Medical Workforce Management

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Learning Objectives

Readers will gain an understanding of key aspects of:

- Credentialling and Defining Scope of Clinical Practice (CSoP) including.
  - Historical reasons for requirement of CSoP.
  - Establishing a governance system for CSoP.
  - Implementing key operational processes for CSoP.
  - Documentation requirements for CSoP.
  - Processes for Recredentialling, Emergency Credentialling, Temporary Credentialling, Appeals process and Credentialling for New Technologies.
- Performance Enhancement or Performance Development including.
  - Importance of Performance Development.
  - The continuous Performance Development cycle commencing at the time of appointment.
  - Conducting a Performance Development meeting.
  - Pitfalls in establishing a Performance Development system.
- Performance Management including.
  - Importance of setting performance standards in an organisation.
  - Factors contributing to underperformance.
  - Process of performance management.
- Managing Inappropriate Workplace Behaviour including.
  - Definitions of disruptive behaviour.
  - Factors contributing to disruptive behaviour.
  - Process of managing disruptive behaviour.
- Managing Health and Well-being of Doctors including.
  - Introduction of the concept of "Flourishing" as a model for complete mental health.
  - Understanding the buffering and amplifying effects of individual and organisational risk factors and protective factors through a conceptual model.
  - Introduction of a conceptual framework for a Workplace Complete Mental Health Strategy.

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4.1 Credentialling and Defining Scope of Clinical Practice

Definitions: as per the National Standard for Credentialling and Defining Scope of Clinical Practice (the National Standard) [1].

- **Credentialling** refers to the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of medical practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high-quality health care services within specific organisational environments.
- **Defining the scope of clinical practice** follows on from credentialling and involves delineating the extent of an individual medical practitioner's clinical practice within a particular organisation based on the individual's credentials, competence, performance and professional suitability, and the needs and capability of the organisation to support the medical practitioner's scope of clinical practice.
- **Recredentialling** is the formal process used to re-confirm the qualifications, experience and professional standing (including history of and current status with respect to professional registration, disciplinary actions, indemnity insurance and criminal record) of medical practitioners, for the purpose of forming a view about their ongoing competence, performance and professional suitability to provide safe, high-quality health care services within specific organisational environments.

4.1.1 Introduction

For almost a decade and a half now, the governing bodies of health services are required by their funders and regulators as well as by legislation to ensure that all medical practitioners who have independent responsibility for patient care are appropriately credentialled and have their scope of clinical practice defined in accordance with both their level of skill and experience and the capability of the health service. This reflects the reasonable expectations of patients and communities, which should be respected if community confidence in the health care system is to be maintained. It also reflects the healthcare organisation's and medical practitioner's mutual responsibility to provide safe high-quality health care services to the community.

However, this was not always the case. Historically the medical profession was largely self-regulated. Speciality training colleges set standards for education and training and assess the practitioner as competent and able to provide independent clinical care once they have successfully met the requirements of training. Once deemed competent to practice independently, their clinical practice was monitored within the profession by a system of review by peers. High-profile inquiries into poor patient outcomes, like the Bristol Royal Infirmary Inquiry in 1999 [2] and the Bunderberg Hospital Commission of Inquiry in 2005 [3], led to the erosion of trust in the profession for self-regulation and paved the way for external regulation to protect the public and ensure that health care is provided by appropriately trained medical practitioners who are fit to practice.

A robust system of credentialling and defining the scope of clinical practice of medical practitioners ensures that this key clinical governance responsibility is upheld. These processes also protect medical practitioners by ensuring that the environments within which they practice support and facilitate safe and high-quality care. Credentialling and defining scope of clinical practice are essential elements of the initial appointment and ongoing relationship the organisation has with its medical practitioners. It forms part of the overarching organisational clinical governance systems that are designed to ensure the delivery of high-quality health services and minimise the risk of harm to the patients.

A process of defining scope of clinical practice supports the mutual responsibility of medical practitioners and healthcare organisations to provide safe patient care. Medical practitioners' pro-

fessional responsibility to provide safe patient care is outlined in professional registration standards and codes. This includes the obligation of working within their area of competence and training. By matching the medical practitioners' credentials and competence to the organisation's capability to provide services, the organisation assists the medical practitioner to work within their area of competence. In other words, the practice of medical practitioners is supported by organisational capability.

4.1.2 Policy Framework

The National Standard for Credentialling and Defining Scope of Clinical Practice (the Standard) developed by the former Australian Council for Safety and Quality in Health Care in 2004, provides the framework for States and Territories and health services to develop and implement systems for credentialling and defining the scope of practice of their medical practitioners.

Since then, all state departments of health have their own credentialling and defining scope of practice policies for public health services. In general, these policies mandate public health services to ensure that medical practitioners with responsibility for independent medical care are credentialled and have their scope of clinical practice defined at appointment to the health service. Most states also require that there is a process for regular review of scope of practice as a part of an annual performance appraisal and a formal process for recredentialling every 5 years.

Private hospitals are licensed to operate by the state health departments under state and territory laws and regulation. While state department policies on credentialling and defining scope of clinical practice do not apply to private hospitals, to maintain the licence to operate private hospitals are required to comply with legislative requirements, relevant professional standards, relevant guidelines, current best practice and occupational health and safety standards. In addition, contracts with health funds drive the need for having good systems for credentialling by requiring that private health services maintain accreditation status against safety and quality accreditation standards.

The National Safety and Quality Health Services Standards also require both private and public health services to have a system in place to define and regularly review the scope of practice of the clinical workforce [4]. In addition, the Standards also require that health services have mechanisms in place to monitor that the clinical workforce is working within their scope of practice.

4.1.3 Approaches to Defining the Scope of Clinical Practice

The Standard suggests the following approaches for defining Scope of Clinical Practice.

- **Checklist:** Developing a detailed checklist of all the clinical services, procedures, interventions and/or conditions that can be supported from which medical practitioners can request their scope based on their training and competence. Some large organisations use the Medical Benefits Schedule as a framework for developing these lists.
- **Categorisation**: Certain specialities can be subdivided into broad categories with each category comprising of a set of procedures with some common characteristic. For example, within the discipline of cardiology, the scope may be categorised as interventional cardiology, electrophysiology and general cardiology. Surgery may be categorised as general surgery, upper gastrointestinal surgery and colorectal surgery.
- **Core**: Core scope of clinical practice refers to the range of clinical activities within a specialty or subspecialty that any appropriately trained medical practitioner would be expected to be competent to perform. For example, the core training of the Royal Australian and New Zealand College of Radiologists makes fellows eligible to perform basic diagnostic angiography and interventional techniques including angiography, nephrostomy, abscess

drainage and biopsy. To undertake more complex interventions like neuro-interventional procedures or vascular interventional procedure additional training is required with the Interventional Radiological Society of Australasia.
- **Descriptive: The medical practitioner requesting a scope of clinical practice describes in** narrative format, the procedures that they would like to perform based on their training and competence.
- **Combination:** The most common would be a core scope of practice with a checklist of additional procedures that the practitioner is able to demonstrate competence. For example, a Fellow of the Royal Australasian College of Surgeons may start with a core surgical scope of practice but later add laproscopic surgery to their practice.

