Regular practice review: promised joy or naught but grief and pain?

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Steinbeck took the title for his book *Of Mice and Men* from Robert Burns' poem *'To a mouse—on turning her up in her nest with the plough'*. The poem tells of an unfortunate field mouse whose home is destroyed by Burns' plough. Burns reassures the mouse that she is not alone (*'no thy-lane'*) in proving foresight vain, as the best-laid schemes of mice and men often go awry (*'gang aft agley'*). In this column, I consider whether the introduction of regular practice review is yet another well-laid scheme doomed to leave us naught but grief and pain for promised joy. I consider whether regular practice review (RPR) will help to improve quality and safety, and to assure the public that all practising doctors are competent and fit to practise, or whether it will merely increase the cost of health care, reduce access to care, and deepen mistrust in the medical profession.

Why introduce regular practice review?

High profile medical scandals in recent years, both internationally and in New Zealand, have contributed to increasing public concern about the adequacy of medical professional regulation, leading to calls for greater oversight and external scrutiny of the medical profession.[2,3] In response, the Medical Council of New Zealand has encouraged the development of more robust continuing professional development (CPD) programmes that include RPR, and the Council has made RPR compulsory for doctors on the general register as part of the newly approved Inpractice CPD programme.[4]

What is regular practice review?

Practice review is a supportive and collegial review of a doctor's practice in the doctor's usual practice setting. The review is an interactive process, generally involving one or two peers visiting over one or two days. The reviewer/s will usually interview the doctor, the doctor's colleagues, and (for general registrants) the doctor's collegial relationship provider. The reviewer will discuss the doctor's CPD activities, including continuing medical education (CME), peer review, audit, and multi-source or patient feedback. The reviewer will also observe the doctor in consultation with patients and/or performing procedures, review the doctor's medical records and clinical reasoning, and sometimes also review the doctor's prescribing and laboratory testing report.

Practice review is intended to be a formative process, with a focus on learning 'to help individual doctors identify areas where aspects of their performance could be improved'.[4] But while the Medical Council states that the 'primary purpose of RPR is to help maintain and improve standards of the profession', the Medical Council acknowledges that 'RPR may also assist in the identification of poor performance which may adversely affect patient care'.[4] A practice review may, then, result in a doctor being referred to the Medical Council for more thorough assessment.

The provision of feedback is critical to the success of practice review. Feedback from the reviewer to the doctor is used as a motivational

But, Mousie, thou art
no thy-lane,
In proving foresight
may be vain:
The best-laid schemes
o' mice an' men
Gang aft agley,
An' lea'e us nought
but grief an' pain,
For promis'd joy! [1]

The **ETHICS** column explores issues around practising ethically in primary health care and aims to encourage thoughtfulness about ethical dilemmas that we may face.

THIS ISSUE: Our guest ethicist and GP Katharine Wallis explores the potential benefits and costs of including regular practice review in professional development programmes.

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tool to improve performance, education and personal development.[5] To be successful, peer review must overcome self-protecting etiquette and be judgmental, while also being supportive.

The promised joy

Improving quality and safety

How could it not be helpful, for both doctors and reviewers, to spend time together in practice, talking and sharing learning? We know that doctors are generally not well-skilled at identifying their own learning needs. Having a peer sit in and observe for a day can provide a more objective assessment and help to identify areas for improvement. Regular practice review might also prompt self-reflection and self-care, thereby helping to improve the quality of care.[6] However, while it is assumed that RPR is beneficial, there is little evidence to show that the process does help to improve performance or to protect patient safety.[7–9] Further, even if RPR did help to improve individual performance, this would not greatly improve health care quality and safety, as the individualistic approach of RPR overlooks important determinants of quality and safety, including effective health care teams, and the context and systems that teams work in.[10,11]

Helping to assure the public

The Medical Council was not motivated to introduce RPR solely by quality and safety imperatives. The introduction of RPR was in response to public demand for increased oversight of the medical profession, to help assure the public that all practising doctors are competent and fit to practise, and to help boost perceived flagging trust in the medical profession.

However, there is no evidence that RPR does help to ensure ongoing competence and fitness to practise. It is possible that RPR might be providing false reassurance. The time spent in RPR could be 'time wasted in rituals of inspection'.[12] The introduction of RPR could be the Medical Council's attempt to be seen to be doing something while really doing nothing at all, or an attempt to transfer responsibility for failures.[13] The introduction of RPR could be what McGivern identified as the 'response of a self-interested regulator in a wider culture of blame'.[14]

There is also no evidence that RPR fosters trust in the profession. Rather than boosting trust, the introduction of RPR could foster distrust. As O'Neill has argued, accountability processes may simply deepen the mistrust they seek to remedy.[15] Trust and trustworthiness march to the beat of a different drum. In attempting to prove trustworthiness, such systems of surveillance risk undermining trust and implying mistrust (that doctors are not to be trusted; that unless they are watched they will be negligent, incompetent or psychopathic).[16] Thus, while more robust CPD programmes might help to demonstrate trustworthiness, they might also damage trust.[17–19] Wilson agrees, suggesting:

> Bioethicists now argue that the stress on oversight has damaged public trust and needs to be replaced by a focus on global health inequalities and a more 'principled autonomy'.[20]

In any case, yet more regulation may not be the answer to the perceived problem.[14] To gain trust, rather than demonstrating trustworthiness, a doctor may be better cultivating '... a friendliness and kindliness essential to gaining the confidence of the patient, and thus to convincing him [or her] of the physician's capability to heal.'[21] As Gawande noted recently, this is something salespeople (including drug reps) understand well:

> Evidence is not remotely enough, ... You must also apply 'the rule of seven touches.' Personally 'touch' the doctors seven times, and they will come to know you; if they know you, they might trust you; and, if they trust you, they will change.[22]

While it remains important that the profession demonstrate it is trustworthy through robust accountability processes, these processes should be designed to demonstrate trustworthiness, without damaging trust.

