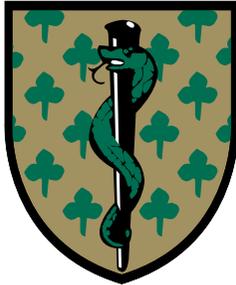


Performance in Practice

Maintenance of Professional Standards



The Medical Council
Comhairle na
nDochtúirí Leighis



**Irish Medical Council
Consensus Statement**

**Performance in Practice
Maintenance of Professional Standards**

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Foreword

Performance in Practice

Maintenance of Professional Standards

The Draft Medical Practitioners Bill proposes that the Medical Council shall "satisfy itself as to the ongoing maintenance of Professional Standards and competence of registered medical practitioners". This consensus statement outlines the scheme that the Council proposes to use in fulfilling this duty. The majority of doctors are practising for the benefit of their patients and going to great lengths to keep themselves up to date. This scheme will demonstrate this.

This consensus statement is the result of much work by many people including representatives of training bodies, doctors organisations and public interest advocacy groups. It is informed by international best practice and what is outlined is an accepted part of life for medical colleagues around the world.

I am pleased that this statement is being published during the public consultation period for the Draft Medical Practitioners Bill. Doctors have been concerned that recent negative media commentary would lead to the development of an environment in which even more was expected from them without the necessary support. The Draft Bill while stating the responsibilities of the Medical Council and of individual medical practitioners also delineates the responsibilities of employers. The Draft states the duty of the HSE to "facilitate the maintenance of professional standards and competence of registered medical practitioners". The new Medical Practitioners Act will protect confidentiality "in relation to participation in schemes relating to the maintenance of professional standards and competence". It will also give privilege to documents and witnesses in civil proceedings as regards information relating to participation in any scheme related to the maintenance of Professional Standards. I welcome such statutory support for the work doctors do and will continue to do in maintaining their competence.

I hope that all doctors will consider this document and give feedback to the Council. This development process will continue to be a co-operative one with an evolving scheme that promotes good practice, protects patients and is compatible with everyday clinical activities. Finally I thank Dr. Colm Quigley (Vice-President and Chairman of the Competence Assurance Committees) and Dr. Lynda Sisson (Director of Competence Assurance) for the work they put into the production of this document and for their ongoing leadership and commitment to the Performance in Practice development process.

John Hillery FRCPsych, FRCPI
President

Executive Summary

Introduction

The Medical Council opened the discussion on Competence Assurance Structures (CAS) in 1997. From there, many activities have taken place to develop this important area and formulate guidelines and procedures, in order that doctors' competence can be assured, therefore reinforcing the public trust in the medical profession.

Council has brought together the consensus opinion of the profession and developed the structures necessary to provide a system that will encourage and reinforce competence in doctors. This booklet, a Consensus Opinion Statement on Performance in Practice, Maintenance of Professional Standards, outlines the ways in which Council intends to structure competence assurance in doctors through reviewing their performance in practice. The recently published Heads of Bill for the new Medical Practitioners Act have indicated that these processes will be mandatory. Confidentiality and privilege will be preserved for all participants.

Council intends to establish a Performance in Practice Committee to oversee and implement the Performance in Practice (PIP) Structures. The PIP Structures can be broken down into three levels;

Continuing Quality Assurance

- All doctors will be asked to participate in a CQA programme (50 hours per year) and should align themselves with a Post Graduate Training Body (PGTB) where possible
- Council will monitor doctors who cannot align themselves with a PGTB
- Doctors should submit evidence of participation in educational activities to their monitoring body
- Doctors will be encouraged to participate in clinical audit and peer review activities as part of their ongoing education (up to 50% of their annual hourly total)
- Council will formally accredit the PGTB programmes on an ongoing basis

Professional Practice Review

- A pilot study will be carried out this autumn using a multi source feedback questionnaire, a quality improvement tool
- A number of general practitioners will be asked to volunteer to have their practice reviewed
- The doctor will nominate medical, non-medical peers and patients to fill out questionnaires
- A confidential summary of the results will be sent to the doctor
- Council will receive a collective statistical report and a confidential copy of the lowest five percentile
- If the pilot is successful, the program will be rolled out to other specialities in time

Performance Assessment

- If concerns are expressed about a doctor, a doctor may be asked to have his/her performance assessed
- The processes, standards, measurement tools, and report are currently being assessed as part of a pilot study
- A structured assessment will be carried by two trained peer assessors and one lay assessor
- Recommendations will be made for individual doctors accordingly

Performance in Practice

Introduction

The Medical Council opened the discussion on Competence Assurance Structures (CAS) in 1997. Problem doctors, internationally and nationally, had caused the media to question the competence and safety of doctors in Ireland and this, in turn, had seemed to undermine public trust in the Medical Profession.

