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Problem psychiatrists?

Neil Margerison

Abstract This article focuses mainly on issues regarding doctors' clinical performance (capability) and behaviour (conduct), and is aimed at medical managers who deal them. It covers identifying problems and how to manage them, describes typical underpinning (disciplinary) frameworks and sets out the role of the UK's National Clinical Assessment Service and other external bodies in more serious cases.

Information on 'problem doctors', and in particular 'problem psychiatrists', in the UK is limited. Some countries, for example Australia, Canada and the USA, have had a long-standing interest in concerns regarding doctors' clinical performance (capability), behaviour (conduct) and health. They are ahead of the UK in having developed physician health programmes that deal with these matters. For example, the Ontario Medical Association's programme, set up in 1995, addresses among other things what it calls 'disruptive behaviour in physicians' (Kaufman, 2005). The recent Department of Health White Paper *Trust, Assurance and Safety* (2007) looks to introduce such a service in England.

At present, concerns regarding National Health Service (NHS) doctors in the UK (excluding Scotland) may be referred to the National Clinical Assessment Service (NCAS, discussed below). During the first 6 years of its existence (2001–2006), NCAS received about 4000 referrals. About a fifth of these concerned physicians' health; the remaining four-fifths were divided equally between clinical (capability) and behavioural concerns – with a significant minority involving both. There was an excess of men and of psychiatrists among the cases. At any one time NCAS has nearly 300 active cases: relating to 0.2% of the 150 000 or so doctors practising in England and Wales. (For more detailed information on the first 4 years of referrals see National Clinical Assessment Service, 2006.)

When it comes to UK doctors removed from the Register of Medical Practitioners by the General Medical Council (GMC), there are as many cases involving dishonesty (sometimes linked to drug misuse) and improper sexual behaviour as there are involving inadequate clinical performance (see judgements of the GMC's fitness to practise panels: follow the link 'Concerns about doctors' at www.gmc-uk.org). It follows that it is (almost) as important for consultants, medical managers and their employing mental health organisations to find ways to help them identify and address conduct problems as it is problems regarding clinical standards.

Medical managers should feel confident about managing problems such those outlined in the two examples below. This article is intended to increase this confidence.

Example 1

A senior house officer (SHO) in old age psychiatry is regularly half an hour late for the start of her out-patient clinic. In addition, it has been noticed that she is sometimes late on other days. The team's medical secretary draws this to the attention of the consultant.

Example 2

A staff-grade doctor in community psychiatry does not write up case notes until several days after he has seen patients. The entries are often difficult to read and the mental state examination is sometimes incomplete.

Who are medical managers?

Medical managers are 'different' because they are obliged to make judgements about doctors who were previously their peers.

A brief aside is necessary to remind ourselves of who medical managers are. Essentially, a medical manager is anyone who has a prescribed role in relation to the work of other doctors. Usually this

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is defined in terms of some formal relationship. In most organisations, this is obvious with respect to the medical director, associate/deputy medical directors and any clinical directors. It may be less clear for lead consultants.

Anyone with a formal role in medical management needs to understand who is accountable to them – and for what. In some organisations, behavioural standards such as punctuality and good manners are the responsibility of a general (or divisional or service) manager, whereas clinical standards are the responsibility of the clinical director (or associate/deputy medical directors, etc.). In others, these responsibilities are combined in the role of the clinical director (or associate/deputy medical directors). Formal authority is clearly important, but any medical manager working with doctors would be foolish to try to separate clinical and behavioural issues: they come together in one person and often interact.

Medical managers work closely with general managers, especially in relation to clinical teams. Dealing with multidisciplinary teams and understanding the ever-changing roles of doctors within them are key skills.

Consultants sometimes do not see themselves as medical managers. Nevertheless, NHS consultants with junior doctors in their team – whether trainee, staff grade or associate specialist – are line managers for these individuals. In some organisations medical personnel (within the human resources department) do much of the work (NHS consultants rarely receive sickness certificates from their SHOs). However, the consultants have the formal authority and are required to act as line managers under the relevant policies of their organisations. When it comes to trainees this responsibility is shared with clinical tutors and the deaneries.

Mentors and coaches are not medical managers. However, when consultants act as locally approved appraisers for an organisation, they are acting on behalf of its management.

