Tricky Appraisals

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70 YEARS
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Tricky Appraisals

When things don't go according to plan…..

- Identify the issues
- Do you have to act?
- Is appraisal the place?
- Should the appraisal be halted?
- Does it need to be escalated?
- How do I record this in the summary?

Scenario 1. “Appraisal is a burden….”

You are discussing the appraisal process with a doctor who has been late selecting an appraiser, slow to arrange a meeting, then postponed a couple of times, SOAR documentation and supporting evidence not really enough so postponed again, and then only just adequate.

The doctor explains that just getting by at work is hard enough without the added burden of appraisal.

Facilitators' Notes Scenario 1

- **"Appraisal is a burden…."**

'Wilful blindness' or 'extenuating circumstances'.

Is this a cry for help?

Non-engagement processes – when do you tell the RO about repeated delay?

What if the last appraisal was more than a year ago?

What if the doctor is a locum?

Scenario 2 “My life is out of control”

When discussing reasons for non-engagement the doctor discloses a whole series of events in both their personal & professional life.

An appraisal is the last thing they need right now.

You work on a different site and were not aware of these events.

Facilitators' Notes Scenario 2

- **"My life is out of control"**
- *What do you need to be told?*
- *What should you be told?*
- *How should you be told? (Officially vs rumour)*
- *Anticipated tricky situation*
- *Ideally avoid getting to this point*
- *Appraiser is not the appraisee's doctor or social worker*

Scenario 3 “Why should I apologise when I’ve done nothing wrong?”

You are discussing a complaint. The doctor’s letter of response was checked by the MDO who suggested several amendments.

The doctor comments “ It’s the job of the MDO to defend me, not to appease the complainant – why should I apologise when I’ve done nothing wrong?”

Facilitators' Notes Scenario 3

- **"Why should I apologise?"**
- *Are there any other complaints in their evidence?*
- *Do they understand/comply with the complaints process? MDO advice often advises apology without admitting fault.*
- *What else is in their folder/appraisal history?*
- *Lack of INSIGHT – do they understand why the patient has complained?*
- *Can you change attitudes?*
- *Not the role of the appraiser to dig into the complaint*

Scenario 4 “I think I’m in the wrong job....”

The doctor has a big folder of CPD with plenty of reflection and appears to be very competent and successful.

When discussing the PDP for next year they announce that they are

a) Thinking of changing specialty

b) Leaving medicine

c) Emigrating

because they are no longer enjoying their work.

Facilitators' Notes Scenario 4

- **"I think I'm in the wrong job...."**
- *Why? Good evidence of a doctor performing well. Are they acting for the right reasons?*
- *You can act as a 'sounding board' for their possible plans.*
- *Changes the emphasis of the appraisal*
- *Pastoral role vs 'business' of the appraisal*
- *Is this a depression issue, if so they should not make any decisions when ill but should wait until well.*

Scenario 6 " I don't see why I should pander to time-wasters"

This is the doctor's comment when you are discussing their MSF.

Most of the colleague questions score highly but 3 areas have a number of low scores:

***Communication**: is willing to listen to what other colleagues have to say?*

***Respect for colleagues**: values the contribution of others?*

***Insight**: recognises the effect their behaviour has on others*

Scenario 6 “ I don’t see why I should pander to time-wasters” comments :

“tendency to be blunt”,

“can be impatient”,

“doesn’t suffer fools gladly”,

“always on time – never runs late”,

“can seem unapproachable”

“very good clinically”

Facilitators' Notes Scenario 6

- **"I don't see why I should pander to time-wasters"**
- *Lack of INSIGHT*
- *Remember to emphasise the positive when looking at feedback*
- *Ask "Do you recognise yourself in this?"*
- *Ask "What do you think about this feedback?"*

Red Flags

There are only two real RED FLAGS that should be taken outside or be acted upon:

- Patient safety issues: If you feel that the doctor's patients are at risk you have a duty to act. This is best done by the doctor self-referring to their MD/RO/CD or the GMC. If not, you should ensure this goes higher.
- Illegality: You have a similar duty under law or you become complicit in the activity. Again, self-referral is the preferred option.

How to proceed?

- The default position would be to continue with the appraisal unless you feel that the appraisee is not going to benefit from continuing in their current state.
- Illness, lying/probity issues can be dealt with within the appraisal
- Any remedial actions should be noted in your comments to the RO and in the PDP for ‘follow up’ in the next appraisal.
- There is no text book way to proceed in the absence of RED FLAGS, use your own skills, experience and style to continue the discussion and record it appropriately.

Non-engagement

- **What if the doctor is a locum?**

Locums including short term locums are not exempt from regular appraisals and these should be recorded with a PDP.

The doctor should not have more than one RO at any one time.

We should not be appraising an agency locum, who should have an RO provided by that agency.

If there are ‘missing’ appraisals rather than annually this is a concern.

Tricky Situations

- Any Questions?

Scenario 5 “I’m not a bully….”

You ask the doctor what they would like to discuss first.

They tell you that since their appraisal folder was closed they have been informed that a colleague has made an accusation of bullying against them, and they are really upset about this.

They think it could be an unprepared medical student who recently left a teaching session in tears, or possibly a nurse who couldn’t take a joke about her appearance.

Facilitators' Notes Scenario 5

- **"I'm not a bully…."**
- *We cannot 'unknow' this information.*
- *Incomplete - should certainly be an entry in the next appraisal folder but may be better discussed while 'fresh'.*
- *Look for other complaints/feedback in the appraisee's history. Discuss why the complaint may have arisen.*
- *Is there evidence of any INSIGHT into how their actions/words affect those they work with?*
- *PDP – Equality/diversity training?.*
- *Not just about the appraisal information – be alert to other cues.*

Scenario 7 “Reflections in my appraisal can be used against me”

The submitted documentation has several items of supporting information but there is little if any evidence of reflection.

The doctor explains that given the recent publicity over Dr Bawa-Garba they have chosen not submit any written reflection for the appraisal.

The doctor comments that they are worried that reflecting on a complaint or SEA may be viewed as an admission of poor practice.

Facilitators' Notes Scenario 7

The focus of reflection should be on learning, rather than what has gone wrong.

As far as possible, patient details in any reflections and feedback should be entered anonymously.

Appraisers need to be able to document the doctor has demonstrated reflective practice.

Reflection does not have to be written – there is evidence doctors prefer face to face reflection with a colleague - as in appraisal

All doctors have a duty of candour.

This resource may be made available, in full or summary form, in alternative formats and community languages. Please contact us on **0131 656 3200** or email **altformats@nes.scot.nhs.uk** to discuss how we can best meet your requirements.

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