The Council has always acknowledged that most doctors are practising competently and are working hard at keeping up to date. Unfortunately no method exists by which this can be proven. Doctors who have sat on Council are also aware that doctors who are sanctioned by the Fitness to Practise Procedures often come to the notice of Council when it is too late. By too late we mean too late for patients and too late for the doctors. It is no longer good enough that we have no means of manifesting the competence of doctors beyond their qualifying exams. It is also unacceptable that doctors who are having problems are only dealt with when they cause harm and when remediation for the doctor's problems is difficult if not impossible.

The aim of CAS is to demonstrate that the majority of Irish doctors are keeping up to date and competent, and to find doctors who are not, in order to prevent patient harm and to give those doctors an opportunity to prevent their practice falling below an acceptable standard.

Council and the Postgraduate Training Bodies (PGTB) have taken a proactive approach to the development and implementation of CAS for doctors, from as early as the 1990's. Since the publication of a strategy booklet in 2002 entitled 'An Agenda for Implementation', Council has overseen the introduction and ongoing development of comprehensive Continuing Medical Education (CME) and Continuing Professional Development (CPD) programmes by the PGTBs. Over the years Council has seen a broad acceptance and implementation of these concepts by the profession.

This document is intended to replace the above publication and forms the basis for the implementation of Council's Performance in Practice (PIP) strategy for the future.

The recent publication of the Lourdes Hospital Inquiry and the recommendations of Judge Harding Clark have served to highlight the importance of doctors maintaining competence. Doctors are responsible for keeping themselves up to date and fit to practise in all areas of their clinical practice. The implementation of a comprehensive PIP programme means that doctors will need to demonstrate regularly that they are doing this. The introduction of this programme in an encouraging and non-threatening way is essential. It is believed that most doctors already participate in some form of Continuing Quality Assurance (CQA) and so this is unlikely to be unduly onerous.

In Council's Guide to Ethical Conduct and Behaviour, doctors are reminded that where a risk exists in relation to a colleague's conduct or competence, there is a responsibility to act appropriately. Council also regards the maintenance of competence as a professional responsibility for every doctor.

It is now recommended that staying on the Register of Medical Specialists (RMS) will require evidence of maintenance of competence. Doctors will be required to be on either a training register or the RMS. It is recommended that the intern year becomes the first postgraduate training year and this will end the need for provisional registration. Council is also recommending that medical students be placed on a Council register.

Doctors who are out of active clinical practice may be required to prove that they have maintained their competence before returning to clinical practice. In exceptional cases, doctors will be allowed to stay on the general register e.g. those not in mainstream medical practice, full time medical journalists, doctors in pharmaceutical companies etc. although they are still expected to maintain competence in the usual way.

Despite the implementation of PIP, it is inevitable that some doctors will fail to meet acceptable standards. More objective ways of identifying and assessing performance have been developed and are currently employed in many developed countries. Existing mechanisms are currently inadequate to protect patients or to maintain public confidence in doctors who may be underperforming.

Under the 1978 Medical Practitioners Act, participation in CME, CPD or any of the following evaluation processes is voluntary. The recently published Heads of Bill for the next Medical Practitioners Act supports the developments outlined here and state that both doctors and employers have responsibilities with regard to their implementation. There is also reassurance with regard to the confidentiality of the processes.

This consensus document is the result of broad consultation with the profession, their representatives, their defence bodies and their postgraduate training bodies, as well as relevant stakeholders including the Department of Health and Children, the Health Service Executive, and representatives of those who employ doctors. Opinions have been sought from those who assess and support employees in non medical arenas as well as those who assess and support doctors in other jurisdictions.