For the rest of this article I will mainly use the term 'clinical director' to cover all the various formal roles below that of medical director. I will also continue to write with reference to the NHS, although many of the principles are generalisable to other healthcare organisations.

Identifying problems and concerns

There is no great mystery about what is a problem or a concern, nor how to identify it – though this does take time and energy. When a doctor acknowledges a problem and wishes to overcome it, and works with their clinical director to resolve it, this can be highly satisfying for both parties.

Box 1 Sources of information identifying problems and concerns

- Complaints from patients and relatives
- Concerns raised by colleagues regarding untoward (critical) incidents and serious untoward incidents
- Routine monitoring of clinical performance
- Audit data
- Review of performance against job plan
- Appraisal (not to be relied on)
- Doctors' concerns about themselves

When a doctor denies or disputes a problem then what the clinical director knows or thinks they know counts for little: what matters is what evidence they have to confirm the allegation. It follows that to be effective, medical managers need to adopt a legal approach and mindset at times. This has similarities to the 'white hat thinking' described in Edward De Bono's *Six Thinking Hats* (De Bono, 2000). Clinical directors cannot be, and are not required to be, lawyers, but they will sometimes need to think like one.

Information about a problem regarding a doctor usually reaches the medical manager either after some sort of patient incident or from the doctor's colleagues (Box 1).

Complaints

> If you are not receiving any complaints, you are not seeing any patients.

Clinicians make mistakes and people (patients and their relatives) may complain. This is as it should be. Patients and relatives will also complain at other times, for example, during the course of a person's illness.

Each organisation will have a complaints policy, and *Good Medical Practice* (General Medical Council, 2006: para. 31) reminds everyone involved to respond promptly and openly. Clinical directors and general managers are usually asked to review or sign off the findings. Clinical directors will invariably discuss these with the consultant (and similarly consultants with their trainees).

Untoward incidents

Untoward (critical) incidents and serious untoward incidents are a normal and inevitable part of clinical medicine. In psychiatry, patient suicide is a regular

occurrence in every organisation and for many consultants. None the less, the capacity of a single suicide to upset and disturb even experienced clinicians is well recognised. It can also send shock waves up to the Board and back down.

More powerful still are homicides carried out by psychiatric patients. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (Appleby *et al*, 2006) provides an impressive overview of these occurrences in England and Wales. It reports that such homicides occur at a fairly steady rate of about 50 per year. They do not affect every trust and do not happen for some consultants in the whole of their career. However, bookshelves and journals are filled with the collected pain, persecution, guilt and self-recrimination of the many reports covering these incidents.

Such cases can become part of the local and national news – and of political agendas. The furore (and sometimes fury) associated with them is not the best place from which to make a reasoned assessment of the strengths and failings of an individual doctor. Sometimes the inquiry process will grind its way through the organisation and will leave behind its casualties. Medical directors who can keep their heads and their perspective during these times are likely to serve their colleagues well.

Every medical organisation will have a policy and process for addressing serious untoward incidents or malpractice claims. Invariably, lessons can and should be learned.

Concerns raised by colleagues

Concerns are often raised by colleagues. Staff communicate their concern about doctors in various ways. All clinicians must tolerate degrees of difference in working, priorities and behaviour. Sometimes staff work around someone whose decision-making they distrust or whose displeasure they wish to avoid. However, doctors who make poor clinical decisions, keep inadequate patient records, are repeatedly rude or have health problems will usually come to the attention of their medical managers through the staff that work with them. The responsibility to report such colleagues is clearly spelled out in *Good Medical Practice* (General Medical Council, 2006: paras 43–47).

The Department of Health's New Ways of Working initiative suggests more varied, more flexible and perhaps more limited roles for NHS consultants and other doctors within multidisciplinary teams (Care Services Improvement Partnership *et al*, 2005). Tensions and performance issues arising from this may come first to the attention of the team manager. This individual needs to have a sufficiently close working relationship with the relevant medical manager so that they can take a joint, united approach to addressing such concerns.

