

Consultant appraisal: pitfalls and how to avoid them

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ABSTRACT – Appraisal for consultants offers a unique opportunity to discuss and record professional issues, identify constraints to practice and plan personal development. Participating in appraisal also offers a painless route to revalidation. Making the best use of the process requires preparation and planning on the part of the appraiser and the appraisee. This article discusses some of the potential pitfalls that might impede a successful appraisal outcome, and considers how they might be avoided. Both appraiser and appraisee should approach the meeting with a positive view of achievements in the past year, a clear focus on the issues that need discussion, and an open mind on potential solutions to any problems that have arisen. It is important that the organisation supports appraisal by responding to identified constraints, workload issues and resource limitations in a planned, constructive manner.

KEY WORDS: appraisal, consultant, revalidation

Consultant appraisal is now part of the annual calendar. However, despite advance warning of its introduction, consultants in many trusts were ill prepared for the scheme. Many have not undergone specific training in consultant appraisal and some training courses have been criticised as inappropriate for the needs of consultants. Therefore, even those who have attended training can feel uncertain about the process. Carried out correctly, it should be a positive, forward-looking developmental discussion, even when problems are identified.

In the Directorate of Medicine and Elderly Care in Southampton, we are now entering the fourth round of appraisal for many of the consultants. Personal experience, and the opportunity to talk to a number of colleagues from other trusts while facilitating consultant appraisal workshops at the Royal College of Physicians, has led me to reflect on why the process can go wrong and how this can be avoided.

Consumer resistance

The General Medical Council (GMC) currently proposes to use appraisal as the means of delivering revalidation, and will be looking for evidence in each of the components of Good Medical Practice.¹ This

has inevitably introduced a greater element of assessment into appraisal than many consultants feel comfortable with, and some feel threatened by it. However, even without revalidation, an effective appraisal needs to consider evidence of the nature and quality of clinical practice, to inform personal development, to ensure high quality of service delivery and to address service development needs. Most doctors aim to achieve or maintain excellence. If this is the focus, then review of clinical activity should not be seen as threatening.

The link between appraisal and revalidation has led some consultants to see the appraisal as a tool for identifying 'bad' doctors. The GMC envisages that only a very few will even have their practice called into question. For most consultants the only hurdle is to provide enough information to satisfy the GMC in all categories of Good Medical Practice.

If a consultant sees the appraisal process purely as a data collection exercise for revalidation, then it will become a 'tick box' activity that will seriously devalue the potential of the appraisal. This is probably the first opportunity that most consultants have had to sit down with a colleague and enter into a structured and constructive professional conversation about their medical practice and career progression. The evidence presented at the appraisal should be used to support the discussion about their needs and aspirations.

The success of appraisal in commercial organisations critically depends on the management culture. If management supports and responds to the process, it is much more likely to work. Consultant appraisal is therefore most likely to be successful if the trust takes a constructive and proactive role in



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Key Points

The appraiser should focus on the positive aspects of the past year

If problems have been identified, the appraisee should be encouraged to identify potential solutions, drawing on experience from past successes

The personal development plan should set realistic and achievable goals for the next year

The trust should ensure that there is a credible and realistic response to planning resolution of issues such as excessive workload or inadequate resources

designing and implementing the system. If this is not done, then there is a risk that some consultants will be poorly prepared for the meeting and their suspicions may be confirmed when the process fails to deliver any results.

Trusts must have a credible response to the concerns of consultants and restraints on their practice that will inevitably be identified during the appraisals. Some of these can be handled at directorate/divisional level; others will require the involvement of the executive. In several trusts, all appraisals are read by the medical director, so that where appropriate, common themes that arise across different specialties can be presented to the trust board for action. Consultants should not be led to believe that a single or even several appraisals will resolve all the issues that constrain their practice or result in an excessive workload. However, it does provide the opportunity to plan for effective use of resources as they become available, and to allocate priorities across the organisation.

Consumer resistance, or a medical culture of 'nothing can be relinquished or done better', can be a significant constraint to a successful outcome from appraisal. We all need to continuously challenge preconceived views about our practice, especially in the light of changing healthcare needs. It can be both depressing and frustrating to identify an individual who feels hard pressed and stressed, but then to be unable to engage him or her constructively in resolving the problems.

