

# Underperforming doctors in general practice: a survey of referrals to UK Deaneries

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## SUMMARY

**Background:** National Health Service Executive guidelines for rehabilitation of general practitioners (GPs) who require professional support state that these GPs should be advised to contact the Director of Postgraduate General Practice Education in their Deanery. There has been concern about how the needs of these GPs can be met without additional resources.

**Aim:** To monitor and describe the process and outcome of these referrals over a two-year period to assess the size of the problem, to share good practice, and to identify any deficiencies in the system.

**Design of study:** Quarterly postal questionnaires.

**Setting:** Deaneries in the United Kingdom, which are geographically-based organisational units for the management of general practice education.

**Methods:** Three postal questionnaires were devised to cover General Medical Council (GMC) referrals to Deaneries, health authority referrals, and referrals made by Deaneries to the GMC. Non-responders were contacted by telephone.

**Results:** Twenty-seven GPs were referred by the GMC, 72 were referred by health authorities, and 18 referrals were made by Deaneries to the GMC. The information provided to Deaneries by the GMC was timely in just over half the cases, and was left to be appropriate in two-thirds of cases. Information provided by health authorities was almost always timely, detailed, and appropriate. The action required by the GMC was felt to be inappropriate in five cases, and not feasible in eight cases. No extra resources were available in the majority of cases. Information about outcome for the GP was either unavailable or unclear in over half the cases.

**Conclusion:** This monitoring exercise has revealed several deficiencies in the system for dealing with the educational needs of underperforming GPs. There is a need for a clear national protocol for referral of GPs to Deaneries and for the support that Deaneries can be expected to provide.

**Keywords:** postgraduate general practice education; professional competence; professional support.

## Introduction

THE standard of performance of doctors is a major concern for patients, government, and the medical profession. On 1 July 1997, after a lengthy consultation process, the UK General Medical Council's (GMC's) Professional Performance Procedures<sup>1</sup> came into effect. These allowed the GMC to take action in cases where the doctor's performance was seriously and consistently poor.

Educational support for general practitioners (GPs) in the UK is provided by networks of educators, who are managed in 24 geographically-based Deaneries and three Armed Forces departments by a senior team of educators. This team is usually made up of a Director of Postgraduate General Practice Education and a small number of part-time Associate and Deputy Directors. The National Health Service Executive (NHSE) Guidelines for rehabilitation of doctors who require professional support<sup>2</sup> state that, following an assessment, GPs will be advised to contact the Director of Postgraduate General Practice Education. Clearly, there is the expectation that the Deaneries will then be able to offer help and support as required in accordance with the GMC's recommendations.

This issue was considered in 1997 by the Executive Council of the UK Conference of Postgraduate General Practice Advisers and Universities, of which one author (JB) is a member. There was concern that, without additional resources, it would be very difficult to undertake such an open-ended commitment. There was no information about the number of doctors who might be referred or what their educational needs would be.

Nonetheless, all the Directors agreed that, by virtue of their experience and educational expertise, they had an important role and should be actively involved in this process. They agreed that there should be regular monitoring of such referrals so that the size of the problem could be assessed, the examples of good practice shared, and any deficiencies of the system identified and addressed.

The aims of the monitoring were to keep a record of the number of all GPs who were referred on account of underperformance, to identify the reasons for referral, to assess the feasibility of remedial training and education, to consider resource implications, to highlight emerging difficulties and problems associated with such referrals and, where possible, to determine the outcome of the referral. This paper describes the results of the first two years of monitoring, from 1 September 1998 to 31 August 2000.

## Method

Three questionnaires were developed to gather information on doctors who had been referred by the GMC to the Deanery, by the health authority to the Deanery, and by the

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**HOW THIS FITS IN***What do we know?*

UK Deaneries are now expected to provide professional support for doctors whose performance is seriously and consistently poor. The workload involved and the feasibility of providing this support was unknown.

*What does this paper add?*

The number of GPs referred was small, but most cases were time consuming for Deanery educators. Problems of poor communications and unrealistic expectations resulted in an unsatisfactory outcome in several cases. There is a need for a national protocol for dealing with referred GPs. The development of advanced training practices able to provide remedial training is also a priority.