Monitoring of performance/audit data

Routine monitoring of performance and audit data does not feature strongly in the operation of many mental health services. There are no clear equivalents to wound infection rates and returns to theatre, or to the prescribing and other 'quality and outcomes framework' data considered in NHS general practice. This is unfortunate because it is human nature to wish to be compared to one's peers on shared criteria. And behavioural psychology shows that we respond and make changes when given appropriate feedback.

Review of performance

From a management perspective, one of the ideas behind consultant job planning in the NHS was to introduce clear, shared objectives. This seems to have happened only in limited ways (waiting-list targets for surgeons are a standard example) and hardly at all within mental health services. If a consultant fails to reach agreed job-plan targets, this may add further evidence to other concerns, but on its own it is unlikely to be sufficient grounds for concern. It should also be remembered that where objectives are set, these are increasingly team objectives. Achieving these depends on a well-knit, well-functioning team, of which the consultant is an integral part.

Appraisal

Appraisal 'must' be on the list but it is not a reliable source of concerns. There are various reasons for this. One is that the NHS appraisal system for consultants is generally appraisee led – and so the appraisee can leave out potentially difficult areas. More importantly, any significant concern should never be left to be discussed in appraisal: it should be acted on as soon as possible.

Concerns raised by doctors about themselves

There will be occasions when doctors themselves raise some issues of concern. This is to be expected in trainees (see 'Supervision' below) but is unusual among consultants and other grades. Health concerns should be the most common issue raised but all too often doctors may avoid mentioning this. Where a doctor does raise some concern about their clinical practice or perhaps about relationships with colleagues or patients, they have already taken the first steps towards resolving the problem.

NHS guidelines on professional standards

Current NHS medical managers in England who have been asked to deal with a concern about a doctor will already be aware of *Maintaining High Professional Standards in the Modern NHS* (MHPS; Department of Health, 2005), guidelines agreed between the Department of Health and the profession via the British Medical Association (BMA) in 2004 and introduced into all trusts in England in the summer of 2005. Strictly speaking, foundation trusts were not required to adopt these guidelines but I believe that most, if not all, have done so.

The MHPS guidelines provide a formal approach to the investigation of concerns, to ensuring public safety by restriction and exclusion (see below), and to dealing with identified problems of conduct (behaviour) and/or of capability (clinical performance). In describing how to deal with such problems, the guidance progresses towards and includes disciplinary action. Therefore, in most NHS organisations, these guidelines (which have replaced HC(9)90) form part of the disciplinary policy, although their scope is much wider than that.

I would encourage all doctors to become familiar with their local disciplinary policy, particularly with its 'informal' stages, as these are the ones that they are most likely to use. They should also be aware of MHPS (Box 2) and the kind of guidance that it offers. They can expect their medical staffing managers and staff in human resources to provide local expert knowledge.

Part I

Part I deals with the investigation of a concern. If a decision is made to proceed to formal investigation, it sets out roles for the case investigator, case manager and designated board member, as well as setting some time limits. There is a helpful distinction between gathering and compiling facts (the work of the case investigator, which must include the views of the doctor) and making a decision based on that evidence (the responsibility of the case manager).

Box 2 MHPS

- Part I – action when a concern arises
- Part II – restriction of practice and exclusion
- Part III – conduct hearings and disciplinary matters
- Part IV – procedures for dealing with issues of capability
- Part V – handling concerns about a practitioner's health
- Final section – guidance on 'clinical academics'

Part II

Part II is about restriction or exclusion, primarily in the interests of safety. Exclusion replaces the term 'suspension' for hospital doctors (but note that the GMC may still 'suspend' a doctor's registration). It warrants a special feature summarising the main points (Box 3).

Part III

Part III gives guidance on conduct hearings and disciplinary procedures. The main advice is to follow local policy. There is also guidance on what to do when a doctor has been arrested for or charged with a criminal act. In such cases the GMC must be informed (General Medical Council, 2006: para. 58).

Part IV

Part IV sets out in detail procedures for dealing with issues of capability. Clinical directors taking doctors through these procedures should ensure that someone (perhaps themselves) is responsible for sticking precisely to what is required and for recording everything. This includes recording reasons for delays and departures. Employment tribunals are likely to accept a trust's decisions, if honestly made, but will not allow failures to follow proper procedure.

