



PEARL

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Published in:

Journal of Continuing Education in the Health Professions

DOI:

[10.1097/ceh.000000000000167](https://doi.org/10.1097/ceh.000000000000167)

Publication date:

2017

Link:

[Link to publication in PEARL](#)

Citation for published version (APA):

Price, T., & Archer, J. (2017). UK Policy on Doctor Remediation: Trajectories and Challenges. *Journal of Continuing Education in the Health Professions*, 37(3), 207-211. <https://doi.org/10.1097/ceh.000000000000167>

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The United Kingdom's policy on doctor remediation: trajectories and challenges

Abstract

Around the world policy-makers, academics and health service professionals have become increasingly aware of the importance of remediation, the process by which poor performance is “remedied”, as part of the changing landscape of medical regulation. It is therefore an opportune time to critique the United Kingdom’s (UK) experience with remediation policy. This article frames, for the first time, UK remediation policy as developing from a central policy aim that was articulated in the 1990s: to accelerate the identification of underperformance and, subsequently, remedy any problems identified as soon as possible. In pursuit of this aim three policy trajectories have emerged: professionalising and standardising remediation provision; linking remediation with other forms of regulation, namely relicensure (known in the UK as *medical revalidation*); and fostering obligations for doctors to report themselves and others for remediation needs. The operationalisation of policy along these trajectories, and the challenges that have arisen, has relevance for anyone seeking to understand or indeed improve remediation practices within any healthcare system. It is argued here that the UK serves as an example of the more general challenges posed by seeking to integrate remediation policy within broader frameworks of medical governance, in particular systems of relicensure, and the need to develop a solid evidence base for remediation practices.

Introduction

Globally, the systems in place to address remediation vary, both between and within countries, but within “western” medicine there has been an identifiable trend towards increasing the accountability of medical practitioners. This trend was identified in the medical education literature by the late 1990s and involved the expansion of regulatory bodies to deal with practices that had traditionally been beyond their remit.¹⁻³ Yet beyond the broader goal of increasing the accountability of medical practitioners, there remains global diversity in terms of how different systems address performance concerns.

Humphrey, in a 2010 study, compiled evidence of the types of remediation and assessment available across 15 different systems in five Anglophone countries, finding, “variation in the formality, intensity and rigor of remediation activities”.^{4, p.35}

While the UK’s experience as a whole may be considered relatively unique, the individual policies that comprise the UK’s approach are found in healthcare systems around the world. Therefore, the way in which the UK has combined and linked these systems to address the issue of doctor underperformance, and the challenges that have arisen, has relevance for anyone seeking to understand or indeed improve remediation practices within any healthcare system.

Framing developments in terms of policy trajectories requires us to think of policy not just in terms of a snap-shot of what is happening at a particular moment in time in a given policy area, but where the impetus came from, its direction of travel, and the implications for how we expect policy to develop if, as can be reasonably assumed, it continues to move along the same path.

We focus here on remediating medical performance, rather than issues of health (rehabilitation) or conduct. While these issues, particularly practitioner health, cannot be divorced from issues of medical competence, it is the increasing focus on lower level performance concerns that has characterised regulatory change.

Background

Remediation is a process by which a sub-optimal situation is “remedied”, i.e. cured, through a particular action. Consistent with the wider usage of the term, within medical education Cohen, Rhydderch and Cooper define remediation as “an intervention, or suite of interventions, required in response to assessment against threshold standards of performance”.^{5, p. 433} As the term implies, the aim is to remedy the problem and return the doctor to safe practice.

However, in the mid-1990s the concept of remedy was lacking in the UK’s approach to underperformance in doctors. A series of medical scandals, coupled with a more general shift in societal attitudes to medicine, meant that regulatory deficiencies in the UK system received increasing public and political attention. The incoming Labour government in 1997 argued that performance problems were, “seldom seen as an opportunity to initiate educational or remedial solutions..., they are dealt with as punishable offences”.^{6, p.19}

Accordingly, the government argued that there was an urgent need to address performance concerns at a much earlier stage and thus to, “reduce the need for legal involvement and for lengthy, expensive suspensions”, which in 1999 were calculated at a cost of £2.5 million.^{6, p.}

⁷⁷ The resulting policy aim was clear and coherent: identify and if possible remedy performance concerns as early as possible once such concerns have been detected.

In pursuit of this aim, policy has developed along three trajectories, each of which is discussed below.