4.1.4 System for Credentialling and Defining Scope of Clinical Practice

4.1.4.1 Principles

Processes of credentialling and defining the scope of clinical practice of medical practitioners should:

- Be conducted with the objective of ensuring the safety and quality of health care services.
- Uphold the principles of equity and merit.
- Operate according to the rules of natural justice and procedural fairness.
- Comply with relevant laws including those governing health services provision, privacy, competition, whistleblowing and equal opportunity.
- Be transparent, to maintain patients and the community confidence.
- Undertaken by professional peers, who can verify credentials, evaluate competence and performance, and recommend the appropriate scope of clinical practice.

4.1.4.2 Governance

Processes of credentialling and defining the scope of clinical practice of medical practitioners should be integrated within overarching clinical governance systems.

4.1.4.3 Governing Body

Role of the governing body or Board of Directors with respect to credentialling and defining the scope of clinical practice of medical practitioners can be summarised as follows:

- To demonstrate strong leadership and commitment to ensuring that healthcare is provided by appropriately credentialled medical practitioners working within their scope of practice in an environment that supports the practice.
- To establish comprehensive governance systems for effective processes of credentialling and defining the scope of clinical practice of medical practitioners.
- To formally delegate authority for implementing and monitoring the performance of its governance systems of credentialling and defining the scope of clinical practice of medical practitioners to an accountable executive.
- To ensure that it receives regular, systematic reports on the effectiveness of processes of credentialling and defining the scope of clinical practice of medical practitioners.

4.1.4.4 Accountable Executive

The Chief Executive Officer is usually the accountable executive who may formally delegate this responsibility to the Chief Medical Officer, Head of Human Resources, Director of Medical Services or any other senior managerial role depending on the size and structure of the organisation. This role must ensure that

- Resources are allocated to implementing and monitoring the process of credentialling and defining the scope of clinical practice.
- Structures for implementing the process are set up including organisational Credentialling

and Scope of Clinical Practice Committee with clear terms of reference, administrative supports, meeting schedules and record-keeping systems.
- Clear policies and procedures are developed, implemented and regularly reviewed.
- Key performance indicators to monitor the effectiveness of the process are developed, measured and reported on a regular basis.

4.1.5 Credentialling and Scope of Clinical Practice Committee (the Committee)

The Committee structure will vary depending on the size and structure of the organisation. In general the Committee must have the relevant expertise to be able to assess the medical practitioner's competence to perform the role and delineate the appropriate scope of clinical practice.

The role of the Committee includes
- To provide advice and endorse the organisational policies and procedure for credentialling and defining scope of practice.
- To determine the information to be requested from an applicant for appointment to a specific role.
- To determine the minimum credentials required to fulfill the duties of a specific position.
- To review and endorse the credentials of applicants and approve the appropriate scope of clinical practice based on the provided credentials.
- To provide advice on matters related to complaints and concerns about a medical practitioner's competence or scope of practice.

The membership should include
- Chair-usually the Chief Medical Officer or the role accountable for credentialling and defining the scope of clinical practice.
- Medical practitioners from a range of specialties.
- Human Resources department representative.
- Professional college or university representative as required-desirable.
- Consumer representative-desirable.

4.1.6 Policy and Procedure

Policy on credentialling and defining the scope of clinical practice that applies to all medical practitioners with independent practice rights within the organisation should be formally adopted. This policy should comply with all relevant legal requirements including relevant State/Territory and Commonwealth legislative requirements.

The policy should cover the following details:

- Specify the accountable executive to whom the responsibility to ensure effective processes of credentialling and defining the scope of clinical practice has been delegated by the governing body.
- Provide for the establishment of the organisational committee that assumes responsibility for credentialling and defining the scope of clinical practice of medical practitioners.
- Provide for the establishment of an Appeals Committee to be convened when required and describe the process for appeals.
- Outline the process for credentialling and defining scope of clinical practice including in emergency situations and on a temporary basis when required.
- Define the timeframe and process for recredentialling.
- Define the process for credentialling when new technology or clinical practices are introduced within the organisation.
- Define the circumstances under which an unplanned review of a medical practitioner's credentials and or scope of clinical practice may be initiated.
- Outline the circumstances and process for suspension, temporary or permanent, in part or full, of a medical practitioner's right to practise within the organisation.
- Describe the process for appeals.

- Specify the extent to which the organisation will disseminate information about each medical practitioner's authorised scope of clinical practice.
- Describe how the process should be documented.
- Describe the process for monitoring the effectiveness of the credentialling and defining scope of practice process including an audit framework and schedule.

4.1.7 Process of Credentialling and Defining Scope of Clinical Practice

The operational process for credentialling and defining scope of clinical practice forms part of the appointment process and different models may exist depending on the governance structure, size, and complexity of the organisation.

The table below outlines the key structures, processes and outcomes for a robust credentialling system

Structure (role/group/committee)	Process credentialling and defining scope of clinical practice	Outcome
Medical leader to whom the new position will report Medical leader may seek advice from relevant colleges, societies or expert members of the position	Development of the position description and determination of the minimum credentials to be considered for the position	Decision about appropriate credentials for the position is made
Medical leader assisted by administrative support	Advertisement and review of applications to shortlist suitable candidates who have the required credentials	Preliminary check of credentials was done, and suitable candidates were shortlisted for interview
Appropriately convened interview panel with relevant expertise. This should include the medical leader, human resource representative, relevant multidisciplinary team representatives (nursing, allied health), experts like college or university representatives and medical administration representatives	Interview process to select a preferred candidate	Panel with required expertise interviews the shortlisted candidates and makes an informed decision about the suitability of the candidate for the role
Medical leader assisted by administrative support	Scrutiny of relevant documents for verification of credentials and reference checking	Assurance that the preferred candidate has the required credentials and positive references for the job
Medical leader	Job offer made to the preferred candidate	Formal job offer is made for the candidate to accept
Applicant	Request for scope of practice by the successful candidate	Applicant exercises their judgement and self-assessment of their competence and requests appropriate scope
Medical leader/group of peers working in the same field/ Credentialling and scope of practice committee	Review of requested scope of practice and assessment against credentials and recommendation of the appropriate scope of practice to the relevant organisational committee/executive/governing body	Peers working in the same field make an informed decision about the appropriate scope of practice
Credentialling and scope of practice committee/accountable executive/ governing body	Endorsement of the scope of clinical practice	The organisation fulfills its obligation to ensure competent professionals working within their approved scope of practice provide healthcare

4.1.8 Documentation

Documentation related to the process of credentialling and defining the scope of practice must be maintained and stored as per legislative requirements and organisational policy.