The MHPS guidelines set out requirements that must be met before any case can reach a capability hearing: the case must have been discussed with NCAS, which must have considered the possibility of conducting its own assessment (see below).

Part V

Part V addresses concerns about a doctor's health, and specifies a key role for the occupational health service and occupational physician. As one would wish, the issue of any health concern should be dealt with first, before considering any disciplinary action.

Final section

The final section outlines specific guidance on addressing concerns regarding clinical academics

Box 3 Exclusion and restriction

The long-term 'suspension' of doctors was a scandal within the NHS. Some doctors were off work for several years – on full pay – without the original concern being resolved. New guidance (HSC 2003/012) was introduced by the Department of Health in 2003 to address the issue. This, and *Maintaining High Professional Standards in the Modern NHS* (MHPS), which superseded it in 2005, has resulted in a progressive reduction in the number of doctors in this situation, especially from the hospital sector, and the total is now about half the pre-2003 maximum.

Figures for England are monitored by NCAS. In 2005/06, 96 employed doctors and dentists (of whom 47 were consultants) were excluded (see below). This reduced to 68 (32 consultants) in 2006/07. The length of exclusions has also shown a downward trend, with 37% lasting less than 3 months in 2006/07, compared with 5% the previous year. Worryingly, earlier figures found that 18% of those excluded and suspended elected to resign from their post rather than complete any local investigation.

Exclusion

Part II of the professional standards report defines clear criteria for the use of exclusion – essentially linked to the safety of patients and/or staff. Immediate exclusion may be used for up to 14 days. The decision to progress to formal exclusion should be taken only after discussion with NCAS. Formal exclusion is limited to 4 weeks at a time: there must then be a review, including a further discussion with NCAS, before renewal. The firm objective is a maximum duration of 6 months. What the MHPS calls 'gardening leave' is not allowed.

Exclusion should be very much a last resort, but there are a few limited circumstances in which it may be needed, for example if the doctor:

- is unlikely to comply with the restrictions (e.g. insists on seeing patients, or interfering in clinical team meetings)
- might pose a risk to staff (e.g. alleged sexual assault of a member of staff)
- might interfere with the internal investigation (e.g. in alleged bullying or fraud cases).

Alternatives to exclusion

There are four main alternatives to exclusion:

- medical or clinical director supervision of normal contractual duties
- restricting the practitioner to certain forms of clinical duties
- restricting activities to administrative, research/audit, teaching and other educational duties
- sick leave for the investigation of specific health problems.

Restriction

The middle two alternatives above are forms of restricted practice and should normally be sufficient to protect patients even when clinical practice is very poor. After all, a doctor restricted to non-clinical duties should not be a risk to patients.

and provides an outline protocol for interactions between universities and NHS organisations. This kind of joined-up guidance is essential since clinical academics are almost always employed by a university.

Summary

The procedure that medical managers (or human resources managers) should follow in addressing concerns reported to them may be summarised fairly simply:

- investigate the concern – gather evidence, make a judgement about it
- ensure public safety while the investigation is underway – consider restriction or exclusion
- look into any health concerns – health almost always takes priority
- take appropriate action – remedial action or a conduct or capability procedure.

A parallel may be drawn with clinical management of a patient's illness (Box 4). Underlying these processes is the need to ensure the commitment of the doctor: this is akin to establishing some sort of therapeutic rapport.

Management of concerns and problems

Let us return to the case examples at the start of this article. Why is the SHO in example 1 consistently late? This would be an obvious question for many clinical directors. Those who are temperamentally inclined towards action need a word of caution. The doctor should not be late for work. The clinical director could simply tell her that this is unacceptable and if it happens again there will be consequences (presumably disciplinary). However, if her child care and travel arrangements make punctuality almost impossible, this response is provoking a potential

Box 4 Parallel between management of a performance concern and clinical management

Management of performance problem
- Concern expressed
- Investigation
- Consideration and decision-making (making a judgement)
- Action taken

Clinical management of illness
- Symptom of illness reported
- Diagnosis
- Review of options and discussion with patient
- Therapeutic intervention

crisis. Some other solution is needed. The clinical director needs to identify the underlying problem: treat the illness, not the symptom.