Deaneries to the GMC. These questionnaires were sent out at quarterly intervals to the Directors of Postgraduate General Practice Education in each Deanery. Each questionnaire enquired about the number, type, and purpose of referral, appropriateness of the referral, and whether or not the information supplied by the referring agency was timely, detailed, and appropriate. Information was also requested on what action had been taken at the Deanery, by whom, in what capacity, and for how long. Directors were also asked to state whether they thought that the whole referral process had been satisfactory for the referred doctor and a worthwhile achievement for the Deanery. There was also an open space for comments. Non-responders were contacted by telephone.

Quantitative data were totalled for the first year, and for the second year they were analysed using Microsoft Excel. The numbers in the conduct and health categories of referral, and the numbers where the outcome was known, were too small for meaningful statistical correlation of referral type with outcome.

Qualitative descriptions of the actions requested, the actions taken, and the problems encountered, were summarised. No attempt was made to quantify these aspects precisely because of the differing circumstances of each case.

**Results**

The overall response rate was 98.6%. Non-responding Deaneries were telephoned repeatedly until all had replied. There are still three replies outstanding from the last quarter reported.

*Cases referred by the GMC to the Deaneries*

The numbers of cases, reasons for referral, information provided, appropriateness of action required, and outcome where known, are summarised in Table 1.

In some cases referred by the GMC, the Deaneries had experienced serious difficulty in getting access to the relevant information before dealing with the doctor referred. This often made the initial interview unproductive and almost a waste of time.

The actions the Deaneries were requested to take included extensive remedial training, the provision of information to the doctor, educational support, and clinical supervision. The action taken by the Deaneries included career advice, arranging clinical attachments, appraisal interviews, counselling, specific educational programmes, and in some situations an assessment visit to the doctor concerned.

The key staff in the Deanery education networks dealing with such referrals were the Directors, the Deans, Associate Deans, and GP tutors. Their role varied from acting as supervisor, mentor or assessor, to being 'judge and jury'. This latter role caused a dilemma at times for some of the Directors, who found it difficult to combine a policing role with that of an educational adviser. Other Directors had resolved this conflict of interest by devolving one-to-one mentoring, appraisal, and educational supervision to a Deputy and/or GP tutor. In such situations, the Director functioned mainly as a co-ordinator and reporter of the doctor's progress. The amount of time necessary to deal with each referral varied from hours to days and, in one case, nearly two-and-a-half years. With the exception of one case in which the referred doctor was expected to pay for the cost of remedial training, in all other cases the Deanery carried the cost.

There were several reported problems with the provision of information. In one or two cases, all that the Deanery received was a copy of the letter sent to the doctor by the GMC. In a few cases, the referred doctors had appeared suddenly at the door of the Deanery in the expectation that the Director knew about their cases and could help them to get back into practice immediately.

In several cases the action required by the GMC was not feasible, usually because it was not possible to find a place for the doctor to work to fulfil the supervision and training requirements. In other cases the action was felt not to be feasible because the doctor did not accept that he or she had a problem, or because the doctor was felt not to be retrainable.

In several cases the Directors reported that the referred doctors had unrealistically high expectations of what could be done for them. Some doctors exhibited a totally negative attitude and almost a denial of the problem. A few believed that the reasons for referral related to racial and institutional prejudice. Many had little appreciation of the process and implications for failure to comply with the GMC requirements. Some doctors were confused by the timescale necessary for remedial training.

In one particular case, a doctor who had been subjected to extensive assessment and remedial education in two Deaneries independently for nearly three years (because the doctor had moved from one region to another) was referred back to the Deanery again for further 'remedial training'.

In eight cases the outcome for the doctor was not known, usually because the case was continuing. In some cases, retirement or career change was recorded as a satisfactory outcome for the doctor. There were also cases in which an unsatisfactory outcome for the doctor — for example, being prevented from practising — was recorded as a worthwhile achievement for the Deanery.

