outcomes of an investigation are:

- no cause for concern
- concern exists and needs to be addressed (a Remediation Plan will be formulated)
- concern exists but needs to be further investigated or assessed for it to be managed appropriately.

With concerns of a serious nature, the following may apply:

- notification is made to AHPRA
- the GP is stood down from practising at practice X.

With notifications to AHPRA, AHPRA will conduct an investigation and make a determination that includes the reasons for its decision, the areas of concern, the undertaking that the GP is to comply with, and any conditions imposed on the GP's practise. Practice X may have a role in supporting the GP regarding any determination made by AHPRA.

3. Performance assessment

A performance assessment may sometimes be required when there is uncertainty as to the adequacy of the identified GP's clinical skills. Practice X will be guided on the need for such an assessment by an expert on performance management. The aim of a performance assessment is not only to identify any deficits in a practitioner's performance, but also that a suitable management plan be developed to assist the GP in attaining the expected standard.

4. Management plan

Management plans will:

- be developed in consultation with the identified GP
- be tailored to the identified GP's needs
- address all the concerns
- have clear objectives
- have a set time frame
- have provision for evaluation of the outcomes
- have defined actions with respect to the outcomes.

Practice X is committed to support the identified GP throughout the implementation of their management plan.

5. Outcomes

The outcomes of the management plan will be evaluated upon its completion. Possible outcomes include:

- resolution of the problems/concerns
- the problems/concerns remain the same
- the problems/concerns have worsened.

In the latter two instances, the situation will be reassessed and a decision made about further action, including whether the GP should continue to work at practice X.

Practice X may be assisted with the evaluation by an expert on performance management. Evaluation will take into consideration:

- the GP's progress and whether it is sufficient
- whether the identified GP is capable of achieving the required objectives if progress has not been sufficient
- whether the GP will require further assistance.

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