Why is the doctor in example 2 not completing case notes properly? Well, of course, he may be lazy and incompetent. But does he know what is expected of him? Sometimes this needs to be spelled out in very concrete terms. He might think that his typed letter to the GP is a sufficient record (it is not). He may be in the habit of recording only positive findings in mental state examinations and not recording the important negatives.

Local interventions

Once it is established that there is a concern, the intervention needs to match both the concern and the attitude and personality of the doctor. Let us consider some local interventions aimed at resolving concerns (Box 5).

Education – personal development plan

Gaps in knowledge or skills can usually be addressed through the doctor's personal development plan and someone (the clinical director?) must check that the deficiencies have been overcome. Better still (in suitable cases) the doctor concerned will write to the clinical director confirming their resolution.

Address conflict within team

Clinical errors (or problems) due to systemic failures are likely to require some sort of reorganisation of that element of the service (revising the care pathway – or business process re-engineering in technical language). The doctor will usually be keen to help. Sometimes it is necessary for the medical manager, working closely with the general manager, to address issues of team functioning such as clarifying roles and resolving underlying conflicts.

Performance management

Behavioural problems are traditionally more difficult to manage and yet there are some simple steps. The doctor should be told to 'stop it'. It helps to refer the individual concerned to the standards of clinical behaviour set in local policy (Kaufmann, 2005). The GMC's *Good Medical Practice* (General Medical Council, 2006) is also useful. The clinical director should write down as specifically as possible what they expect of the individual and they should set up some sort of monitoring or review (this can include self-monitoring).

It is important to remember that supporting evidence will be needed if it is decided to follow through with the 'or else' part of 'don't do it again'. If a clinical director says that they will take (further) disciplinary action if the doctor does not achieve certain standards then they must be prepared to do so – and should. This approach is often known as performance management. There are clear parallels with the approaches to improving standards embodied in clinical audit and the audit cycle.

Effective performance management includes providing appropriate support to the doctor. This is only right. Clinical directors should not be setting a doctor up to fail – a local employment tribunal will set a price for this sort of 'constructive dismissal'. Various supportive measures are possible. There has been a vogue for anger management and communication skills training. This has its place, but the lessons need to be applied in the workplace. There may be a clear role for a coach and/or a mentor, and perhaps a supervisor.

Box 5 Local interventions

- Education – personal development plan
- Address conflict within team
- Team objectives (and care pathways)
- Performance management
- Remedial action/retraining
- Disciplinary action
- Informal counselling
- Coaching and mentoring
- Supervision
- Career planning and advice
- Revised job plan
- Addressing health issues
- Reasonable adjustment (as per Disability Discrimination Act)

If a clinical director sets out clear standards to be met (and provides any necessary support) and the doctor still fails to meet them – the director will have been monitoring the results – the director must look into the problem again. The doctor may need some remedial training. There may be health or domestic problems affecting work.

Disciplinary action

The range of disciplinary action available will be set out in an organisation's policy. Most have an informal counselling stage at which the clinical director and doctor agree on the nature of the problem and that 'it won't happen again', and decide what sort of remedy (if any) is needed to help prevent recurrence. These informal actions should be recorded. More serious problems and cases in which there is dispute about what happened usually go to a disciplinary hearing or panel. The details of how these are conducted should be available from the human resources department. The outcomes are most often:

- no case to answer
- verbal warning
- written warning
- final written warning
- dismissal.

The implication of the final written warning is that if the doctor does it again, he or she will be dismissed. Healthcare organisations in the UK that dismiss a doctor should send their findings to the GMC. These written warnings are time limited, typically lasting for up to 12 months.

Coaching and mentoring

The Royal College of Psychiatrists provides training in coaching skills, through its Education and Training Centre, and has issued guidelines on the role of mentor (Dean, 2002). The NCAS Toolkit also offers information (follow the link from 'Developing' to 'Mentor and coach' at www.ncas.npsa.nhs.uk/toolkit). A coach will be more directive. For example, a clinical tutor struggling in the role would do well to ask another tutor for advice. The relationship with a mentor is a more reflective and 'mature' one. A mentor is likely to encourage the individual to explore such and such or to notice a pattern in their problem behaviour.

