Appraisal standards in occupational medicine

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Abstract
Following a series of serious misdemeanours by British doctors, the General Medical Council (GMC) has introduced a system of re-licensing called ‘revalidation’. Annual medical appraisal forms an important cornerstone of the proposed system, but specific guidance is lacking on the content of appraisal for occupational physicians, and the kinds of evidence that they might bring to critical reviews of performance. Two educational bodies, the Revalidation Committee of the Faculty of Occupational Medicine, Royal College of Physicians and the Education Panel of the Society of Occupational Medicine, have jointly developed a set of recommendations on appraisal to further the process. In this paper we summarize the background and present the guidelines promulgated by the Faculty and the Society.

Key words
Appraisal; governance; professional standards; revalidation.

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Background
In April 2003, the General Medical Council (GMC), the regulatory body that maintains a statutory medical register in Britain, notified doctors of changes to the system designed to license their practice [1]. In the wake of serious professional misconduct by a few British doctors [2–8], and a rising expectation that health services and health professionals should be more accountable [9–17], the GMC introduced a new process of ‘revalidation’, under which renewal of a practitioner’s medical licence becomes contingent on evidence of continuing fitness to practice, submitted periodically to an external review panel [1,18].

The broad framework of the process and some core principles have been laid down [1]. All doctors must collect a folder of evidence to show that they uphold appropriate standards of medical knowledge, clinical care, behaviour, probity and health against benchmarks set out in general terms in the GMC guidance, Good Medical Practice [19]. The majority of British doctors have to undergo annual performance appraisal by medical line managers under their NHS arrangements for clinical governance, and the GMC has indicated that evidence of a satisfactory appraisal can be used to support revalidation [1]. But medical appraisal and revalidation are immature schemes, and many details of their workings within each specialty have still to be established.

In particular, the generic principles of Good Medical Practice, which were written for all doctors, have somehow to be translated into standards that are measurable and relevant to practitioners with very different daily responsibilities. For example, occupational physicians, in distinction to most other doctors, often consult in the context of routine preventive checks, or at the behest of employers, or to fulfil a statutory need; they have obligations to employers and groups of workers, as well as to individual patients; and they spend a good deal of time in advising on the health needs of the whole organization as well as the individuals who constitute it. Even the definition of a ‘patient’ needs specification to cover situations outwith the traditional model of personal consultation (e.g. the obligation to workers who may be affected by health-based policy decisions).

To aid interpretation of the GMC’s values, the Faculty of Occupational Medicine, Royal College of Physicians of London (FOM) developed and publicized Good Medical Practice for Occupational Physicians [20,21], a specialty-specific version of the GMC’s Good Medical Practice. This was necessarily a long and detailed...
document, borrowing where possible the original phrases of the GMC to emphasize the commonality of obligations as well as the differences. A need existed, therefore, to offer a more compact, accessible set of guidelines to facilitate self and external assessment. In this paper we describe a resource developed to bridge the gap, and to guide the content of appraisal in occupational medicine.

Two bodies contributed to the development of the guidelines reported here. In 1999, the Society of Occupational Medicine (SOM) established an Education Panel, with occupational physician representatives from industry, academia, the NHS, the military, and the independent sector, and also the Academic Dean and Director of Continuing Professional Development of the FOM. Patterns of working had changed radically in the run up to the Panel's inception, and it was tasked with defining the main competencies for contemporary occupational medical practice, and developing tools to assess and direct its members' educational needs.

In parallel, the FOM, which had been conducting its own review of training and competencies, established a Revalidation Committee to facilitate revalidation. The membership of the Committee was chosen to achieve a similar representation to that of the Panel and to include a member of the GMC. By intention and to promote shared working, five members belonged to both groups.

The panels were invited to address the GMC's requirements, and by common consent both groups fixed, as a first step, upon the need to develop speciality-specific guidelines on the content of appraisal, with emphasis on the kinds of evidence occupational physicians might bring to critical reviews of performance.

The basic framework for this guidance was laid in nine full meetings and two subcommittee meetings of the Panel, in which a list of important competencies was agreed and painstakingly rearranged to fit the headings of Good Medical Practice. Also, some competencies concerned with the managerial skills of medical managers were defined and added, and illustrative material was drawn from Good Medical Practice for Occupational Physicians [20] and from ideas supplied in a similar document being constructed by the Royal College of Physicians. Consensus was finally achieved between the two bodies, and their report was approved by the SOM's Council and the FOM's Board as well as by the GMC's committee representative.