Organisational issues

In medium and large-size trusts, there will be difficulty with the sheer numbers of consultants who need to be appraised. It is important to choose carefully those who will act as appraisers and ensure not only that they have the skills for the role, but also that they fully understand the objectives of appraisal. They must be aware of the strategic direction of the trust and the directorate/division and understand the requirements for revalidation. This does not mean that appraisers must be in a management role, as long as they are informed and prepared before the meeting.

In most organisations, there will be enough people with the skills and trust of their colleagues to undertake the role. Any consultant allocated to an appraiser should be free to choose an alternative. The appraiser does not need to come from the same specialty or even have a high level of understanding of the type of work the consultant does. So many of the issues have common ground that it is possible to appraise somebody in an area in which the appraiser has little or no specialist knowledge. The only absolute requirement will be the ability to assess the quality and perhaps the quantity of work undertaken, but this can be gained from peer review or audit that takes place before the appraisal meeting.

Appraisal was designed to be a one-to-one process but for academic clinicians a joint process is envisaged in which the academic and NHS appraisers contribute to a single appraisal discussion. Some NHS consultants choose to have two appraisers: both can be medical or one may be a manager. If there is more than one appraiser and both are active participants, it is impor-

tant to agree the agenda before the appraisal. This can be particularly helpful for academic consultants who may be concerned about the pressures of conflicting demands on their time.

Adequate administrative support for appraisal should not be overlooked. Conducting 360 degree surveys, collating the information and typing the summaries of appraisal discussion is time-consuming and the extra work should be properly resourced.

Time

Appraisal can be viewed as yet another requirement on top of an already over-committed timetable. Adequate time must be made available for both appraiser and 'appraisee' to prepare for their meeting. Ideally, this begins with appraisal training. Consultants will not get the best out of the process as appraisees unless they take time to understand how their appraisal can fulfil the requirements for revalidation, help the trust to use its consultant workforce most effectively, and still plan for delivery of the individual's aspirations or needs.

Preparation of the appraisal folder can be daunting on the first occasion. Having started to collate evidence, it requires discipline to continue collecting relevant pieces of information throughout the year. Most of the information in the folder is presented to the appraiser without comment and the additional time involved should not be onerous if the folder is regularly updated. The appraiser should review the appraisal folder in detail before the meeting. It may be necessary to set the agenda for the meeting in advance if particular concerns need to be addressed or additional information needs to be included. Adding this to the time taken for the appraisal meeting and for preparing the summary of appraisal discussion will probably amount to four hours of an appraiser's time for each appraisal carried out. If problems arise, it may be necessary to arrange an interim review which might be carried out by the appraiser or the clinical director. The trust should be encouraged to allow at least one session for both appraiser and appraisee to facilitate a successful appraisal programme.

Information

Demonstrating Good Medical Practice requires evidence. It is the responsibility of the appraisee to collect this, but the trust should assist in the process. All trusts hold a wealth of information about the clinical activity of individual consultants. However, much of this is high level, says little about the quality of practice and can be inaccurate. There is also a risk that information is collected because it is easy to do so rather than because it is relevant. Instead of dismissing the available information, consultants should engage with the trust to ensure that they have reliable data that are a valid measure of what they do.

There will often be gaps in the evidence presented in the appraisal folder. During the meeting, the nature of the evidence that needs to be collected for the next year should be agreed between the appraiser and appraisee, and also how this will be achieved. A gradual approach to collecting information over two

or three years is more realistic than attempting everything at once.

Interpretation of data

Some consultants are concerned that they will be judged on data that should be attributed to other members of the team. It is important to agree how the data are interpreted. Most consultants work as members of a team and assume a degree of clinical responsibility for many of the activities of that team. Poor performance of a junior member of the medical team may reflect their inexperience, lack of ability, or poor supervision. A robust judgement needs to be made before attributing responsibility. Dysfunctional teams can also affect clinical performance. If such problems are apparent, the consultant's role and contribution to the way the team works need to be carefully explored.

What makes a good appraiser

Appraisal skills can be taught but what makes a good appraiser? Attributes of a good appraiser include a mixture of skills and self-awareness. A good appraiser will be well-prepared for the appraisal meeting and aware of any prejudices that s/he might hold. If prejudices are not consciously put aside, the appraisal can become a critical review.