Supervision

My personal view is that supervision (Box 6) is underused as an aspect of good management. Those of us who work as educational supervisors are well aware of the opportunities for improving knowledge, for carrying out assessments (in accordance with Modernising Medical Careers) and for offering help in problem-solving. I believe that the majority of psychiatrists still see a place for teaching about transference and countertransference issues, and many would have this as a central theme, although not always using this language.

Box 6 Scope of supervision

- Knowledge
- Assessment
- Problem-solving
- Transference/countertransference
- Personal problems
- Health problems
- Career advice

How many psychiatrists, though, use supervision to provide an opportunity for their trainees to identify emotional, personal or health problems? Unhappy or overstressed doctors are more liable to underperform and make mistakes. It is not the role of a supervisor to treat such problems; but if the supervisor is aware of them, it is likely that (together) they will be able to overcome or at least manage them.

Career planning and advice

Some doctors do not suit psychiatry; others may be heading for burnout. Discussing current achievements and future plans is one way of identifying issues that need career advice (for most trainees their deanery can provide access to such a service). If a doctor's aspirations and current job diverge significantly, they are likely to find work increasingly mundane and be looking outside it for fulfilment. Career management is particularly important for consultants, because a career spanning 25 years or more is likely to need new challenges every few years and may benefit from some sort of 'winding down' in its later phases. The BMA is one of several organisations that provide this sort of career advice.

It follows that consultants can also benefit from regular supervision. Informal links with peers may work well, especially if they can find one-to-one time when it is needed. A consultants-only regular meeting is one way of providing the kind of ongoing consistent contact that makes it easier to ask for help, and also makes it easier to spot when a colleague may be struggling. Clinical directors are advised to pay extra attention to lone consultants. Isolation is associated with a number of risks.

Addressing health issues and disability

Health issues must be addressed, and in this local occupational health services play a key role. However, it can sometimes be difficult for occupational physicians (and nurses) to assess or deal with mental health problems in psychiatrists. Clinical directors may need to encourage or support them in making a referral to a specialist: usually a consultant psychiatrist or consultant clinical psychologist (sometimes both).

Occupational health services should also be able to advise on the application of the appropriate disability discrimination legislation (e.g. the Disability Discrimination Act 2005) and the need to make 'reasonable adjustments' to working conditions.

Transference issues

Medical managers are, of course, only human. They have to deal with sometimes infuriating and frustrating individuals; they can overreact when an allegation or concern is raised. Box 7 offers a fictitious scenario in which a clinical director expresses her thoughts and advice regarding an allegation against a colleague for accessing pornographic websites during at work.

There will be times when a doctor will take out a grievance or try to sue a trust or other employer. Sometimes, the people involved even feel under personal attack. Whatever a doctor may do or threaten, an NHS trust is required to behave properly: trusts are public bodies and are expected to uphold the values of the NHS and the laws of the land. Of course, the officers of such public bodies are also people. They need to be able to look after themselves and their emotions. Psychiatrists acting as clinical directors may be well placed to help non-clinical colleagues in this, so that collectively they can maintain fair and proper processes.

External help and advice

Box 8 lists some of the external bodies and resources that can be of help.

The National Clinical Assessment Service

Medical managers facing complex or worrying cases, or simply feeling out of their depth, would be well advised to contact the National Clinical Assessment Service (NCAS). This offers expert advice on how to handle the concern and how to manage any attendant risks. The discussion may also be a welcome aid to objectivity and proper process.

The service is a separate division within the National Patient Safety Agency, a special health

Box 7 Clinical vignette

A child and adolescent mental health service consultant in an NHS trust was noticed to be spending more and more time in his office, using the internet. An IT audit found that he was accessing pornographic sites during working hours and the matter was reported to the clinical director. Here are her initial thoughts on the problem.

'Cases involving sex always upset or anger people. The savvy manager – after their initial disappointment in the doctor – will be thinking along the following lines. IT audit: that's pretty strong evidence. Some sort of disciplinary action against the doctor for not working during working hours should be fairly straightforward. We need to check exactly what the IT policy says about accessing pornographic sites.

But if someone asks you "Was he accessing child pornography?", your response is likely to be rather different. Once the question has been raised, it won't go away. One natural reaction would be to exclude the doctor until you know the answer. And yet the evidence has not changed, just what you think it might mean.