The final guidance, Standards in Occupational Medical Practice: Guidance for Appraisal, was posted on the websites of the FOM and the SOM in June 2003 [22,23]. It is repeated here (with minor amendment), to reach a wider readership and to stimulate suggestions for improvement. We hope it may also be of interest to standard setters and members of the speciality overseas, in contemplation that their medical practice may one day be subject to stricter regulation.

The aim has been to encompass the practice of most occupational physicians and to make clear to their appraisers some essential differences between occupational medical practice and that in other disciplines. We believe the guidance is necessary in this respect, and timely in its aim of helping occupational physicians to fulfil an important but presently unfamiliar obligation.
Standards in Occupational Medical Practice: Guidance for Appraisal

Introduction
The purpose of this document is to guide those involved in appraising an occupational physician’s medical practice. The standards and examples of supporting evidence provided are based on the GMC’s framework, as adapted by the SOM’s Education Panel in consultation with the Revalidation Working Group of the FOM and the GMC. They also reflect the principles expressed in Good Medical Practice for Occupational Physicians [20], and this can be consulted as a further source of detailed advice.

They are illustrative of the standards that most specialists in occupational medicine maintain. However, this document does not seek to include every skill that an occupational physician may require. Also, because there is variation between physicians in the content of their work, the relevance of each standard to their personal practice may vary. Clearly, account should be taken of this in any formal appraisal of performance based on this document.

The focus here is on the content of appraisal, rather than the process or its documentation. Further guidance on process, on how to identify a suitable appraiser, and a set of recording forms, can be found in the FOM’s Revalidation Folder (Section 3B) [24]. However, in Appendix 1 (available as supplementary data at Occupational Medicine Online) of this guidance, a summary table is included that can be completed following appraisal to record the outcome and any identified learning needs. An identical table appears in the Revalidation Folder, the intention being that this guidance can be used as an aid to completing the Folder. Doctors who practice in the NHS or the Armed Services may use their institutions’ forms to summarize their appraisal and will not wish to duplicate; but they may still find it helpful to draw on this guidance in directing the content and context of their appraisal. Similarly, doctors in training and part-time non-specialists may wish to take account of these standards in any appraisal reviews they undergo, but at a level appropriate to their practice. (Appraisal for trainees will be encompassed by the RITA process.)

Some definitions
1. The term ‘patient’ is intended to include:
   - individuals who consult when they are obliged or requested to by third parties
   - workers undergoing routine preventive assessments
   - those attending a pre-employment or fitness to work assessment
   - individuals who consult of their own volition
   - individuals who may be affected by the occupational health advice given to employers, or by the health policies an occupational physician advocates
   - individuals who may use the health and safety services for which a doctor has management responsibility.

2. The term ‘colleague’ is meant to include fellow doctors and other occupational health care workers, and health and safety professionals.

Section 1. Good occupational medical practice

Range of activity: Occupational physicians will usually work in one of three basic settings: with individuals, with groups of people and with organizations.

1a. Working with individual patients

Standard: Normally occupational physicians should be able to:
1. make an adequate assessment of the patient’s health status (by history, physical examination, clinical procedures and relevant tests)
2. make an adequate assessment of the patient’s occupational health needs (by occupational history, physical examination, clinical procedures and relevant tests)
3. obtain or arrange for additional medical or paramedical information from specialists or relevant therapists
4. make a functional assessment of the patient’s physical and psychological capability for his job (or the job he might be asked to do)
5. make an assessment of the impact of a patient’s work on their health
6. make an assessment of the risk a patient’s health or fitness poses to the safety of themselves and others
7. provide patients with information on their health, its
occupational impact, and the steps needed to control and reduce their personal risks
8. communicate respectfully with patients and ensure that they are fully informed
9. provide advice on the relevant options for treatment, rehabilitation and redeployment
10. advise on the short and long-term modifications to a patient's work dictated by their state of health
11. keep a clear, accurate and contemporaneous patient record that details the clinical findings, the results of tests, reports given and received, decisions made and advice given to patients and others, and relevant details of treatments and referrals
12. involve other health and occupational health professionals where appropriate, including the patient's general practitioner
13. communicate with human resources and line managers about the patient in an ethical and meaningful way, while maintaining the important requirement of medical confidentiality
14. work within their limits.

Supporting evidence for 1a. Working with individual patients
The following are examples of the sort of evidence that will help to demonstrate that this competency has been achieved. None are mandatory and other kinds of proof may be acceptable, depending on personal practice.

- Records of audits of clinical activity covering:
  - reviews of clinical notes
  - reviews of letters of referral
  - reviews of the written procedures supporting clinical activity
  - reviews of patient feedback including complaints.
- Records of any audits conducted involving clinical outcomes.
- Minutes of meetings at which clinical audit was conducted or personal clinical performance was reviewed.
- Any routine indicators of performance—e.g. evidence to show compliance with medical policies or protocols; or that Personal Development Plan objectives have been met.
- Records of any lessons learned from dealing with patients or participation in critical reviews for this purpose.