Detailed minutes of Committee processes and decisions must be maintained, and all decisions must be formally communicated to applicants in writing.

4.1.9 Information for Credentialling That Must Be Provided by the Medical Practitioner

Essential documentary evidence

- Current professional registration which is now available from the Public Register of Health Professionals from the Medical Board of Australia.
- Evidence of relevant education and training including certified copies of all diplomas, degrees and recognised post-graduate qualifications.
- Evidence of Fellowship of relevant professional college, membership of associations or societies.
- Information about relevant past and continuing health care-related employment. The performance at recent employment should be validated with reference checking.
- Evidence of participation in continuing medical education programmes.
- Evidence of current professional indemnity insurance and its type and scope.
- Relevant safety clearances including police check and working with children check.
- Adequate identity documents.

4.1.10 Information Usually Required in Curriculum Vitae That Can Be Then Validated by Reference Checks

- Information on clinical activity undertaken in recent employment and outcome of that activity.
- Evidence of experience in teaching and research, where applicable.
- Evidence of experience in medical leadership positions, where applicable.

4.1.11 Declarations About Relevant Past Conduct and History

- Declaration regarding any prior change to the defined scope of clinical practice, or denial, suspension, termination or withdrawal of the right to practise, other than for organisational need and/or capability reasons, in any other organisation.
- Declaration regarding any prior disciplinary action or professional sanctions imposed by any registration board.
- Declaration regarding any criminal investigation or conviction.
- Declaration regarding the presence of any physical or mental illness that could affect the medical practitioner's ability practice safely or competently.

4.1.12 Recredentialling

The process of recredentialling ensures that credentials are verified periodically and relevant information updated for the organisation's record. It also provides an opportunity for the medical practitioner and their medical leader to review their scope of practice and make necessary alterations to it based on their current personal and organisational circumstances. New procedures may be added to the scope if appropriate qualifications and experience has been gained. Procedures may be dropped from the scope of practice. Some of the reasons for doing this may be because of the practitioner's decision to wind down or change their practice, change in organisational scope where the service is no longer performed or other health or competence related reasons.

Most State policies require that recredentialling is performed every 5 years. Organisations may undertake this in conjunction with their contract renewal process. Organisations with perma-

nent ongoing contracts will need to undertake the process separately.

4.1.13 Information Required for Recredentialling

- Current professional registration, which is now available from the Public Register of Health Professionals from the Medical Board of Australia. However, it is recommended that organisations have a process for checking the currency of registration more frequently. It is possible to set up real-time alerts for any changes to registrations on electronic systems used for Credentialling.
- Evidence of any additional education and training undertaken and any endorsement or accreditation awarded by a professional college, association or society since the previous declaration.
- Update on professional activities undertaken such as clinical audits, peer review activities and continuing medical education programmes since the previous declaration.
- Request for change to scope of clinical practice and supporting documentation justifying the request.
- Evidence of the type and scope of current professional indemnity insurance.
- Declaration that there has been no change to the previous information provided regarding:
  - Scope of clinical practice, including denial, suspension, termination or withdrawal of the right to practise, other than for organisational need and/or capability reasons, in any other organisation,
  - Disciplinary action or professional sanctions imposed by any registration board,
  - Criminal investigation or conviction,
  - Presence of any physical or mental illness that could affect the medical practitioner's ability practice safely or competently.
- In case there have been changes, a new declaration describing the specific changes to the information previously provided is required. However, organisational processes must require medical practitioners to inform the organisation of any changes to professional status at the time that it happens and not rely on the 5 yearly recredentialling process.

4.1.14 Emergency Credentialling

At times of emergencies due to natural disasters, mass casualty events or pandemics the increased requirement for medical services may require health services to allow medical practitioners whose credentials have not been formally reviewed and verified according to the organisation's standard policy to assist in the provision of clinical care.

This process should involve

- Verification of identity through inspection of relevant documents, for example, a driver's licence with photograph.
- Verification with the relevant professional registration on the public register.
- Confirmation with a member of senior management of the organisation nominated by the medical practitioner as his or her most recent place of appointment to verify claimed employment history and good standing.
- Assessment as soon as possible of the medical practitioner's available credentials by a senior medical practitioner who practices in the same speciality area.
- Confirmation as soon as practicable by at least one professional referee of the medical practitioner's competence and good standing.
- Detailed documentation of the process and decisions.

Regular credentialling process must follow as soon as reasonably practicable. The scope of practice in this situation is restricted to that required for the specific emergency.

4.1.15 Temporary Credentialling

Occasionally appointments may need to be expedited to allow continued service delivery, as when locums and other medical practitioners are

appointed on a short-term basis to provide health care services. In such situations, organisations may decide to authorise an appropriate senior manager and senior medical practitioner to undertake the necessary assessment and verification of credentials and allow the practitioner to commence clinical practice without waiting for the final endorsement of the Credentialling and Scope of Practice Committee.

To ensure safety and minimise risk, this process requires the authorised manager to

- Interview the applicant.
- Verify all information required from applicants for initial credentialling.
- Define the applicants scope of practice on a time-limited basis.
- Document the process and decisions.

The process must be completed as per organisational procedure and referred to the next meeting of the Committee responsible for credentialling and defining the scope of clinical practice, for formal consideration and endorsement.

4.1.16 Appeals Process

To uphold the principles of natural justice, it is required that an appeals body that is independent of the Credentialling and Scope of Clinical Practice Committee is set up. The appeals body should advise the governing body directly.

Appeals may be made in the following circumstances

- Dispute over credentials.
- Rejection of scope of practice request.
- Decision to change the scope of practice.

Suggested membership of the appeals body

- Member of senior management.
- Senior independent member of medical staff with expertise in the relevant area of practice.
- Relevant college representative.