Performance in Practice Committee

It is proposed that Council establish a committee known as the Performance in Practice Committee (PIPC). The Committee will oversee the implementation of the PIP strategy. It will have the proposed composition and terms of reference:

Proposed Composition of PIPC

- That the committee shall consist of a total of eight members - four doctors and four non-doctors
- One doctor nominated by the PGTBs
- One doctor nominated by the indemnity bodies
- One doctor nominated by the doctors representative bodies
- One doctor in training
- One non-doctor, selected and trained as a performance assessor
- One patient representative nominated by Council
- One person from the allied health professions nominated by Council
- That the committee be chaired by a non-doctor, a person with an outstanding public profile and record of public service.

Proposed Terms of Reference

- To accredit the PGTBs delivery of CQA Programmes for their members and associates
- To deliver and audit a CQA programme for those doctors not aligned to a PGTB
- To oversee the screening programme of random selection of doctors, Professional Practice Review (PPR), using a Multi - Source Feedback (MSF) tool, including appropriate analysis of results and recommendations when necessary
- To assign a level of concern (i.e. high or low) to cases referred from the PGTBs, the complaints process and/or screening processes and make recommendations accordingly
- To refer cases with a high level of concern for further evaluation including the assignment of a performance evaluation team and a case manager in accordance with accepted protocols
- To seek advice and guidance on complex cases from the PGTBs and others as required

- To make recommendations to Council with respect to best international practice in the area of PIP
- To manage an ongoing case load with appropriate follow-up, monitoring and case closure within accepted time frames
- To liaise with the Education and Training, Registration and Professional Standards Sections on related issues at all times

Performance in Practice Structures

Continuing Quality Assurance (CQA)

Continuing Medical Education/ Continuing Professional Development

Doctors must demonstrate that they are maintaining their skills in their clinical practice. Doctors already participate in lifelong learning to make sure that they are competent to practice. Most doctors participate regularly in educational activities on a voluntary basis. Doctors want to provide quality care for their patients and are motivated to learn.

At present doctors on the specialist register are enrolled in PIP programmes through their PGTB and are required to submit evidence of their participation in educational activities. Currently doctors are asked to participate in 50 hours of CME/CPD per annum or 250 hours in a 5 year period. PGTBs are expected to audit returns on a regular basis.

Extension of Current CQA programmes

Doctors on the general register have not been enrolled in a formal PIP programme although many participate in educational programs. All doctors will be asked to participate in a CQA programme, although it is recognised that not all doctors will be able to align themselves with a PGTB. Council will be directly responsible for overseeing the CQA programmes of those doctors who are not aligned with a PGTB.

Doctors will also be asked to include evidence of participation in peer review processes and clinical audit in their CQA portfolios, up to maximum of 25 hours per year out of an annual total of 50 hours of CQA.

Limitations of CME/CPD

Review of the literature suggests that CME alone has low validity as a measure of competence. Participation in CME has little effect on changing doctors' behaviour. There is no evidence that participating in research activities, publishing articles etc. has any effect on clinical competence. For CME to be effective it needs to reflect individual educational needs and take into consideration different personal learning styles and preferences. CME is thought to be more effective if used in combination with other activities. Importantly CME/CPD does little to identify poorly performing doctors.

Clinical Audit

Clinical audit can be defined as the *assessment, evaluation and improving the care of patients in a systematic way*.

Setting of standards, measurement of practice compared to 'gold standard', identification of deficiencies and addressing deficiencies (closing the loop) is an accepted model of clinical audit.

Examples of ways doctors can participate in clinical audit at a local level include:

- Analysing patient outcomes
- Analysing department outcomes
- Double reading scans or slides
- Patient satisfaction surveys

Participation in clinical audit can enhance quality of clinical services. Clinical audit at a local level, however, is limited and is more effective if used to measure established norms at national or international level. There is a need to focus on good quality practices and not just audit for audit sake. Organisations such as the Health Information and Quality Authority (HIQA) are pivotal in setting the national quality agenda for clinical audit and clinical governance. Individuals are encouraged and facilitated to participate in national programmes.

It is recognised that clinical audit is effective as a quality improvement tool, especially if part of a national clinical audit system. Clinical audit is not useful as a screening tool for competence, but may help to identify outliers in particular circumstances.