Keep in mind that studies of young men (and women) suggest that viewing sexual material during work time is a common occurrence. Note that viewing child pornography is a criminal offence. If evidence suggests this – or there is a clear allegation – the police should be contacted.

As a medical manager you are required to be impartial. This may involve distancing yourself from the doctor. If that means that you suddenly stop talking to the doctor, you should explain what you are doing and why. It is not that you have made up your mind already – which the doctor may be only too ready to believe.

It is a good idea to talk to others and to avoid the potential trap of feeling under pressure to act "immediately".

If you do distance yourself from the doctor, or if you feel negatively towards him, you should remember that the trust still has a responsibility to him as an employee. You must ensure that someone is providing appropriate support and checking on his health. Usually human resources and your occupational health service will do this.'

Box 8 Useful external bodies

- National Clinical Assessment Service
- Medical defence organisations
- Police
- Counter-fraud services
- NHS trust solicitors
- Other medical directors
- Strategic health authorities
- General Medical Council

authority within the NHS. Advisors for NCAS are drawn from a range of senior and experienced clinicians, managers and medical managers. The London office, covering England, employs about ten secondary care advisors (all working part-time) for acute and mental health trusts, and a similar number of primary care advisors. There are smaller offices in Cardiff (covering Wales) and Lisburn (Northern Ireland). At the time of writing Scotland is not covered, although NCAS does provide some input on a case-by-case basis.

The offices deal with about 50–60 cases (including dental) each month. Roughly 60% of these receive telephone advice and support; about 30% require meetings with the trusts and doctors concerned. The remaining 10% or so are beyond local resolution or require more detailed understanding and formal recommendations from an external body; these are considered for a specially designed NCAS assessment.

More information about what is involved can be found on the NCAS website (www.ncas.npsa.nhs.uk/aboutus/whatwedo/assessmethods).

Most medical Royal Colleges, including the Royal College of Psychiatrists, also consider requests to review the work of a doctor and/or their department.

Calls to NCAS mainly come from medical/clinical directors and human resources directors, as well as medical staffing managers. Self-referrals (i.e. doctors referring themselves) are also accepted, but NCAS will wish to work with both the doctor and their employing trust. It does not provide a service for isolated (unemployed) individual doctors or for those working for private organisations. Also note that sometimes a deanery can act as a doctor's employer.

Medical defence organisations

Medical managers should all be members of medical defence organisations. These provide telephone helpline services and can respond quickly to urgent calls. They provide excellent advice, which they will, if necessary, confirm in writing.

Police

Some acts committed (or allegedly committed) by doctors are criminal offences. For example, within my own case-load as an NCAS advisor referrals for indecent assaults on patients or on staff are not uncommon. The police should be contacted. They may ask for any local organisation's investigation to be suspended until they have completed their inquiries.

Counter-fraud services

It is usually necessary to contact the local counter-fraud service if a case involves financial or similar irregularities.

Trust solicitors

All NHS trusts have their own legal advisors. This can be extremely helpful on those few occasions when only they can provide the advice you need. Access to a trust's solicitors is likely to be restricted (it has a cost) via one of the executive directors, but the medical manager should already be discussing the case with the medical director and chief executive.

Other medical directors

It is unlikely that a medical manager is facing a new problem. Some areas have their own local networks of mental health medical directors who meet regularly. The Royal College of Psychiatrists also has such a group, the Medical Managers Network.

Strategic health authorities

Each strategic health authority has a clinical governance lead or someone similar, often a director of public health, who usually has experience of issues regarding 'problem doctors'. The strategic health authority is responsible for issuing 'alert notices', which are addressed to NCAS and state that a named individual poses a significant risk of harm to patients, staff or the public and may seek work in the NHS (Department of Health, 2006).

The GMC

My sense is that medical managers have a mild aversion to contacting the GMC, as if whatever they tell them will amount to the referral of a doctor and all that follows after that. This is unfortunate because the GMC has a great deal of experience in dealing with more serious conduct and capability issues as well as the consequences of ill health. It is quite possible to discuss a case in general terms.