4.1.17 Process of Appeal

- Process for appeal must be clearly outlined in the credentialling and defining the scope of clinical practice policy.
- Appeals must be made within the specified interval from the date of the decision, usually 30 days.
- Appeals must be made in writing. It is recommended that an appeals form is developed to ensure all required information is provided to the committee.
- The appeal should be addressed to an agreed organisational representative independent of the Credentialling Committee. This may be the Chief Executive or another Senior Manager.
- The Organisational representative should convene the appeals body with the necessary expertise. The appeals body may decide to interview the appellant and relevant other individuals to gain a better understanding of the dispute.
- The decision of the appeals body must be communicated to the appellant in writing within a specified timeframe.

4.1.18 Introduction of New Technology or Clinical Practices: Implication for Credentialling

The process for introduction of a new technology includes

- Request to introduce the new technology usually made by a medical practitioner or a group of practitioners.
- Assessment of the technology for evidence of safety, effectiveness and cost effectiveness.
- Assessment of the alignment of the change to the organisational strategy.
- Assessment of the organisation capability to support the new technology.
- Assessment of the operational and financial impact of introducing the new technology.

- Consideration of the skills and training required by staff to use the new technology.

Most large organisations have a New Technology Committee that usually performs these tasks. Smaller organisations may use the expertise of larger organisations or the Department of Health. Based on these assessments, the New Technology Committee would advise the organisation whether the new technology should be introduced in the organisation.

In the assessment of the technology, consideration would be given to the skills and training required by health professionals to use the new technology and the New Technology Committee would advise the organisation of the necessary credentials required by medical staff if the new technology was introduced.

Based on this advice, the Credentialling and Scope of Clinical Practice Committee would perform its task of verifying the credentials and making the decision about whether the use of the new technology should be added to the scope of practice of the medical practitioner.

4.1.19 Review of Scope of Clinical Practice

Due to changes in community needs for services, changes in technology and models of care, the skills and training required by clinicians may change, driving the need for review of their scope of clinical practice. Ideally, scope of clinical practice should be reviewed between the medical practitioner and their medical lead during the process of annual performance review. This is an ideal platform for a discussion about new skills and training that has been acquired, changes to service delivery including any disinvestment of services that may have occurred and the plans for the clinical area going forward. Based on this discussion, there may be an agreement to review and change the scope of practice. The Recredentialling cycle provides another opportunity for electively reviewing the scope of clinical practice.

In addition, the organisation should have internal monitoring systems that medical practitioners are working on competently as well as within their scope of clinical practice. These monitoring systems include clinical audit, peer review, mortality and morbidity reviews and benchmarking of clinical outcomes.

4.1.20 Unplanned Review of Scope of Clinical Practice

An unplanned review of scope of clinical practice will usually occur following a complaint or concern about a medical practitioner's competence. Complaints may arise internally from staff or patients or externally from regulatory bodies, complaints bodies or patient advocacy groups. Similarly, colleagues, team members, or even the practitioner's family members may raise concerns about competence. In addition, concerns may also be raised in the context of organisational quality management systems like peer review or clinical audit. Organisational incident investigation management processes may reveal that individual clinical performance rather than systems failure led to the incident.

The organisation must be responsive to complaints and concerns about a clinician's competence and have a structured process to manage them, ensuring that risks to safety are minimised, and the principles of natural justice and procedural fairness are upheld.

Management of such complaints or concerns is covered in detail in the section on Performance Management. For this section, it is sufficient to say the outcome of the investigation of the complaint or concern about the performance may be to review the scope of practice with a view to modify, restrict or suspend it temporarily or permanently. If that decision is made, it should be communicated to the Credentialling and Scope of Practice Committee, which will formally endorse the change to the scope of practice.

4.1.21 Credentialling of Junior Medical Staff

It is expected that Junior Medical Staff will always practice under supervision. The level of supervision will depend on their level of competence based on their length of training and experience and demonstrated performance. As

they do not practice independently, the process for credentialling and defining their scope of practice is not mandated by government policy. However, interest in this area is growing, and health services are expected to have processes to ensure that they can demonstrate that Junior Medical Staff hold current registration and necessary police and work with children's checks and are supervised at the level of competence.

4.2 Performance Enhancement or Performance Development

Supporting doctors to continuously enhance their performance and managing underperformance is an important medical workforce management task. Doctors are the key decision makers about patient care, and the performance of doctors is critical to the delivery of high-quality care. In the complex heath environment, a doctor's performance is not just dependent on their own level of competence but may be affected by other influences including their personal and family circumstances, their physical, mental and psychological health and their work conditions, environment and culture.

The Department of Health, Victoria, uses the term Performance Enhancement for the ongoing process between a doctor and the organisation, to support continuous professional development, promote engagement and ensure a standard of performance that meets and exceeds the expectations of the community [5]. Performance Enhancement is a positive process in which shared goals are developed between the organisation and the doctor, who then support each other in the achievement of those goals. Putting the delivery of high-quality patient care at the centre of the process allows for mutual interest and benefit from the process. Management of underperformance, generally known as Performance Management is an important but small component of the broader process of Performance Enhancement.

Performance Enhancement commences at the time of appointment and is intricately linked to the credentialling cycle. The medical leader, be it clinical director, unit head or equivalent, to whom the doctor reports is critical to driving the process. The table outlines key steps in the process of Performance Enhancement.

Time	Process	Outcome
Appointment	Credentialling and defining the scope of clinical practice	Assurance that the doctor is competent to provide the clinical care that they have been appointed to deliver and the organisation is able to support their agreed scope of practice
Within a month of appointment	Formal meeting of the doctor with their medical leader	Clarify role and mutual expectations Set performance goals aligned with organisational objectives Commence the building of a good professional relationship for ongoing mutual benefit
Ongoing	Access to performance development, clinical improvement and leadership development activities	Continuous improvement of skills and performance Meeting of medical board and college CPD requirements
Ongoing	Quality assurance activities like clinical audit, peer review, mortality and morbidity meetings	Monitoring of performance Ongoing communication about clinical care ensures that organisations and senior doctors are collaborating around a shared commitment to enhancing patient care
Ongoing	Informal conversations about clinical practice	Real time feedback about performance and opportunity to refine and adjust goals and progress towards those goals
Ongoing	Recognising outstanding performance	Increased engagement of medical staff

Time	Process	Outcome
Ongoing	Identifying underperformance	Early management of underperformance allowing successful outcome
One year after the appointment and then yearly	Formal performance appraisal	Review past performance to inform goals and plans for the coming year Review and update scope of practice if required Review career progression and future opportunities
Every year	Repeat tasks of the annual cycles	Continuous engagement, performance improvement and achievement of shared goals
5 years	Recredentialling	Informed decision made about continuation of employment

Hence it is clear that Performance Enhancement is not a one-off process of an annual meeting between the doctor and their medical leader but an ongoing supportive process of building a mutually beneficial relationship with the organisation that leads to achievement of personal and professional goals for the medical practitioner and ensures the organisation meets its obligation to provide safe and high-quality care. It leads to improve attraction and retention, increases discretionary effort and productivity through a process of clinical engagement.