Peer Review

There are a range of peer review models in use in the international sphere. In fact several levels of performance evaluation using peer review are recognised. It can be a very effective way of assessing a doctor's performance. In some countries it is the only PIP tool used. The most widely accepted peer review programme is the Physician Assessment Review (PAR) in Alberta, Canada.

Peer Review can be defined as the *'Evaluation of the performance of individuals or groups by members of the same profession or team'*.

Doctors participate in local peer review activities on a daily basis although usually in an informal way. Examples of peer review include:

- Joint review of cases
- Review of charts
- Discussion groups
- Morbidity and Mortality Meetings
- Interdepartmental review of cases
- Formal feedback and guidance
- Multi-source feedback questionnaires

Accreditation of Programmes

The PGTBs implement CQA programs on behalf of Council and Council acknowledge the many difficulties in administering these programmes. In particular Council acknowledges the need for the proper resourcing of this function in both time and money, work that is currently carried out on a voluntary basis. It is expected that each PGTB will develop guidelines and core competencies that are specialty specific and in consultation with their members and Council. PGTBs will provide guidelines, assess and recognise courses and activities and audit returns for their members. Council acknowledges the goodwill, support and co-operation of the PGTBs in this regard.

Council will accredit the PGTB programmes using the CPD guidelines of the World Federation for Medical Education (WFME). Accreditation will take place on a five year cycle.

Processes for identifying underperforming doctors: Professional Practice Review

It is proposed that a random screening programme that reviews a doctor's practice be introduced. The proposed measurement tool is a Multi-Source Feedback (MSF) questionnaire. This tool will be piloted in a study in Autumn, 2006. PPR assists doctors in identifying areas in their everyday practices in which they can make improvements. Evidence from the literature would suggest that participants have found the feedback very useful.

Professional Practice Review - Pilot Study

The MSF questionnaire will be piloted in a study carried out this year and is outlined below:

Participants

- 200 general practitioners will be asked to volunteer for the project

The Process

- Volunteers will be contacted by Council who will ask them to nominate:
 - ◆ 8 medical colleagues
 - ◆ 8 non-medical colleagues
 - ◆ 25 patients
- Volunteers will also be asked to complete a short self-assessment questionnaire
- Council will send a questionnaire to each of the nominees
- Nominees will be asked to fill out a short questionnaire and return it to an independent data processing company
- Nominees will remain anonymous throughout the whole process
- Colleagues and patients will be informed that the evaluation is part of an ongoing quality programme for doctors and that no concerns have been expressed about their doctor

The Questionnaire

- Questionnaires are specialty-based and are being developed in conjunction with the Irish College of General Practitioners (ICGP)
- The questionnaires will rate doctors on a number of domains including patient care, communication/humanistic factors, clinical performance, professional development and other issues

The Report

- Volunteers will receive an individualised report on their performance

The Outcome

- Council will only receive reports on the lowest 5% percentile of those assessed
- Those about whom concerns are expressed will be referred to the PIPC of the Medical Council

- Volunteers will receive 3 CME points for their participation and are exempt from the PPR for 5 years
- Particular attention will be paid to assessing the complex processes in this screening programme
- The tool will be validated for the Irish context and used to establish Irish norms

Information Systems

- The pilot study will address the feasibility of filling out the questionnaire on line

Evaluation and Quality Improvement

- The pilot study will answer the question about the validity, acceptability, reliability and cost effectiveness of the questionnaire as a screening tool in the Irish context
- Feedback from all participants will be sought
- Issues such as confidentiality and accessibility will be explored

If the pilot study is successful, a project plan to roll out the PPR to the rest of the profession will be drafted.

Concerns about underperforming doctors: The Performance Evaluation Programme

Overview

The following questions need to be asked of doctors about whom concerns are expressed.

1. Is this doctor fit to practise without restrictions?
2. What is it about this doctor that led to these concerns?

The questions can be answered by carrying out a thorough performance evaluation. Doctors should be evaluated in the context of their practice.

- Environmental issues such as personal or family concerns, or organisational issues such as excessive workload may contribute to poor performance.
- A doctor's health may also affect his/her ability to practise safely and may also need to be assessed.
- Other behaviours and attitudes, including personality traits such as arrogance or over-conscientiousness, can sometimes contribute to poor performance and should also be considered.