Additional comments
1. Occupational physicians who care for patients should monitor their own clinical performance regularly through audit and structured peer-review with colleagues.
2. Assessment should occur against an explicit standard and any faults or concerns should be addressed.
3. Clinical notes and letters of referral to professional colleagues should make clear the current medical and occupational health needs of the patient.
4. The clinical notes they make should be legible and clear.
5. Letters to managers should enable them to understand the rationale for the advice given and (in so far as it relates to an individual) the occupational health needs of the patient.

1b. Working with groups of patients

Standard: Normally occupational physicians should be able to:

1. understand the nature of the hazards in the workplace settings for which they are responsible
2. assess the risks to the health in these settings (including risks to employees, contractors, temps, agency staff and members of the public) by:
   • ensuring appropriate data are collected
   • adopting a structured approach to site visits—to observe hazards, and workplace practices and behaviours
3. maintain adequate records of such data collection, site visits and assessments
4. advise on the measures required to control the health and safety risks arising from work activities
5. design and implement an effective programme of health surveillance where indicated, involving managers and patients' representatives in the process
6. provide additional sources of help for patients and effectively communicate such information to them
7. plan and organize for the health and safety needs of employees, including their need for health and safety training
8. provide advice on suitable programmes of health promotion for groups of employees.

Supporting evidence for 1b. Working with groups of patients
The following are examples of the sort of evidence that will help to demonstrate that this competency has been achieved. None are mandatory and other kinds of proof may be acceptable, depending on personal practice.

- Risk assessments made by the doctor in workplaces for which he or she has responsibility.
- Written reports by the doctor following site visits to workplaces.
- The findings of studies into the health of working groups for which the doctor has responsibility.
- Policies which the doctor follows that relate to the health of working groups (including, for example, their rationale and the basis on which they have been constructed and are assessed).
- Reviews of existing, or newly designed, programmes of health surveillance related to the doctor's practice.
(including, for example, their rationale and the basis on which they have been constructed and are assessed).

- Periodic reports by the doctor to management on the health of working groups.
- Surveys of patients and other consumers of the doctor’s service (see also Section 3).
- Minutes of reviews related to clinical governance, including any information on resulting changes in practice.

Additional comments

Where appropriate, occupational physicians should participate in clinical governance schemes.

1c. Working with organizations

Standard: Occupational physicians should normally:

1. be able to understand how their organization works in terms of: its structures, reporting lines and business cycles; the personnel, representatives and colleagues most closely connected with health and safety; and the working groups with special needs
2. know the main management processes, data and quality systems relevant to occupational medical practice—e.g. policies on sickness absence, rehabilitation and ill-health retirement—and relevant performance indicators
3. be able to advise on the data an organization needs to collect to assess its occupational health performance and requirements
4. be able to analyse and interpret the significance of such data
5. be able to report on it in ways that are accessible to managers, placing it within a business framework and also providing the medico-legal context
6. have a range of influencing styles that reflect the difference between medical and managerial concerns.

Supporting evidence for 1c. Working with organizations

The following are examples of the sort of evidence that will help to demonstrate that this competency has been achieved. None are mandatory and other kinds of proof may be acceptable, depending on personal practice.

- Health plans or business plans prepared by the doctor and which relate to health issues within their organization.
- Examples of evidence-based company advice that the doctor has given, or employs, in their dealings with managers.
- Examples of correspondence with managers or presentations to managers, illustrating the clarity and relevance with which the doctor communicates on health matters.
- Feedback from managers on the quality of the services a doctor provides and the employer’s satisfaction with service level agreements.

Section 2. Maintaining good medical practice

Range of activity: Occupational physicians should make and regularly review their own training plan and keep a log of all of their training activity. Current and anticipated areas of activity should be included. Their current practice should be subjected to systematic audit to ensure its high quality.

2a. Maintaining an appropriate knowledge base

Standard: Occupational physicians should:

1. regularly review their training needs
2. keep their knowledge and skills up to date and appropriate for all areas of practice
3. participate in regular educational activities that maintain and further develop their competence and performance
4. keep abreast of clinical developments relevant to their practice
5. keep abreast of the changes in legislation and codes of practice that affect their practice.

Supporting evidence for 2. Maintaining good medical practice

The following are examples of evidence that will help to demonstrate this competency. Other kinds of proof may also be acceptable.