4.2.1 Multisource (360°) Feedback

This is another tool that can be utilised to inform the Performance Enhancement process. It enables a senior doctor to receive structured feedback from their medical leader and a small number of peers, subordinates and colleagues. Implemented effectively, with appropriate resourcing, support and training, it can assist senior doctors and organisations to gain valuable insights into performance across a range of roles and competencies. However this must be used with caution as implementation without adequate resourcing, training and in an environment lacking in trust it may result in significant harm and disruption of relationships with medical staff.

It is a valuable formative tool that provides meaningful information about the doctor's performance to himself or herself and to the organisation. The doctor can use this information to further refine their professional development plan. It works well with those who have the insight and willingness to reflect on and improve their performance. The role of the medical leader is critical to guide the doctor in the use of the information. This method should not be used as an evaluative tool or as a tool for performance management.

4.2.2 The Performance Development Meeting

The annual performance development meeting is the formal process in the Performance Enhancement cycle as described above. Organisations should ensure this expectation is clearly communicated to all medical staff and the medical leaders of the organisation. It is also the responsibility of the organisation to provide the necessary time, resources and training to medical leaders to drive this process.

Performance Enhancement meetings should be formally scheduled between the medical leader and the doctor and both parties should have adequate preparation time. Organisations should have approved proformas to ensure consistency of the process and assist in documentation. During the preparation phase, both parties should independently reflect on and evaluate past performance and consider goals for the upcoming year. Previous year's documentation of the performance meeting should be reviewed with a view to evaluate achievement of agreed goals.

At the meeting, the achievements and challenges of the past year should be discussed, and ideally, a mutually consistent evaluation of performance is arrived at and documented. If the

performance enhancement cycle has been carried out as described above, this meeting should have no surprises, and both parties are likely to be on the same page about the doctor's performance.

Following the evaluation of past performance, goals for the coming year should be discussed, and a plan to achieve those goals agreed to and documented.

4.2.3 Setting Goals

Setting of specific, measurable, achievable, relevant and time bound (SMART) goals increases the possibility of success in achieving the goals. Various frameworks can be used to define areas in which goals can be set. The Department of Health, Victoria, suggests using Work Achievement, Professional Behaviours, Learning and Development and Career Progression as domains to set goals.

Goals discussion should include an agreement on how the organisation will support the achievement of the goals and monitor progress. The process should be documented, and the organisation must have a system for monitoring completion of the process as well as ideally have an evaluation process for its effectiveness. Feedback on the experience of conducting and going through the process should be collected from medical leaders as well as doctors in order to continuously improve it.

4.2.4 Pitfalls in the Performance Enhancement Process

If undertaken properly Performance Enhancement will lead to better clinical engagement, co-ownership of organisational objectives and job satisfaction for doctors. However poor execution may result in dissatisfaction and possibly cause significant harm to the relationship between the organisation and doctors.

Some suggested cautions include

- Clear messaging about the purpose of Performance Enhancement as a supportive and developmental process for doctors.
- Ensuring frequent, ongoing, real-time feedback on performance with no surprises at the formal annual appraisal meeting.
- Use as a formative tool and not as an evaluative tool.
- Ensuring clear distinction from performance management.
- Adequate resource allocation in terms of non-clinical time and administrative support.
- Training of medical leaders in giving feedback and goal setting.

4.3 Performance Management

Performance is not just about good technical knowledge and skills, but also considers other important non-clinical attributes such as professionalism, teamwork, leadership and communication. The performance of individual medical practitioners may be influenced by many factors including their health status, personality, and the broader personal and professional environment within which they work.

Underperformance is performance that does not meet expected standards and can be broadly categorised as:

- Clinical performance of a standard that is below what is expected from a practitioner of similar training or experience. These standards are usually set by the profession through professional colleges and prevocational training bodies and reflect the clinical competence that is expected to be demonstrated by a practitioner who has successfully completed the training requirements.
  - Examples.
    - Individual training standards of professional colleges and societies.
    - The Australian curriculum framework for Junior Doctors.
- Behaviour or conduct that is below the standard required by the profession, regulators, employers or the community. These standards are usually outlined in organisational codes of conduct and policy documents or professional practice guides of regulators or professional bodies.

  - Examples.
    Good Medical Practice from the General Medical Council (GMC), UK.
    Good medical practice: a code of conduct for doctors in Australia.
    The Australian Medical Association Code of Ethics.

These standards provide a benchmark against which the performance of a doctor is assessed.

Failure to meet clinical standards leads to a breach of professional duty, causes a risk to patient safety and undermines public confidence in the practitioner and the profession. Failure to meet behavioural standards may affect the morale of the team, disrupt functioning, decrease productivity and put the health and safety of patients as well as co-workers at risk. Doctors enjoy a position of privilege and trust in society. In return, society expects that doctors will provide safe and high-quality medical care that meets professional standards. Healthcare organisations that employ or contract doctors are also accountable to its patients and funders to ensure that its employees including doctors are fit to provide the standard of care expected of them.

Hence doctors have the professional responsibility to maintain competence in their field and demonstrate a high standard of professional conduct. Organisations that employ doctors are obligated to ensure that they have processes to monitor their doctors' performance and identify and manage underperformance early to minimise risk to patient safety.

In addition to the risk to patient safety, underperformance if not identified and managed both appropriately and sensitively, can lead to unhealthy and unproductive outcomes for the individual practitioner as well as the organisation and teams that they work in. Early identification and management of underperformance increases the chances of successful remediation.

4.3.1 Factors Contributing to Underperformance

Factors other than deficient clinical knowledge, skills, training or experience may contribute to underperformance. These may include:

- **Individual factors.**
  - Health-physical, mental and emotional.
  - Personality.
- **Organisational factors.**
  - Workload.
  - Job design: skill-challenge match.
  - Organisational culture-safety, fairness, equity, leadership, teamwork.
  - Organisational processes – supervision, rostering, training.
  - Organisational support.
- **Life factors.**
  - Family and personal circumstances including relationships.
  - Financial circumstances.
  - Career progression.