The grief and pain

Increased cost and reduced access to care

Any potential benefits of RPR come at a cost. The Dutch estimated their scheme of professional

visits cost over £60 million per annum.[23] The American Board of Medical Specialities charges up to US$10,500 for on-site visits.[24] In New Zealand, the Colleges and Branch Advisory Bodies generally charge in the order of a few thousand dollars for a visit, while for general registrants on the Inpractice programme, the cost of regular practice review is built into the programme membership fee. Any cost is inevitably passed on to patients or comes directly out of the health budget (District Health Boards pay the CPD programme membership fees for their employees, amounting to millions of dollars of the health budget each year).

There are also the opportunity costs of RPR. RPR redirects resources away from patient care—when doctors are reviewing other doctors' practice they are not seeing patients. Regular practice review may further reduce doctor availability by reducing the number of practising doctors. If RPR raises the bar, some doctors might not make it. This might be a good thing, to protect patients from poorly performing doctors, but RPR might also cause good doctors, who still have a lot to offer, to give up practice. Doctors might not endure the constant inspection, just as 'a fragile plant may not endure inspection of its roots, even when they were, before inspection, quite healthy'.[15] Getting rid of doctors and reducing their availability has implications for access to care.

Demoralising and demotivating

Even if RPR does not prompt an exit from the profession (even if doctors do endure), their performance might become worse rather than better following the introduction of RPR.

RPR adds yet another layer of bureaucracy to remaining in practice. Increasing surveillance risks demoralising and demotivating doctors and threatening compassion and professionalism.[17,25] Professionalism entails a commitment to medical knowledge and skill, to performing well for the benefit of others, to integrity, compassion, altruism, and continuous improvement.[26,27] The strength of professionalism lies in motivation. Professionalism is important for good patient care.

RPR might also add to the stress of being a doctor and contribute to burnout. While practice review is intended to be 'supportive and collegial', doctors can feel 'guilty until proven innocent', and a pending review may provoke anxiety and contribute to already high stress levels in doctors.[28,29]

An alternate joy?

Perhaps RPR might deliver some other unintended benefit? It is possible that RPR might help to foster a change in attitude in medicine. As long ago as 1983, McIntyre and Popper were calling for the development of a new attitude in medicine to improve patient care.[30] They called for a critical attitude to one's own work and that of others; an attitude of candour about the things that go wrong, a willingness to listen to criticism and to admit that one has erred, and a readiness to learn and to change. More recently, Francis, in his report into the shocking failures in health care at Mid-Staffordshire, called for a transformation in culture (attitudes and behaviour) to avoid repeat failures.[31]

Doctors are not used to performance appraisal. Many consider practice review a threat or an intrusion, rather than an opportunity to learn and to improve, and some find it difficult to accept critical feedback. But perhaps it is time that, as a profession, we learn to welcome and accept feedback and criticism?

The change to develop a critical attitude in medicine may not come naturally to doctors who are 'socialised to be collegial and non-confrontational'.[32] While it is not easy to change people's attitudes and behaviour, regulatory change has proved a powerful tool in the past. Consider, for example, the changes that followed the introduction of legislation requiring people to wear seatbelts. The legislative change led to a change in behaviour (people started wearing seatbelts) and then a change in attitude (today most people consider it unsafe to drive without wearing a seatbelt). It may be easier to act our way into a new way of thinking, than to think our way into a new way of acting. Festinger's cognitive dissonance theory explains the change in attitude following the change in behaviour.[33]

By requiring a change in behaviour (to undergo practice review and receive feedback), RPR might help to bring about a change in attitude (to welcome practice review and accept critical feedback as an opportunity to learn). As this doctor who had a practice review said:

> The idea of having a peer come and look over your shoulder for half a day may sound daunting. ... But a Regular Practice Review is a great way of helping you reflect on and improve your practice.[34]

Does the promised joy justify the grief and pain?

RPR was introduced in response to perceived public demand for increased oversight of the medical profession. Medical care is now subject to more scrutiny and regulation than ever before, but there is little evidence that quality and safety are improving, or that public trust and confidence in the profession is increasing. While the potential benefits of RPR remain unproven, there are real costs associated with the process: costs to both doctors (time, money, morale) and patients (increasing health care costs, reduced access to health care, and deepening mistrust). The public might have got what it was looking for with the introduction of RPR (increased external scrutiny of doctors), but it is yet to be determined whether the benefits will ultimately outweigh the costs: RPR may yet prove to be another scheme that leaves us naught but grief and pain for promised joy. Nevertheless, we can at least take comfort in the fact that we are providing the increased oversight our way. As Frank Sinatra sang, 'I faced it all and I stood tall and did it my way'.

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