Policy trajectory 1: Professionalising and standardising

A clear policy trajectory has developed around the objective to professionalise and standardise the identification and remediation of poor medical performance. A significant first step in this respect was establishing a bespoke advisory and assessment service. The National Clinical Assessment Authority, which later became the National Clinical Assessment Service (NCAS), was set up in the spring of 2001. It offers advice and guidance to employers on addressing performance concerns related to doctors, later expanded to cover dentists and pharmacists. In around 10% of cases, where advice and support is insufficient, NCAS undertakes a full clinical performance assessment to ascertain the nature of the performance concerns.⁷ NCAS assessments are rigorous and multi-faceted, assessing the clinician's occupational health, behaviour and clinical competence.⁷ NCAS also provides prescriptive guidance for employing organisations for returning doctors and dentists to safe professional practice.⁸⁻¹⁰

Having established the advisory and assessment service, the government then sought to instigate reform within healthcare organisations aimed at focusing their efforts to address remediation concerns. This included the 2009 report, *Tackling Concerns Locally*, the report of the working group of the same name, which explicitly outlined the responsibility of healthcare organisations to, "establish systems for collating and analysing a variety of

sources relating to potential early warning signs of poor performance” and to develop, “quality assured and resourced strategy for remediation, reskilling and rehabilitation where this is appropriate”.^{11, p.9}

Yet despite a significant increase in the number of organisations reporting that they have official remediation policies in place¹², standardising and professionalising remediation has not been a smooth process. A 2011 report by the Department of Health noted that, although there were identifiable areas of good practice, many of the problems identified in the late 1990s, concerning a reliance on informal mechanisms to address performance concerns, were still perceived to exist. There remained, the Report argued, “a lack of consistency in how organisations tackle doctors who have performance issues”.^{13, p. 31}

To address this lack of consistency, the 2011 Report argued that postgraduate deaneries, which supported doctors in training (residents), “may be in a good position to assist in the sourcing of remedial placements for doctors not in training grades.”^{13, p.38} This idea received the support of the Academy of Medical Royal Colleges in 2013, which argued that professional support units, which were attached to deaneries, could be further developed to bring together expertise from the deaneries, NCAS, and the regulator (The General Medical Council (GMC)) and provide remediation services which could effectively be purchased by employers.^{14,15} Such a development, it was argued, could help to “ensure consistent quality assurance of remediation processes.”^{14, p. 19}

However, since the reorganisation of the NHS and the formation of Health Education England (HEE), which now commissions undergraduate and postgraduate medical education in England, the progress has stalled or in some cases halted. The primary function of HEE is

to support trainee doctors through the four Local Education and Training Boards which serve as committees to HEE and replace the old structure of local deaneries. However, HEE has no indemnity cover for the provision of support for those doctors who have completed their training. In other words, if professional support units were to offer remediation services to doctors who have completed their training, then HEE may be legally accountable for any decision to return a doctor to practise after completing a remediation programme. There are currently ongoing discussions around linking some of the individual expertise that exists in the professional support units and making it available to doctors not in training, but doing so outside of the remits of HEE in order to get around the issue of HEE's indemnity.¹⁶

The current model of outsourcing remediation to local employers also faces the challenge of remediating poor performance that is caused by the workplace environment itself. There is increasing recognition of the role of teams and systems as determinants of medical performance¹⁷⁻¹⁹ and in the UK, NCAS research has highlighted the importance of the workplace environment as a contributory factor to poor performance in doctors.^{20,21} Over 80 percent of NCAS Action Plans following assessment include recommendations for changes to the workplace and NCAS offers a mediation service for those situations where team dynamics play a role in performance. Yet employers themselves rarely identify the workplace environment as a problem at the point of referral to NCAS and are not obliged to act on NCAS recommendations.²²

The challenge therefore will be to ensure that local employing organisations have the time and resources so that models of good practice, that recognise the environmental factors

that determine performance as well as the interplay between a practitioner's health and their clinical competence, are adopted at the local level. Forging closer links between employers and advisory bodies such as NCAS, as well as the professional support units linked to the postgraduate deaneries, may help further professionalise and standardise provision if practical and legal challenges can be overcome.

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Policy trajectory 2: Linking regulatory systems

Perhaps the most significant recent development in identifying remediation concerns has come with the introduction of medical revalidation, the UK's relicensing system for practising doctors. Introduced as a statutory requirement in 2012, medical revalidation is a distinctly centralised and top-down approach to medical regulation and has been driven by the perceived need to provide a robust response to exigent patient safety concerns.²⁴ Revalidation is a process whereby all UK doctors demonstrate to the regulator (the GMC) that they are fit to practise through collating evidence every five years from their annual performance appraisal.²⁴ Since the 2010 Medical Regulation (Responsible Officers) Act, each healthcare provider or employing organisation (known as a designated body) must have a Responsible Officer who is a senior doctor within the organisation.²⁵ The Responsible Officer then evaluates the portfolio of evidence and makes one of three decisions: a recommendation to the GMC for the doctor to be relicensed; a deferral pending further evidence; or a notice of non-engagement in the process. If underperformance is identified through the revalidation process, or through any other channel, then the Responsible