Initial concerns about under-performing doctors should be dealt with at a local level, where possible, preferably with a local clinical hierarchy i.e. Clinical Director/Chairman of the Medical Board. It is only when local governance structures have been exhausted or when cases give serious concern that doctors should be referred to Council.

The processes whereby doctors are referred to PIPC will be developed during the pilot study on Performance Evaluation Programme (PEP) and Processes.

Evaluating Clinical Performance

Clinical capability should be evaluated in the context of the broader performance issues. It is recommended that a series of tools, already in use internationally, be identified and used in the evaluation of clinical performance. Evaluation of knowledge alone may not predict competency, and it is important that competency-based-evaluations are employed in the evaluation of performance. Performance evaluations will be carried out by trained peers and non-doctors as a part of a team-based evaluation.

Performance Assessors

Criteria for potential assessors have been drawn up.

- Successful applicants will have had previous experience in working as assessors in some capacity.
- A knowledge or familiarity with complex systems such as the healthcare system can be an advantage.

- Working with a team, yet being able to make independent judgements are critical qualities.
- Sensitivity and an open mind are essential to ensure fairness and transparency.

Potential medical and non-doctor assessors have been identified and are awaiting training. Medical assessors have been selected from general practitioner and hospital physician specialties. Training of other specialties will follow as a matter of course. Consideration will be given to employing performance assessors from other countries in the sub-specialities if it is found to be necessary.

Performance Evaluation Programme and Processes Pilot Study

The following will be evaluated and considered in a pilot study.

1. Criteria for use of evaluation tools

Evaluation tools must meet certain criteria if they are to achieve what they set out to achieve i.e. they must be valid and robust if challenged. They must be acceptable to patients and the profession as well as having a degree of credibility with the public. The evaluation must be sufficient yet proportionate. An effective tool will correctly diagnose deficiencies in underperforming doctors yet accurately show competence where no deficiencies are found. All measurement tools should be evaluated and their use monitored effectively.

2. Existing tools

The following tools are already available and are used regularly in various undergraduate and postgraduate evaluations. It is important to emphasise that although the tools are generic, specialty-based criteria may apply

- CPD audit
- Site Visit
- Evidence of participation in clinical audit
- Interview with doctor
- Chart/Record Review
- Prescribing Review
- Occupational Health Evaluation
- Occupational Psychology Evaluation

3. Tools in Development

The following tools are available and used internationally, and will be developed for the Irish context:

- MSF questionnaire and other peer review tools
- Case Based Oral assessments
- Direct Observation of Consultations
- Direct Observation of Procedural Skills

Other tools will continue to be assessed and developed as the programme evolves.

The tools for individual evaluations will be decided on a case-by-case basis but is likely to include a basic evaluation with add-on tools as appropriate.

4. Practice in Context

Evaluation of a doctor's environment or their personal circumstances may be necessary to establish the underlying causes of poor performance. Visits to workplace and communication with management may clarify some issues. Use of multi-source feedback tools may also be helpful in these situations. Sensitive questioning by an occupational psychologist may be necessary to fully understand a complex case.

Evaluation by an Occupational Health Physician and/or Mental Health Professionals is necessary in cases where a doctor's health may be affecting his/her performance. Each case must be considered on its individual components.

5. Performance Evaluation Team

The performance evaluation team will be nominated by the PIPC. Each case will also be assigned a case manager. Two peer assessors and one non-doctor assessor will form the team and will carry out the evaluation.

The doctor to be evaluated will be notified in advance as to the identities of the team members and the proposed evaluation tools. In exceptional cases the doctor may object to a particular member of the evaluation team or to a particular evaluation tool. The terms of the evaluation will be agreed in advance.

6. Evaluation Day

The performance evaluation will be carried out on site over a period of one to two days. The doctor will be expected to continue in his/her practice with the assessors acting as observers. The doctor will need to assign some time for an interview with the assessors or for some case based evaluation if this is part of the evaluation process. Assessors will use the evaluation tools to record evidence of good and poor practice.

7. The Report

A structured report with specific recommendations will be compiled by assessors following the evaluation, and this process will be facilitated by the case manager. A copy of the report will be sent to the doctor, and to PIPC for review.