In the cases recorded as not having a worthwhile outcome for the Deanery where an explanation was given, the most

Table 1. General practitioners referred to Deaneries from the GMC and health authorities (HAs) between 1 September 1998 and 31 August 2000: reasons for referral, information provided, appropriateness of the action required, and outcome for the doctor and for the Deanery where known.

	Number referred by GMC		Number referred by HA	
	Yes	No	Yes	No
Total	27		72	
Main reason for referral				
Conduct	10		6	
Performance	14		61	
Health	3		3	
Information provided was				
Timely	15	12	68	4
Detailed <sup>a</sup>	20	6	63	9
Appropriate <sup>a</sup>	17	8	72	0
Action required was				
Appropriate	22	5	65	7
Feasible <sup>a</sup>	18	8	67	5
Resourced <sup>a</sup>	7	18	18	50
Outcome was satisfactory for <sup>b</sup>				
Doctor	5	14	13	4
Deanery	11	10	46	1

<sup>a</sup>Partial non-response in these categories. <sup>b</sup>The outcome was not known for the remaining cases.

frequent reasons were that remedial help was not feasible, either because of the difficulty of finding placements, the level of supervision required, or the attitude of the doctor. In two cases of referral on health grounds, inadequate information was provided by the GMC. In the first case, the doctor was unhappy because health information was requested by the Deanery, and in the second the implications of the health problem were still being worked out. In two cases the referrals were felt to be inappropriate. In the first case of a conduct referral, the Director did not feel there were grounds for referral. In the second case the GMC changed its plans but did not inform the Deanery that input was no longer needed, so effort put into the case was felt to be a waste of time.

### Cases referred by health authorities

The numbers referred in each category are summarised in Table 1.

The majority of health authorities had set up a special arrangement to identify and deal with underperforming GPs in their area. The model used, with some local variations, was based on the SCHARR model<sup>3</sup> which brought together expertise and representations from the Local Medical Committee (LMC), postgraduate education, and health authority. The health authority dealt with most cases, but sought help from the Deanery when there was a special need for extensive mentoring, assessment of competence and/or educational help. The range of actions taken by the Deaneries included appraisal interviews, assessments, visits to the doctor, facilitation of personal learning plans, and reporting and discussion meetings with the health authorities and LMCs. The individuals involved were Directors, their Deputies and/or GP tutors. They acted as advisor, assessor, mentor or even friend. The time spent on each case varied from one hour to one week. In several cases the doctor had responded positively to the intervention, and it was felt that

their practice had been improved.

### Cases referred by the Deaneries to the GMC

The GP Directors referred 18 cases to the GMC, mostly on account of poor performance. There were, however, two cases related to fraud. The group included general practice registrars, non-principals, principals, assistants, and senior house officers and specialist registrars who were intending to pursue a career in general practice. Directors, trainers, trusts or health authorities raised initial concern about the doctors. Each case had been subjected to extensive assessment that included video recording of consultation, direct observation, summative assessment results and/or evidence of poor performance from the employing Trust or Health Authority. In most cases there was full involvement of the Health Authority or Trust in gathering and submitting evidence. In one case, the Trust's legal adviser was also involved. In two cases relating to conduct, the matter had been reported to the police as well. The Directors, Deputy Directors, course organisers, and consultant supervisors were all involved as appropriate. The outcome of these cases was not yet known.

### Discussion

This study describes UK Deanery involvement with underperforming GPs over a two-year period. Although the cases dealt with annually make up only 0.0016% of the workforce, it must be remembered that the survey concentrated only on doctors who had 'serious and habitual' underperformance. In reality, there might have been many more underperforming doctors who were dealt with at the local level without referral to the GMC and/or the Deanery. Furthermore, the survey period covered the first two years after the introduction of the Performance Review Procedures, when there may have been less experience of, or willingness to refer, underperforming doctors. It may be that, with increasing public

and political pressures, there will be an increase in numbers of referrals in future.