Officer has a statutory responsibility to ensure the designated body offers “training or retraining”, as well as rehabilitation if necessary.²⁵

Medical revalidation is thus set up as a proactive process, with the rationale being to identify training needs and address these needs through the process of medical appraisal, in order to prevent performance levels dipping below threshold standards. However, it also clearly has a reactive element, in that underperformance is identified and, preferably, remediated. Indeed, a central purpose of revalidation was to provide a framework in which it would become increasingly difficult for doctors to mask underperformance.²⁶ In theory, by linking professional development and performance management to a system of relicensing, the distinction between the proactive and reactive – the “good” and the “good enough” - is collapsed to become part of the same process.

However, it has not been that straightforward. From a pedagogic standpoint, the mechanisms and procedures that seek to drive up standards across the board are different to those that are designed to identify underperformance.²⁷ During the process of policy formation this was a cause of concern for some stakeholders, particularly those groups representing doctors such as the British Medical Association, which argued that revalidation would undermine the professional and supportive aspects of medical appraisal. Research conducted contemporaneously to the early piloting of revalidation in the UK found that stakeholders, who included the policy-makers involved, were ultimately confused over medical revalidation’s basic aims.²⁸

There have also been concerns raised as to whether medical revalidation identifies remediation needs. Prior to its introduction, it was estimated that the revalidation process would result in around 2% of GPs being classified as in need of remedial training²⁹, yet so far it has only resulted in a fraction of the forecasted numbers being identified.³⁰ However, this raises the question of what constitutes remediation. If enhanced processes of appraisal identify low level concerns which can be dealt with and addressed informally, this kind of activity would not show up as a formal remediation referral, or may negate the need for such a referral. It is therefore somewhat illogical to use the number of remediation referrals as a measure of the effectiveness of the revalidation process. Yet at the same time, it is clearly important to know whether relicensing systems can be effective in identifying instances where a doctor's performance is not meeting threshold standards (the regulatory function) as well as driving up standards overall (the professionalism function).

There are also some practical challenges that have arisen from the one-size fits all model of medical revalidation when it comes to identifying poor performance. Early findings of a comprehensive evaluation suggest that medical revalidation may struggle to capture the performance of doctors working for multiple organisations, including locum doctors.³¹ This relates to the difficulty associated with collating information across organisations so that the Responsible Officer can make an informed judgement in relation to the whole scope of a doctor's practise. This issue was also noted in a recent review of medical revalidation by Sir Keith Pearson.³²

While it is too early to evaluate the longer term impact of linking relicensing within an existing framework of professional appraisal, the lack of clarity in the aims and purposes of revalidation have hindered its effective integration into regulatory practice. Even if, in terms of its professional goals, revalidation proves to be effective, there remains a danger if it fails to fulfil its regulatory function of identifying poor performance: if there is a perception that revalidation identifies remediation needs amongst doctors when it does not, then the public and professional gaze may be diverted from an important issue that may require further regulatory reform.

Policy Trajectory 3: Fostering professional obligations of candour

Research suggests that a combination of factors, including power differentiations and authority gradients prevent healthcare professionals from “speaking up” when they encounter poor performance, even when there is perceived to be a direct threat to patient safety.³³ To address this issue, a further policy trajectory has emerged with the aim transforming the normative and legal structures concerning the duties of healthcare workers to report performance concerns.

In the past, keeping tight-lipped about concerns regarding colleagues was not only part of workplace culture in the UK, but was to some extent incorporated into official guidance for doctors.^{34, p. 5} This approach changed through the early 1990s and has evolved to have a far greater emphasis on patient safety. As early as 1999 the government had explicitly stated that doctors being “willing to report concerns about colleagues” would be a benchmark of the success of regulatory reform.^{6, p. 11} The GMC’s *Good Medical Practice* now outlines the

responsibility for doctors to, “take prompt action if [they] think that patient safety, dignity or comfort is being compromised”.³⁵, para. 25

Since then the duty to inform on colleagues whose professional practice is a cause for concern was given statutory footing in November 2014 with the introduction of a contractual “duty of candour” on all NHS staff.³⁶ Under this duty, doctors would be contractually obliged to report poor performance and could lose both their job and their registration if they fail to do so. This is a deliberate move to change the normative framework concerning what a doctor, or indeed any healthcare worker, “should do” when they witness what they perceive as incompetent practice, as well as altering the legal framework to establish consequences if they fail to do so.