8. Outcomes and Recommendations

There are a number of potential outcomes following a performance evaluation. International experience would suggest that there may be a combination of recommendations as a result of the evaluation.

Anticipated outcomes include:

- No further action
- No further action pending review
- Referral for remediation and re-training
- Referral for counselling/personal development programme
- Referral to Health Committee
- Referral to Professional Standards

The Study will examine these processes and recommend formal links with the various outcomes.

9. Monitoring and Case Closure

Each case will be closely monitored by both PIPC and the case manager. If a review is necessary a performance evaluation team may be reconvened at an appropriate juncture. Council will aim to close cases after appropriate remediation and monitoring at the earliest yet appropriate time.

The extended quality environment - Factors for the implementation of PIP

Legislation

The Medical Council was established and is operating under the Medical Practitioners Act of 1978. At time of writing the Heads of Bill for a new Medical Practitioners Act have been published and state that both doctors and employers have responsibilities as regards their implementation. The Heads of Bill can be viewed on the Department of Health and Children's website, www.dohc.ie.

Clinical Governance

The environment in which a doctor works will impact on his or her clinical performance. Allocated time and proper resourcing of audit, review systems, administrative support and information systems are critical if a quality environment is to thrive. Independent quality efforts need to be supported in a broader quality context, such as a clinical governance framework. Council is on the record as stating that the funding of such systems is essential in order to properly implement a quality programme such as PIP. Council recognises the role and leadership of HIQA in this regard.

Confidentiality/Privilege

The recently published Heads of Bill for the new Medical Practitioners Act indicates that confidentiality will be preserved in relation to participation in schemes relating to the maintenance of professional standards and competence.

In relation to civil proceedings, documents that are submitted in good faith relating to participation in the scheme will be privileged and therefore cannot be disclosed in discovery or admitted in evidence in litigation.

References

Continuing Quality Assurance

"Ten Principles for Continuing Professional Development"
The Academy of Medical Royal Colleges, December 2005

"Continuing Professional Development"
General Medical Council, UK, April 2004

"Continuing professional development and recertification"
Medical Council of New Zealand, October 2005

"Continuing Professional Development (CPD) of Medical Doctors - WFME Global Standards for Quality Improvement"
World Federation for Medical Education, 2003

Mapping the Processes

"Dealing with difficult doctors", BMJ Career Focus 2002

"Disciplinary Action by Medical Boards and Prior Behavior in Medical School", The New England Journal of Medicine 353; 25, 22nd December 2005

"Understanding Performance - difficulties in doctors", a National Clinical Evaluation Authority (NCAA) report November 2004

Random Screening - A Peer Review Tool

"Use of Peer Ratings to Evaluate Physician Performance", The Journal of the American Medical Association, 7th April 1993

"Physician Feedback About PAR" - 2nd Half 2005, prepared by Pivotal Research

"360 degree appraisal system for consultant psychiatrists" by the Royal College of Psychiatrists - Research & Training Unit, 30th November 2005

"RCOG Specimen 360° questionnaires - Patients", developed by Mr J P Calvert FRCOG on behalf of the RCOG, December 2003

"Patient Questionnaire" (Medical Specialist Instruments), College of Physicians and Surgeons, Province of Alberta, Physician Achievement Review

"Patient Questionnaire" (General Practitioner Instruments), College of Physicians and Surgeons, Province of Alberta, Physician Achievement Review
Learning in practice: Use of SPRAT for peer review of paediatricians in training, BMJ Journals 28th May 2005

"Multi-Source Feedback as an Evaluation in Appraisal", Paper prepared for AoMRC by Alastair Mason following the workshop held in January 2006

"Evaluation of physician performance in Alberta: the Physician Achievement Review", 1999 Canadian Medical Association (text and abstract)

"Guidelines for Using 360 Degree Evaluations" by the RCPI, 7th Draft - 06.01.2006

Performance evaluation

Learning in Practice: "Review of instruments for peer evaluation of physicians"
BMJ Journals 22nd May 2004

"What you can expect - The performance evaluation" by Medical Council of New Zealand, updated November 2005