4.3.2 Health as a Contributory Factor of Underperformance

Evidence suggests that doctors enjoy better physical health as compared to the rest of the population [6]. However, recent data on mental health of doctors shows that there is a high prevalence of mental illness in the profession. The National Mental Health Survey of Australian Doctors and Medical Students found that doctors and medical students reported substantially higher rates of psychological distress and attempted suicide compared to both the Australian population and other Australian professionals [7]. Similar findings have been demonstrated in the United Kingdom, where 10–20% of doctors have reported being depressed at some time during their career, and the risk of suicide is raised compared to the general population [8]. Alcoholism and drug dependency also affect a high proportion of doctors compared to other professional groups [9]. The lifetime prevalence of substance abuse disorders among doctors in Australia has been estimated to be approximately 8% [10].

A doctor's ability to practice safely may be affected by the presence of illness. In the United States of America, the term Impaired Physician has been used to describe a doctor whose ill health affects their fitness to practice. The American Medical Association has defined Impairment as any physical, mental or behav-

ioural disorder that interferes with the ability to engage safely in professional activities [11]. This definition reflects the fact that a wide range of health conditions may impact on a doctor's ability to practice safely.

While physical illness may affect a doctor's performance it appears that this is not very common. Amongst the cohort of doctors in the UK who were referred to the GMC Health Committee following performance-related concerns, only 1% had a physical illness while 99% had problems with alcohol, drugs or mental health [12]. Age-related cognitive decline and dementia were the most common physical conditions associated with underperformance.

4.3.3 Health-Related Behaviours and Attitudes in the Medical Profession

Doctors, in general, do not look after their own health, deny ill health and delay seeking medical attention [13]. A survey of junior doctors in the UK showed that they rarely took time off work and were commonly self-prescribed [14]. Responses to postal surveys conducted in Australia, UK and Spain show that most doctors do not have a GP, and those that do, do not use their services often. Many doctors self-prescribe and admit to stress. Alcohol and drug use are not uncommon. Perceived barriers to accessing healthcare are confidentiality, inability to take time off, reluctance to relinquish control of their own health to a colleague, fear of the impact of the illness on their career, role conflict in being a doctor and a patient and a perception that ill health may demean them in the eyes of their patients, colleagues, employers and regulators [15–17].

Therefore, when true impairment in clinical skills becomes apparent, the illness is usually severe and longstanding [18]. Unfortunately, many times impairment is identified after concerns about performance are raised, or clinical errors have occurred, setting off a reactive response to the underperformance.

It is also apparent that the medical profession does not deal well with disability among its own members. A recent working party convened by the Royal College of Physicians of London found that there was a stigma attached to having a disability and that doctors were reluctant to declare non-obvious impairments, particularly mental illness [19].

Early identification and management of illness before it starts impacting on clinical performance would prevent the development of impairment, ensure patient safety and increase the probability of a successful outcome for the doctor.

4.3.4 Personality as a Contributory Factor to Underperformance

The relationship between personality and academic performance in medical students has been a subject of several studies and the personality trait of conscientiousness has been found to be associated with long-term success in medical training [20]. There is less understanding about the association of personality traits and job performance. However, some studies have shown that personality traits of neuroticism and low conscientiousness may be associated underperformance [21]. Paice found behaviour patterns among poorly performing undergraduates or the so called trainee in difficulty that could be consistent with low conscientiousness and high neuroticism including doing the disappearing act, low work rate, ward rage, rigidity, unreliability, turning up late and insight failure' [22].

Personality disorders like borderline, antisocial, narcissistic, and obsessional personalities present with underperformance related to behaviour or conduct below the expected standard [23]. These doctors may demonstrate problems with interpersonal relationships and teamwork, difficulty in adapting to change, anger management problems and are usually identified by patient or staff complaints. The behaviours of concern are usually longstanding but more pronounced during periods of stress. Personality disorders are difficult to manage, particularly when associated with a lack of insight. This form of underperformance is dealt with in further detail in the section on management of inappropriate behaviour.

4.3.5 Work-Related Factors Contributing to Underperformance

Organisational factors such as high workload, shift systems, work patterns, poor leadership and team work, all have the potential to impact negatively on an individual's well-being and to distort patterns of behaviour and ability to perform. These systems-related factors must also be considered as possible contributory factors for underperformance.

4.3.6 Burnout as a Contributory Factor to Underperformance

Burnout is a well-defined syndrome that is commonly seen in the medical profession [24–26]. It is defined as a psychological syndrome that occurs in relation to chronic work-related strain and is characterised by:

1. Emotional exhaustion-decreased emotional energy to meet work-related demands and feelings of being over-extended at work.
2. Depersonalisation-increased emotional distance from one's job role and the feeling of negativity, cynicism and a detached response to other people including patients, colleagues and family.
3. Reduced personal accomplishment-decreased self-worth and feeling of competence related to work [27].

It may be a contributory factor in underperformance. Prinz et al [28] and Amfao et al [29] have authored good reviews of burnout in the medical profession. These reviews have found that factors contributing to burnout are specifically work related. Work overload, work-home conflict and perception of work as stressful have been found to be the factors most strongly related to burnout. Other contributing factors include emotionally demanding situations in the workplace like interactions with difficult patients, managing unrealistic community expectations and dealing with life-and-death situations. Younger doctors in early career stages and female doctors have a higher incidence of job burnout. Burnout has significant effects on the health of the individual and their job performance. It has been associated with withdrawal, intention to leave the job, job turnover, loss of productivity and a reduction in the quality of patient care.

Hence underperformance is a complex issue, and management of underperformance should take into account factors contributing to it and an attempt made to address these. Strategies to reduce or address these contributory factors are discussed in the section on Managing Mental Health and Well-being.

4.3.7 Principles of Managing Underperformance

- Clear and agreed procedures should exist for managing concerns about performance.
- Concerns should be managed promptly and as per existing procedures.
- Principles of natural justice and procedural fairness should be upheld. This implies that the person about whom a concern is raised must be given the opportunity to be heard by an impartial decision-maker.
- Need for patient safety should be balanced with the need to protect the reputation of the practitioner. In case of immediate risk to patient safety from continued practice, suspension from clinical practice may be required till the matter is investigated.
- Confidentiality of proceedings should be ensured.
- Level and depth of investigation should match the seriousness of the concern with more serious matters requiring the involvement of senior management or executive.
- Clear documentation should ensure that records are maintained, and the rationale for decision-making is clear in case the decision in challenged in the future.
- Support should be offered to the person being investigated, and their support person should be allowed at all formal meetings.

