Consultant appraisal

Christopher C Evans

Christopher C Evans MD FRCP FRCPI, Academic Vice President, Royal College of Physicians

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It was the high profile hospital cases in Bristol and Alder Hey and the Harold Shipman and Rodney Ledwood scandals that resulted in the General Medical Council (GMC) introducing a mechanism to ensure that poorly performing doctors would be identified and patients protected, in order to restore public confidence.[1] It was against this unhappy background that doctors received information about appraisal, which is based on sound educational principles designed to further their development rather than be a potential threat to their careers.

Last year the College held a well attended one-day conference entitled 'Consultant appraisal and revalidation'. Professor Pauline McAvoy, Chair of the GMC Technical Group, delivered a paper on the progress of revalidation and its process and piloting modifications. Doctors are appraised against the generic principles outlined under the seven headings of good medical practice.[2] In the case of physicians this is endorsed by the Federation of the Royal Colleges of Physicians.[3] Discussion of this paper revealed that neither appraisal nor revalidation for medical staff had been subjected to evidence-based analysis.

Initial feedback on appraisal was sceptical but most colleagues now consider it a positive process, which can significantly enhance patient care and is potentially beneficial to physicians' professional development.

The paper in this issue by Waller, who has piloted much of the clinical development of appraisal, is an excellent summary of the current state of the process.[4]

Last year the Education and Training Department of this College produced a guidance document for those being appraised (the appraisees) and their appraisers entitled *Consultant appraisal in the NHS*.[5] This describes each step in the process of appraisal, its purpose in relation to the individual consultant and the trust, and its connection with GMC revalidation. By now many colleagues will have completed their second or third appraisal documentation and the majority will have found the exercise less time-consuming than the initial preparation of the folder. Others, however, acting as appraisers, will have spent even more time being trained and preparing carefully the agreed summary statements, which are so crucial for the subsequent revalidation purpose.

In May 2002, Dr David Graham, the Post Graduate Medical Dean for Mersey, was appointed by the Health Minister as the 'appraisal tsar' to encourage the appraisal process not only for consultants but also for general practitioners. His message has been clear throughout and concurs with that of the Department of Health: appraisal is here to stay and, indeed, it is a contractual requirement. As Winearls recently argued, appraisal is not only part of the GMC revalidation process but refusal to participate will be a disciplinary matter that will render the individual ineligible for consideration for discretionary points or a distinction award.[6]

It is hoped that ultimately the appraisal process will be uniform for different groups of doctors across different NHS organisations. Appraisal is all about reviewing performance and developing a personal learning plan. However, when appraisal appears to be more like assessment there are likely to be difficulties with revalidation. As Waller indicates, any potential problems should be clear to both appraiser and appraisee well before the actual appraisal.

There should be no surprises in appraisals; nor should they contain any 'carrot and stick' tactics or be in any way directives passed down from management. Appraisal is neither an assessment nor an evaluation; it is a formative rather than a summative process. One cannot pass or fail since the decisions made are not a review of clinical competence as judged against explicit standards. Appraisal is not hierarchical, disciplinary, or health monitoring. NHS trusts have protocols and management systems to deal with poorly functioning or underperforming doctors.

Colleagues have raised concerns about lack of training for both appraisers and appraisees. The College's 'Physicians as educators' programme[7] offers some assistance, with two of its eight modules focusing on appraisal. One covers how to conduct an appraisal for both consultants and trainees, and the other aims to increase understanding of consultant appraisal. These are available both in London and in the regions, including Mersey, Oxford and Wessex, with the intention to extend further.

The appraisal process for academic clinicians has also led to tension where conflicts exist between service commitment and academic work. In general, this has been resolved by holding a single appraisal

meeting at which there are two appraisers, one representing the NHS and the other the academic institution.

Appraisal permits a consultant to meet with colleagues not necessarily of the same discipline or specialty, and to reflect on and set goals for professional practice and personal professional development. The evidence contained within the appraisal folder, provided by both appraisee and appraiser, is not a mini revalidation but will contribute to the revalidation process to be introduced in 2005. This evidence can be used for revalidation in a summative manner so as to establish fitness to practise.

There are still some issues to be resolved. Appraisal for locum physicians and non-consultant career doctors has not yet been effectively introduced. We do not know whether the techniques which have been piloted by this College for the assessment of specialist registrars, such as 360 degree appraisal, Mini CEX (clinical evaluation exercise) and DOPS (directly observed assessment of practical skills), will be adopted for permanent staff.[8] The appraisal process itself is likely to be subjected to external quality assurance, perhaps as part of the remit of the Commission for Healthcare Audit and Improvement.

From the perspective of a recently retired NHS physician such as myself, the appraisal process has been a very welcome introduction both as appraiser and appraisee. It has offered for the first time a mechanism by which morale is boosted, teamwork fostered and delivery of patient care enhanced. I now have to prepare for revalidation by the independent route, demonstrating that I am adopting standards consistent with Good Medical Practice and that I am continuing with medical education and professional development. It was ever thus.

References

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