2b. Auditing personal professional activities

Standard: Occupational physicians should:

1. understand the professional and managerial obligations to participate in medical audit
2. be aware of a range of audit processes and demonstrate the skills required to conduct audit
3. take part in regular medical and clinical audit and respond to the results of audit to improve their own practice
4. respond constructively to the outcome of reviews, assessments and appraisals of their own performance
5. take part in confidential enquiries and adverse event recognition and reporting organized by appropriate professional bodies; and also investigations of untoward incidents, injuries, adverse health outcomes and dangerous occurrences in the workplaces for which they have responsibility.

Supporting evidence for 2. Maintaining good medical practice

The following are examples of evidence that will help to demonstrate this competency. Other kinds of proof may also be acceptable.
CPD

- Participating in the FOM's scheme for Continuing Professional Development (CPD) and obtaining certificates to verify this (see below).
- Maintaining a folder of evidence on the activities undertaken (e.g. certificates of attendance, programmes from courses and other proofs).
- Maintaining a personal training plan and a training log to show sufficient training in fields relevant to the doctor's practice.

Additional comments

1. Occupational physicians have an obligation to participate in CPD.
2. They should keep documentary evidence of meeting the national minimum annual target of CPD (50 h per year averaged over a 5 year cycle—i.e. ~1 h per week). This should be in a balance appropriate to their work role.
3. The easiest route is to join in the FOM’s scheme and follow its rules (detailed guidance can be found by following links for CPD at www.facoccmed.ac.uk). Participants who submit annual returns will receive certificates to confirm this; periodically the FOM will conduct a formal audit of their records, and then supply an audit certificate. These pieces of evidence should be retained as proof of the activity.
4. The scheme also encourages appraisal of CPD activities. It recommends that, where possible the appraiser should countersign annual returns before they are submitted to the FOM, as confirmation of local review.

Audit

- Having a rolling audit plan that covers all of the relevant areas of a doctor's practice (Section 1a has some suggestions. Another useful list of ideas appears in the guidance to Section 3B of the FOM’s Revalidation Folder).
- Maintaining a record of the audits conducted as part of that plan.
- Keeping a record of the satisfactory completion of all remedial actions recommended as part of such audits.

Additional comments

1. Occupational physicians should audit their professional activities. They should aim, over a 5 year period, to conduct at least two audits in areas relevant to their work and demonstrate how the results have been used to assess (and if necessary improve) standards.
2. They should be able to produce paper records to show that audit is occurring and that they are assessing their performance against an explicit and reasonable standard. (Guidelines set by the FOM, other Royal Colleges and specialist societies can be used to provide a benchmark where they exist.)

Other evidence that you are keeping up to date

- Membership of learned societies and attendance at their meetings.
- New qualifications.
- Subscriptions to professional journals.
- Personally developed evidence-based protocols.
- Copy of Personal Development Plan.

Section 3. Relationships with patients

Range of Activity: Occupational physicians may deal with patients in the normal doctor–patient context and also when they act as advisors to their employers or third parties (e.g. trustees of their pension funds).

Standard: Occupational physicians who care for patients should:

1. Be honest, straightforward and courteous in dealing with patients.
2. Be aware of, and follow, the guidance of the GMC and the FOM on dealing with patients [19,20,25].
3. Actively seek feedback from patients on their performance.
4. Provide patients with a mechanism for raising objections or making complaints by maintaining a formal complaint procedure.
5. Follow written protocols in their practice that ensure the rights of patients are preserved, including:
   - obtaining informed consent whenever relevant
   - explaining the possible outcomes that may follow a consultation
   - ensuring that patients understand their rights when organizing referrals or requesting medical information from other practitioners, and that they agree to the disclosure of their information
   - observing the other rights of patients mentioned in the FOM’s guidance [20,25]
6. maintain contemporaneous, accurate, comprehensive and legible handwritten or computer notes on each patient
7. ensure that such notes are safely stored to preserve confidentiality.

Supporting evidence for 3. Relationships with patients

The following are examples of the sort of evidence that will help to demonstrate that this competency has been achieved. None are mandatory and other kinds of proof may be acceptable, depending on personal practice.
• A written Patient's Charter.
• A written complaint procedure.
• Records of the complaints received and actions taken.
• Record of written compliments received from patients.
• Patient surveys (see also Section 1b).
• Examples of standard handouts and information sheets given to patients to aid communication.
• Audits of performance relating to informed consent, medical confidentiality or the security of patient records.

Section 4. Acting as a medical manager

Range of activity: Occupational physicians may act as managers in two kinds of circumstance: first, as a member of, and sometimes the professional head of, an occupational health service; or secondly, as a normal manager in the business and commercial setting. As distinct from the second role, the first places additional responsibilities and restrictions on the doctor's behaviour, because the doctor is perceived as both a manager and a doctor.