4.3.8 Process of Performance Management

Concerns about performance may be raised from several sources including colleagues, co-workers, supervisors, patients or external sources. The manager of the underperforming doctor should be responsible for managing the concern. In a hospital setting, this responsibility may sit with the unit head, training supervisor or the Director of Medical Services. The process may differ depending on whether the concern is predominantly about clinical competence or about professional behaviour and conduct, but the basic steps are common. The responsible manager must:

- Assess and manage any immediate risk to patient or staff safety. If a significant risk is identified temporary measures to manage the risk may include.
  - Removal from clinical duties till the matter is investigated.
  - Restriction of scope of practice.
  - Increased level of supervision.
  - Allocation to other duties or leave.
- Determine the seriousness of the concern and based on that decide the level of review required. Key considerations in determining seriousness may include whether the concern is an isolated occurrence or part of a trend and to what extent the clinical performance, behaviour, practice or variation in outcome depart from the expected standard. The seniority and experience of the person conducting the review must reflect the seriousness of the complaint.
- Inform the person of the complaint or concern and the process of investigation that will follow. For serious concerns, this should be done in writing, and the letter should outline the concerns, the process of the investigation, the avenues for further communication and an invitation to a meeting once the investigation is completed where they can respond to the concerns.
- Conduct the investigation. The process of investigation will depend on the nature of the concern. Concerns about clinical competence may require review of the doctor's clinical practice by a member/s of the profession who practice in the same discipline. These reviewers must be independent and have no conflict of interest in the proceedings. In small organisations or where internal expertise does not exist, external experts may need to be invited. The process of review and the reviewers should be agreed on with the doctor whose performance is under review Investigation about conduct and behaviour may be reviewed in conjunction with the organisation's Human Resources department. This would include gathering evidence from witnesses about the actual occurrence of the behaviour.
- Invite the person to a meeting with a support person to inform them of the findings of the investigation and provide them with the opportunity to respond. It is advisable to have a member of the Human Resources team at the meeting to support and witness the process. At the meeting, the details of the concern should be explained to the doctor. The expected standard of performance should be outlined, and how the behaviour/clinical performance failed to meet the standard should be clarified. The doctor should be invited to respond. The outcome may be determined in one meeting if all the information is available, or further meetings may be required.
- Based on the response, the outcome should be determined and conveyed to the doctor verbally, followed by a formal letter. Avenues for appeal and support must be communicated.
- All decisions must be well documented.
- A process to follow up on the outcomes of the review must be determined.

4.3.9 Possible Outcomes of the Performance Management Process May Include

- No action required.
- Informal counselling.
- Formal verbal or written warnings.

- Development of a performance improvement plan with clearly defined targets, deadlines and a review date.
- Restriction of the doctor's scope of clinical practice or increase in supervision. This must be appropriately documented and followed up as required by the organisations Credentialling and Defining Scope of Practice policy.
- Suspension from employment till remediation, reskilling or further review is completed. Suspension usually requires approval from senior managers or executive.
- Summary dismissal or termination for gross or serious misconduct may be appropriate but requires approval of senior managers or executive.
- Mandatory notification to the Medical Board of Australia is required if it is determined that the doctor-.
  - Has practised while intoxicated by alcohol or drugs,
  - Has engaged in sexual misconduct in connection with the practice of the profession,
  - Has placed the public at risk of substantial harm in the practice of their profession because the doctor has an impairment,
  - Has placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.

4.3.10 Conclusion

Management of underperformance requires a holistic approach that takes into account possible underlying causes of underperformance including health status, personality, well-being as well as work-related factors. Critical success factors include good clinical governance, occupational health and safety systems to monitor and identify performance issues early, a just and supportive culture that encourages doctors to seek help early without fear of being stigmatised, building capability of senior leaders to manage underperformance and resources to remediate, reskill or rehabilitate the doctor and facilitate return to work as soon as possible. Understanding an individual's motivation to change and engaging them in the process of change should be part of the performance management process.

4.4 Appropriate Workplace Behaviour

All organisations must aim to promote an environment where employees enjoy good working relationships. This means that all staff including medical staff should be able to work in an environment that is free from inappropriate workplace behaviour. The expected behaviour must be outlined in documents like the employee code of conduct, policies and procedures and contracts. All employees must be expected to conduct themselves in a manner that is in accordance with organisational values and respect for the rights and welfare of patients and other employees. In addition, organisational values and culture of respect, teamwork and compassion must be frequently communicated to all employees, and performance should be assessed against the demonstration of those values. Good behaviour driven by values must be recognised and rewarded. All this creates a platform for promoting good behaviour and successfully managing inappropriate behaviour.

4.4.1 What Is Inappropriate Behaviour?

Inappropriate workplace behaviour is a broad term that includes any behaviour that breaches the organisation's values, professional codes of conduct or legislative requirements.

4.4.2 Disruptive Behaviour

Disruptive behaviour is a well-known term for a particular type of inappropriate behaviour and has been extensively described in the context of the medical profession. The American Medical Association has described disruptive behaviour as *"Chronic and repetitive inappropriate*

behaviour that adversely affects the effective functioning of other staff and teams and interferes with patient care" [30]. The College of Physicians and Surgeons of Ontario define disruptive behaviour in more detail as: *When the use of inappropriate words, actions or inactions by a physician interferes with his or her ability to function well with others to the extent that the behaviour interferes with, or is likely to interfere with, quality health care delivery. Disruptive behaviour may, in rare circumstances, be demonstrated in a single egregious act, for example, a physical assault of a co-worker, but is more often composed of a pattern of behaviour. The gravity of disruptive behaviour depends on the nature of the behaviour, the context in which it arises, and the consequences flowing from it* [31].

Stewart et al. have published a good review of Disruptive Physician Behaviour which readers are encouraged to read [32]. Some of the key learnings from the review are described in this section.

- **Impact of disruptive behaviours.**
  - Patient harm.
  - Poor team performance.
  - Difficult work environments.
  - Poor patient satisfaction.
  - Nurse recruitment problems.
  - Litigation risk.
- **What does disruptive behaviour look like?**
  - Inappropriate words.
    Profane, disrespectful, insulting, demeaning or abusive language.
    Demeaning comments or intimidation.
    Inappropriate arguments with patients, family members, staff.
    Rudeness.
    Boundary violations with patients, family members or staff.
    Gratuitous negative comments about a colleague's care (orally or in notes).
    Censuring colleagues or staff in front of patients, visitors or other staff.
    Outbursts of anger.
    Behaviour that others would describe as bullying.
    Jokes or comments about race or ethnicity.
  - **Inappropriate actions/inactions.**
    Throwing or breaking things.
    Refusal to comply with known and generally accepted practice standards.
    Use or threat of unwarranted physical force with others.
    Repeated failure to respond to calls or requests for information.
    Repeated and unjustified complaints about a colleague.
    Not working collaboratively or co-operatively with others.
    Creating rigid or inflexible barriers to requests for assistance or co-operation.