Table 1 Outcomes of 303 hearings of the GMC's fitness to practise panels

Outcome	*n*	%
Erasure	54	18
Suspension	96	32
Conditions	65	21
Undertakings	8	3
Warning	16	5
Reprimand	1	
Impairment, no action	8	3
No impairment	52	17
Voluntary erasure	3	1

Source: General Medical Council, 2006.

The GMC deals with about 5000 fitness to practise enquiries a year (General Medical Council, 2007). Almost half of these are closed after triage (47% in 2006). There were about 300 hearings before a fitness to practise panel in 2006. The relatively wide range of outcomes to these are set out in Table 1.

Conclusions

All psychiatrists should expect to deal with complaints about their practice. Similarly, all medical managers should expect to deal with concerns about the doctors for whom they are responsible. Most of these problems, once identified, will be reasonably straightforward to address, especially with the cooperation of the doctor. Sometimes the informal part of local disciplinary policy should be used. More difficult problems benefit from time taken to understand what may be underlying them. There is a fairly wide range of possible local interventions, including performance management, when the problems are particularly stubborn.

There are a number of external sources of help for more serious or more worrying cases. These include NCAS. Other resources are set out in Box 9. In addition, organisations might be encouraged to set up an 'action learning set' (or something similar) for all the medical managers within it, or individual managers might consider adopting a medical director (or ex-medical director) as a mentor.

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Declaration of interest

None.

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Box 9 Resources

Royal College of Psychiatrists www.rcpsych.ac.uk	The College has a Management in Psychiatry Special Interest Group for medical managers, and the Education and Training Centre runs regular training courses in aspects of management such as management skills training (www.rcpsych.ac.uk/researchandtrainingunit/educationandtrainingcentre/courses.aspx). Publications include *Management for Psychiatrists* (Bhugra *et al*, 2007)
British Association of Medical Managers www.bamm.co.uk	Has some excellent material, and offers training courses and a wealth of experience
General Medical Council www.gmc-uk.org	Carries a good deal of information on its website
National Clinical Assessment Service www.ncas.npsa.nhs.uk/resources	Offers a number of resources, including its own publications (which may be downloaded) and a toolkit for referrers and managers
Articles	Articles regularly appear in *BMJ Careers* and in *Hospital Doctor*: see, for example, Houghton (2006) and other articles listed at www.workinglives.co.uk/articles.htm

Bhugra, D., Bell, S. & Burns, A. (eds) (2007) *Management for Psychiatrists* (3rd edn). Gaskell.
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National Clinical Assessment Service (2006) *Analysis of the First Four Years' Referral Data*. NPSA (http://www.ncas.npsa.nhs.uk/site/media/documents/1424_NCAS_First_Four_Years.pdf).

MCQs

1 MHPS:
a applies throughout the UK
b deals with revalidation in Part II
c outlines disciplinary procedures in conduct cases in Part IV
d states that all exclusion cases should be referred to NCAS
e states that immediate exclusion can be for no more than 28 days.

2 NCAS:
a is a special health authority
b receives 600–700 referrals per year
c does not accept self-referrals
d carries out its own specialised assessment in the majority of cases
e provides support to doctors who are currently unemployed.

3 As regards sources of information identifying problems and concerns:
a health concerns and information from occupational health services are the most common
b the introduction of job planning has led to a rise in the number of identified concerns
c audit data provide a reliable method of identifying clinical concerns
d appraisal is an effective mechanism for identifying performance problems (including concerns about behaviour)
e local investigations should usually include input from a lawyer.

4 Managing performance problems and concerns:
a doctors should not try to resolve some problems themselves
b disciplinary action should be a last resort
c a coach will help the psychiatrist reflect on the problem
d performance management is an essential tool in dealing with behavioural problems
e most consultants receive regular supervision.

5 External bodies:
a 54% of GMC fitness to practise cases lead to erasure
b when a criminal act is alleged the trust should complete its investigation before notifying the police
c discussing a case with NCAS may help improve the clinical director's objectivity
d alert notices are issued by NCAS
e Scotland's Physician Health Programme has been running for over 10 years.

MCQ answers

1	2	3	4	5
a F	a F	a F	a F	a F
b F	b T	b F	b F	b F
c T	c F	c T	c F	c T
d F	d F	d F	d T	d F
e F	e F	e F	e F	e F