4a. Special responsibilities of managing an occupational health service

To be effective as a manager or team leader of an occupational health service, an occupational physician needs to:

1. ensure that the operation of their occupational medical service remains independent of, although not isolated from, the business it serves
2. ensure that patients remain at the core of the service
3. ensure that processes have been established to safeguard the ethical operation of the service and to avoid potential conflicts of interest
4. ensure that team members work within their limitations; and that systems are in place to monitor and assist their performance and to support and train them
5. ensure that there is a proper reporting structure for professional activity
6. ensure that information about patients is securely maintained in order to preserve its medical confidentiality
7. monitor the standard of their service, striving for improvement.

Supporting evidence for 4a. Acting as a medical manager

The following are examples of the sort of evidence that will help to demonstrate that this competency has been achieved. None are mandatory and other kinds of proof may be acceptable, depending on personal practice.

4b. General managerial competency

On other occasions, occupational physicians may be called upon to act in a general managerial role. The following general managerial competencies will assist the doctor in the execution of these responsibilities and in maintaining their standing. Ability and willingness to:

1. analyse managerial problems critically, using relevant data so as to make effective plans and take effective decisions
2. plan ahead; make good use of possible resources; and see plans through to a finish, despite obstacles
3. work at developing their own personal skills as a manager of people and the skills of other team members
4. work to become an effective team member
5. develop their influencing skills and communicate effectively, by a range of techniques and in a variety of settings, (formal and informal, personal and public)
6. be flexible, innovative and adaptable to new circumstances
7. be aware of the impact their services have on the finances and business of their employer.

Supporting evidence for 4b. Acting as a general manager

• Participation in any form of performance review that addresses the main managerial skills required for the role, and is linked to a training programme.

Section 5. Working with colleagues

Range of activity: Occupational physicians regularly work with other doctors and health professionals.

Standard: Occupational physicians should:

1. treat colleagues fairly and not allow views they hold
of a colleague’s lifestyle, culture, beliefs, race, colour, sex, disability, sexuality or age to prejudice the professional relationship between them.

2. communicate effectively with colleagues and seek feedback from them on the occupational physician’s personal performance.

3. participate in regular reviews and audit of the standards and performance of the team and its members, and take steps to remedy any deficiency.

4. be willing to openly and supportively deal with problems in the performance, conduct or health of other team members.

Supporting evidence for 5. Working with colleagues

The following are examples of the sort of evidence that will help to demonstrate that this competency has been achieved. None are mandatory and other kinds of proof may be acceptable, depending on personal practice.

- Review of feedback on personal performance by colleagues, including peer questionnaires.
- Evidence of participation in regular reviews and audit of the standards of team performance, and where relevant a note of any remedial changes to improve performance.
- Written policy on dealing with conduct or performance issues in subordinates.
- See also supporting evidence for Section 4.

Section 6. Teaching, training, appraising and supervising

Range of activity: Occupational physicians may be involved in teaching and training staff, medical colleagues, or other professionals; and may have to supervise and appraise their colleagues.

Standard: Occupational physicians in these roles should:

1. contribute to the education and training of their colleagues.
2. develop the skills, attitudes and practices of a competent teacher.
3. keep up to date in the material that they teach.
4. ensure that junior colleagues and students are properly supervised.
5. be honest and objective when appraising or assessing the performance of colleagues they supervise or train.
6. provide honest and justifiable comments when providing references for colleagues or writing reports about them.

Supporting evidence for 6. Teaching, training, appraising and supervising

The following are examples of the sort of evidence that will help to demonstrate that this competency has been achieved. None are mandatory and other kinds of proof may be acceptable, depending on personal practice.

- Record of undergoing training for this purpose.
- Feedback on teaching the doctor has given.
- Examples of well-constructed teaching materials, demonstrating relevance, clarity and up to date knowledge.
- Evidence that the performance of junior colleagues is periodically appraised.

Section 7. Health and probity

Standard: Occupational physicians should:

1. avoid putting patients at risk as a result of their own ill-health or health concerns in their colleagues.
2. be honest and financially proper in their dealings with patients, employers and third parties.

Additional comments

Further information on these standards is set out in Good Medical Practice for Occupational Physicians [20].

Supporting evidence for 7. Health and probity

To show compliance, the occupational physician should:

- complete the model health and probity declarations from the FOM’s Revalidation Folder [reproduced in Appendix 2 (available as supplementary data at Occupational Medicine Online)].

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Appendices

Please note that the appendices are available as supplementary data at Occupational Medicine Online.