This study does have some limitations. Reporting of referrals may not have been complete, as the system of recording cases is not uniform across Deaneries and questionnaire responses may in some cases have depended on the memory of the Director of Postgraduate GP Education. On the other hand, the responses suggested that Directors had usually been closely involved and would be unlikely to forget cases. A further problem was in tracking individual cases until the final outcome, as the questionnaires asked for new referrals. In some instances, more than one case was reported on a single questionnaire so that it was difficult to determine which response applied to which case. It is also likely that Directors differed in their interpretation of what constituted a 'satisfactory' outcome for the doctor, or a 'worthwhile' achievement for the Deanery. What the responses did provide was a qualitative picture of the problems encountered, and the successes and failures of the system.

One of the problems identified by the study was the lack of information and support available to referred doctors, leading them to have unrealistic expectations of what could be achieved by the Deanery. The information provided should particularly clarify the role and function of the different agencies and the doctor's own responsibility in complying with the GMC/Health Authority/Deanery recommendations.

There was also a problem with the provision of information from the GMC to the Deaneries. This apparent failure in communication might have been owing to legal difficulties that the GMC faced in sharing information relevant to doctors' fitness to practise. However, with the new proposed amendment to the Medical Act 1983, and the changes to the Fitness to Practise Procedures, there is now an opportunity to devise a clear protocol for referral of doctors to the Deanery for educational support. Any such protocol should include the results of any assessment which might have been carried out to identify the doctor's specific educational needs, and the specific actions that would be required from the Deanery.

There was also a continuing anxiety expressed by the Directors regarding the feasibility of what was expected from the Deaneries; for example, the case where, according to the GMC advice, a GP could continue to see patients but under the 'supervision' of the Director. The feasibility and legal implications of this course of action, in the context of general practice, did not seem to have been fully appreciated. There was also the issue of doctors who, despite all efforts, had failed to improve and should have been considered unsuitable for further 'remedial training'. There must come a time when a decision has to be made about the wisdom of repeated referral for remedial training/re-training. In a few cases, it might have been more humane to advise the doctor in question to consider alternative career options.

In cases of referral from the health authorities, the information back-up was exemplary. The arrangement for dealing with such cases was good and referrals were appropriate and feasible. The only, but important, concern related to the cost of remedial training and education which in most cases had to be borne by the Deanery.

For Deaneries there were also some lessons to be learned. For example, it seemed highly desirable to have a nationally agreed menu of assessment methods. An appropriate combination of methods can then be used in each individual case, depending on the reasons for referral. The result could form the basis of a Personal Learning Plan, which can be used as evidence for doctors' progress and feedback to their referring agency. Since there are many excellent assessment instruments already available in general practice, it should not be too difficult to agree on a suitable national package.<sup>4,8</sup>

The survey also indicated certain inconsistencies in the way that the Deaneries had handled each case. A national protocol, with some built-in arrangements for flexibility, appears to be a priority.

There is also a pressing need to select and appoint specific practices for remedial training in each Deanery. An average size Deanery may require only two to three advanced training practices.<sup>9</sup> The characteristics of these practices have been agreed;<sup>9</sup> they must have high motivation to help, an experienced training team, availability of time, and relevant educational facilities. In view of the challenging nature of remedial training and related ethical and legal issues, such practices and practitioners merit a significantly higher level of pay than what is traditionally available to a trainer in a training practice. In addition, these practices should be supported to have a full range of educational facilities and outside resources when necessary.

Also, because of the ever-increasing commitments of the Directors, and the crucial importance of underperformance and issues related to its management, the Deaneries should seriously consider designating a specific person to take responsibility for co-ordinating the management of such referrals. He or she could also take responsibility for the provision of training for those members of the education network who may become involved in supporting such doctors. Separation of 'policing' and 'supporting' roles should also be considered.

Finally, this survey noted 18 doctors who had been referred by the Deaneries (Directors) to the GMC. This is a new and highly significant development. It reflects the changes that have occurred in training where underperformance can now be uncovered by the mandatory use of assessment.<sup>10</sup> It also reflects a change of attitude on the part of employers, Trusts and health authorities, who have become concerned, quite rightly, about the implications of underperformance in their organisations. They are, therefore, less prepared to tolerate it when it occurs.

In summary, Deaneries are having to meet a new need to provide educational support for GPs whose performance gives cause for concern. This is a sensitive and difficult task, which requires nationally agreed protocols, further training of educators, and adequate financial resources.

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