"New South Wales Medical Board - Example 1", July 2005 and Annual Report 2004

"Appointment of Professional Medical Assessors - National Patient Safety Agency"
National Clinical Evaluation Service 2005

"Appointment of Professional Medical and Dental Assessors", National Patient Safety Agency, NCAS medical/dental assessor application form 2005

"Evaluation of physician performance in Alberta: the Physician Achievement Review, 1999 Canadian Medical Association (text and abstract)

"A Comparison of Performance Evaluation Programs for Medical Practitioners in Canada, Australia, New Zealand, and the United Kingdom", Academic Medicine (2003) 78: 837-843, © 2003 by the Association of American Medical Colleges

Education and debate: "Half of all doctors are below average" BMJ 1998; 316:1734-1736 (6 June)

Competence Assurance in a quality environment

"Making clinical governance work", Clinical Medicine Vol 5 No 2 March/April 2005

"Organisational interventions to reduce stress in health care professionals" by Lawrence R. Murphy, edited by Jenny Firth-Cozens and Roy L. Payne © 1999 John Wiley & Sons Ltd

"Team Resource Management and patient safety - A team focused approach to clinical governance", Clinical Governance: An International Journal, Vol. 11 No.1, 2006 pp. 58-68

Education and debate: "Making clinical governance work", BMJ Journals 2004; 329:679-681 (18 September)

Commentary: "Evaluating the culture of safety by J Firth-Cozens, Qual Saf Health Care 2003;12:401 © 2003 BMJ Publishing Group Ltd & Institute for Healthcare Improvement

Paper: "Leadership and the quality of care" by J Firth-Cozens, director and D Mowbray, consultant psychologist, Quality in Health Care 2001;10:ii3-ii7 © 2001 Quality in Health Care

Additional References

"Good Medical Practice" by the General Medical Council, UK, issued September 2001

"Core Attributes of a Medical Practitioner"

Perspective: "Medical Professionalism in the New Millennium: A Physician Charter", Annals of Internal Medicine, 5 February 2002/ Volume 136 Issue 3/ Pages 243-246

"Doctors in society - Medical professionalism in a changing world", Report of a Working Party, December 2005, Royal College of Physicians of London

"Defining and Assessing Professional Competence", JAMA (Journal of the American Medical Association, Vol. 287 No.2, January 9, 2002

"Understanding Doctors Performance", edited and © 2006 by Jim Cox, Jennifer King, Allen Hutchinson and Pauline McAvoy

"Stress in Health Professionals - Psychological and Organisational Causes and Interventions", edited by Jenny Firth-Cozens and Roy L. Payne, © 1999 by John Wiley & Sons Ltd

"Principles of good medical education and training" by the General Medical Council and PMETB, UK

"Competence Assurance Structures - An Agenda for Implementation" from the Medical Council's Working Group on Competence Assurance with input from the Advisory Committee on Competence Assurance, March 2002

"A Guide to Ethical Conduct and Behaviour" by the Medical Council Ireland, 6th Edition 2004

"Assuring the Quality of Medical Appraisal", Report of the NHS Clinical Governance Support Team Expert Group, NHS July 2005

"Guidance on Job Descriptions and Competences for Clinical Governance Lead Roles in Strategic Health Authorities and Acute Trusts", NHS March 2005

"An organization with a memory", Report of an expert group on learning from adverse events in the NHS, chaired by the Chief Medical Officer, Department of Health © Crown Copyright 2000

"A Protocol for the Investigation and Analysis of Clinical Incidents - Clinical Risk Unit & Alarm", University College London, September 1999

"A First Class Service - Quality in the new NHS", December 1997

6 **Media Links**

<http://www.par-program.org>

<http://www.mcnz.org.nz>

<http://www.ncas.npsa.nhs.uk/publications/toolkit>

<http://www.ncas.npsa.nhs.uk>

<http://www.hwac.govt.nz/publications/hwac-fitforpurpose-consultationdocument.pdf>

www.cpso.on.ca/info_physicians/peer.htm

<http://www.jcehp.com/>

<http://pmj.bmjournals.com/>

http://www.ncas.npsa.nhs.uk/site/media/documents/930_1.pdf

<http://www.ihsab.ie/links.html>

<http://www.racma.org.au>

<http://www.rcgp.org.uk>

<http://www.dohc.ie>