The appraiser should always be positive and constructive even when problems have been identified before, or arise during the meeting. The appraiser should be an active listener who shows interest and reflects back what he or she has heard. This will ensure that both parties have the same understanding of what is being discussed and agreed, and may also give the appraisee further insight into the discussion. When necessary, an appraiser should be willing to challenge, and must be willing to tackle difficult issues.

The appraisal meeting

Many appraisals are straightforward, but when problems arise it is important to keep talking. An appraisee is much more likely to be constructive about a difficult area if the discussion first concentrates on bringing out their strengths and skills and reviews what has gone well, rather than focusing on 'bad' practice. The appraisee should be encouraged to use skills and experiences acquired in successfully managing other areas of their practice to resolve problem areas. When information presented in the folder raises concerns, wherever possible the evidence should be triangulated to validate it. An example might be the number of complaints about communication. If there is a problem, helping somebody to gain insight might be more easily achieved if this is supported by evidence from 360 degree feedback from colleagues or through patient surveys. A single appraisal cannot be expected to resolve issues that have been extant for many years, but can initiate insight, and eventually change.

There should be no surprises in an appraisal meeting. Anything that either party wishes to discuss should have been

indicated at least two weeks before the meeting and new information should never be presented at the meeting. If it is, then either the appraiser or appraisee would be within their rights to decline to discuss the issue.

When there is a problem

If a problem arises from the information in the appraisal folder, the appraiser should prepare well prior to the meeting. If there is an apparent performance problem, it will be necessary to decide whether this is due to inadequate knowledge or an inability to apply the knowledge. In a case of procedures, there may also be an issue of competence. The appraiser should carefully consider whether under-performance might be due to inadequate resources. If the appraisee has not already recognised the issue then an important role of appraisal will be to help the appraisee to gain insight, an essential prerequisite to negotiating resolution.

If the problem is one of attitude, it is often more difficult to negotiate change. Problems that might be identified include difficult working relationships with colleagues, poor team working, lack of compliance with agreed protocols or lack of achievement of objectives.

Whether the problems relate to performance or attitude, the appraiser, either alone or in consultation with others, must decide how important it is to resolve the issue. This is especially relevant if there is a potential for conflict arising during the discussion. Most people go through a complex series of emotional reactions before they will accept the need to change and it will often be helpful for the appraiser to indicate any concerns well in advance of the appraisal meeting. If the appraisee has seriously reflected on the information then the phases of shock, denial and emotional defence may have been dealt with before the meeting, making it easier to identify a way forward.

When there is little insight, it may be necessary to consider the evidence in detail and to state clearly the problem and its effects or consequences. Once the problem and the need for change are accepted, it is helpful to encourage the appraisee to use his/her experience to identify a way forward and motivate change. Attitude problems are often the most difficult to resolve and the appraiser may find it impossible to achieve agreement on the nature of the problem or an appropriate way forward. If it is important that the issue should be resolved, a further meeting mediated by a third party such as the clinical director, medical director or a mentor may be necessary.

Outcomes of appraisal

The most important outcomes will be an appropriate personal development plan and revalidation. Before leaving the meeting, the appraiser should have agreed the interpretation of the information in the appraisal folder, reflecting this back to the appraisee to ensure that the outcomes are mutually understood. The appraiser and appraisee should identify and agree SMART goals, ie Specific, Measurable, Achievable, Realistic goals deliverable within an agreed Time. These may relate to the personal

aspirations of the appraisee, planning of appropriate continuing professional development, service development in line with local objectives, or resolution of problems arising from the appraisal. The appraiser obviously cannot and should not commit resources that are not available or achievable within the agreed time span. When resource is an issue, it will be important to identify the service benefits of any proposed development and to use the outcome of appraisal to prioritise planning within the directorate.

A final issue is the nature of the summary of appraisal discussion. This serves two principal purposes. First, it acts as a comprehensive summary of the issues discussed, which may be important if there is a dispute at a later date, and is a useful starting point in preparation for next year's appraisal. Secondly,

a comprehensive summary that lists the evidence discussed and provides an interpretation will provide a painless route to revalidation for most consultants.

Reference

- 1 General Medical Council. *Good medical practice*. London: GMC, 1998.