The rationale behind the duty of candour legislation was to create an open environment in which NHS employees were honest about their own and others’ mistakes, so that these problems could be remedied at the earliest opportunity. However, a Lancet editorial in 2015 lamented a, “a culture of blame, fear, and intimidation in the UK's health system”.³⁷, p.829

And while the NHS has established guidelines for whistleblowing³⁸, there are concerns that the UK, like other comparable systems globally, has failed to adequately protect those doctors who raise concerns about colleagues.³⁹ This matters a great deal because if remediation is going to address issues of poor performance before they threaten patient safety, then it will be imperative that doctors, their employers and other colleagues perceive remediation as part of their professional duty rather than a threat to their professional identity.

This culture of fear is in part fuelled by the negative associations with remedial interventions; as recognised by the Steering Group on remediation, the term remediation has “negative connotations”.^{13, p.16} On one level this is somewhat counter-intuitive. Requiring remediation is, by definition, not failure; integral to the word itself, and thus the process it describes, is an assumption of the potential for “remedy”. And the reality is that the vast majority of doctors who go through a program of remediation continue to practise.⁴⁰

Yet the very definition of remediation makes it difficult to remove these negative associations. Remediation is concerned with *minimum* standards; it is not about good practice, but *good enough* practice. It does not therefore lend itself to the positive associations related to continuous professional development, with its emphasis on high, and improving, standards of care. This problem can be accentuated by the way remediation is presented in guidance documents. It has been noted that much of the postgraduate guidance on remediation frames the doctor as a “problem to be dealt with” as much as an individual in need of support.⁴¹

At a practical level the association between remediation and failure works against the identification of remediation needs.

Conclusion

Historically in the UK there was a dichotomous view of medical regulation where either a practitioner was considered competent and only required partaking in continuing professional development, or the practitioner was not competent and underwent the

stringent assessment and remediation processes of the regulator or its surrogate. The failings of this approach were evident by the mid-1990s and a clear policy aim was articulated: identify and remediate poor performance as soon as possible. Thus medical competence is now seen more as a continuum, where a series of interlinked regulatory processes have sought to engender the use of more frequent remedial interventions with a view to keeping doctors in practise and preventing problems from escalating. However, as policy has developed along the three trajectories described above, a number of challenges have arisen.

Professionalising and standardising remediation practices will only be effective to the extent that local employers embed effective systems into their own performance management procedures. This will be an issue for any regulatory system that seeks to implement change whilst avoiding the risk of developing unwieldy and costly bureaucracies.

NCAS is certainly a valued institution amongst NHS employers and serves as a good example of a regulatory body that provides both advice and support to employers as well as sophisticated assessment services on a relatively small budget. However, effective standardisation will also require that local employers have their own procedures in place to instigate the remediation action plans.

Linking the identification of remediation to other regulatory instruments such as relicensing has a clear logic, but relicensing systems like medical revalidation may have poor sensitivity when it comes to identifying performance concerns as they are based on a professional development rather than a regulatory model. This linkage may therefore compromise the professionalism focus of appraisal, and could be engendering misplaced confidence in the regulatory capacity of the relicensing system.

Any change within a healthcare system that seeks to foster obligations to report performance concerns will require concerted efforts to remove the stigma associated with requiring a remedial intervention and ensure that a duty of candour does not become a culture of blame and fear.

Perhaps most importantly, effective remediation requires a solid evidence base for remedial interventions, and currently that is somewhat lacking. A review by Hauer et al. in 2009 noted that there was, “a paucity of evidence to guide best practices of remediation in medical education at all levels.”^{42, p.1822} In the most recent systematic review, Cleland and colleagues in 2013 found that the existing body of literature on remediation gave, “no insight into what types of extra support work, or how much extra teaching is critical, in terms of developing learning”.^{43, p. 242} In this respect it is encouraging that, in the UK, NCAS is now developing new remediation models based on theories of behavioural change.²³ But in the opinion of the authors, future research on remediation should be directed at answering the question of what works in remediation, for whom, why and how. Answering these policy-relevant questions by developing an evidence base for remediation, and building a network of professional expertise to implement and evaluate remediation programs, will be central to developing a coherent and linked set of policies to guide the issue of poor performance within the current framework of medical regulation.

Lessons for practice

If remediation is to remain the responsibility of the local employers, advice and assessment services for remediation have to work with local organisations to develop effective remediation programmes based on models of best practice

Linking remediation with systems of relicensing can be challenging, especially in situations where a broad system of relicensing is not a sensitive measure of performance

Establishing an environment whereby doctors and other healthcare professionals feel comfortable reporting remediation needs may require proactive measures to remove the stigma associated with undergoing remediation

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