Another framework for categorising disruptive behaviour has been described by Swiggart et al. as a spectrum of behaviours from aggressive through passive-aggressive to passive [33]. Some examples of passive behaviours which can be equally disruptive to patient safety include not answering calls, avoiding meetings, non-participation in unit activities or persistent lateness. Passive-aggressive behaviours have been described as hostile notes/messages, constant complaining or derogatory comments about the institution.

4.4.3 Factors Contributing to Disruptive Behaviour

These may be categorised as individual factors and environmental factors. Individual factors may be further classified into skills, health status and personality-related factors.

4.4.4 Individual Factors

- Skills.
  - Poor communication and influencing skills.
  - Poor conflict resolution skills.
  - Poor leadership skills.
  - Low empathy.
  - Low insight.

- Health.
  - Dependency on drugs or alcohol.
  - Mental illness.
  - Stress.
  - Cognitive impairment, or.
  - Physical illness.
- Traits/Personality.
  - Driven.
  - Compulsive.
  - Perfectionist.

4.4.5 Environmental Factors

- Life.
- Family problems,
- Financial problems,
- Work Environment.
- High work demands with low support.
- System that rewards disruptive behaviour.
- Poor systems for responding to genuine concerns.
- Tolerance of low-level aberrant behaviour.
- Failure to clearly communicate behavioural expectations.

4.4.6 Other Types of Inappropriate Workplace Behaviour

Specific examples of behaviour or conduct that is below the standard include

- *Workplace Bullying* is repeated and unreasonable behaviour directed towards an employee or group of employees that creates a risk to health and safety (WorkSafe). Unreasonable behaviour involves behaviour that a reasonable person, having regard for the circumstances, would see as unreasonable.
- *Discrimination* occurs when someone, or a group of people, is treated less favourably than another person or group because of a protected attribute, that is race, colour, nationality, sex pregnancy, marital status, age, disability, religion, sexual preference (HREOC). Discrimination can be direct or in-direct.
- *Harassment* occurs when someone is made to feel intimidated, insulted or humiliated because of a protected attribute, that is, race, colour, nationality, sex, disability or sexual preference (HREOC).
- *Sexual Harassment* is unwelcome or unwanted sexual behaviour which makes a person feel offended, humiliated and/or intimidated where that reaction is reasonable in the circumstances (Sex Discrimination Act 1984).

4.4.7 Managing Inappropriate Behaviour

Inappropriate workplace behaviour needs to be managed quickly and carefully because in addition to breaching organisational policies, it can also breach state and federal legislation and could result in penalties for both individuals and the organisation. Bullying behaviour may compromise safety of staff either physically or mentally, which can breach Occupational Health & Safety legislation. The formal process for management has been outlined in the section on Performance Management. It is advisable to involve the Human Resources department in serious issues.

Critical success factors in effective management include

- Clear expectations about expected behavioural standards through code of conduct and policy documents.
- Executive support for zero tolerance of inappropriate behaviour.
- Education and empowerment of staff to identify, deal with or report inappropriate behaviour.
- Empowering frontline staff to deal with lower level aberrant behaviour early.
- Training and support for managers in managing inappropriate behaviour.
- Dealing consistently and transparently with complaints about inappropriate behaviour.
- Having a graduated set of outcomes (informal, formal, disciplinary, regulatory) depending on the severity of the incident.
- Making support available to victims as well as perpetrators of inappropriate behaviour.

4.4.8 Conclusion

Inappropriate workplace behaviour is a risk to patient and staff safety, undermines the morale of the workforce, increases turnover and decreases productivity. Bullying comprises an occupational health and safety issue. Employers have a positive statutory obligation to provide a healthy and safe workplace free from bullying. Employers who breach work health and safety laws are subject to penalties under the relevant work health and safety legislation. Discrimination and harassment fall under the legal framework of Anti-Discrimination laws, and when this occurs, employees can pursue legal action against an employer in a court/anti-discrimination tribunal or Fair-work Australia.

Hence it is critical for organisations to have the capability to identify and manage inappropriate behaviour promptly, consistently and transparently, ensuring support for all involved.

4.5 Managing Mental Health and Well-being of Doctors

Complete Mental Health: It is more than the absence of mental illness!

As per Corey Keyes, Complete Mental Health is a state of absence of mental illness and presence of mental health [34]. Mental Health and Mental Illness fall on two separate continua Mental Health is described as a state of positive emotions such as feeling good, and positive functioning or functioning well. Absence of mental health may result in a state of being that is empty and hollow even though the individual may not be mentally ill. This state has been described as Languishing by Keyes. Keyes suggests that the state of Languishing is as bad as a major depressive episode. On the other hand, people who have high mental health and no mental illness are described as Flourishing. For complete mental health in the workplace, we need separate strategies to prevent and manage mental illness and increase mental health.

Therefore, any health and well-being initiative in the workplace needs to address both prevention and management of ill health and promotion of well-being by creating conditions where employees can pursue a fulfilling career, accomplish their personal and professional goals and achieve their full potential.

4.5.1 Understanding Workplace Health and Well-being

The well-being of individuals in a workplace is a product of complex interactions between factors within and outside the workplace. Each individual worker brings with them their own strengths or protective factors and vulnerabilities or risk factors to work, which are usually outside the control of workplace interventions. These factors include:

- Individual bio-psychosocial factors—genetics, personality, early life events, cognitive and behavioural patterns, mental health history, lifestyle factors and coping style.
- Personal life factors-family, social and cultural matters, financial health and significant life events.

In addition, the workplace has its own risk and protective factors for mental health. These factors include:

- The design of the job—demands of the job, control in the work environment, resources provided, the level of work engagement, characteristics of the job and potential exposure to trauma.
- Team/group factors—support from colleagues and managers, the quality of interpersonal relationships, effective leadership and availability of manager training.
- Organisational factors—organisational change, perceived organisational support, recognising and rewarding work, perception of organisational justice, psychological safety climate, organisational culture, safety of physical environment.
- Home or work conflict—the degree to which conflicting demands from home, including significant life events, interfere with work and vice versa.

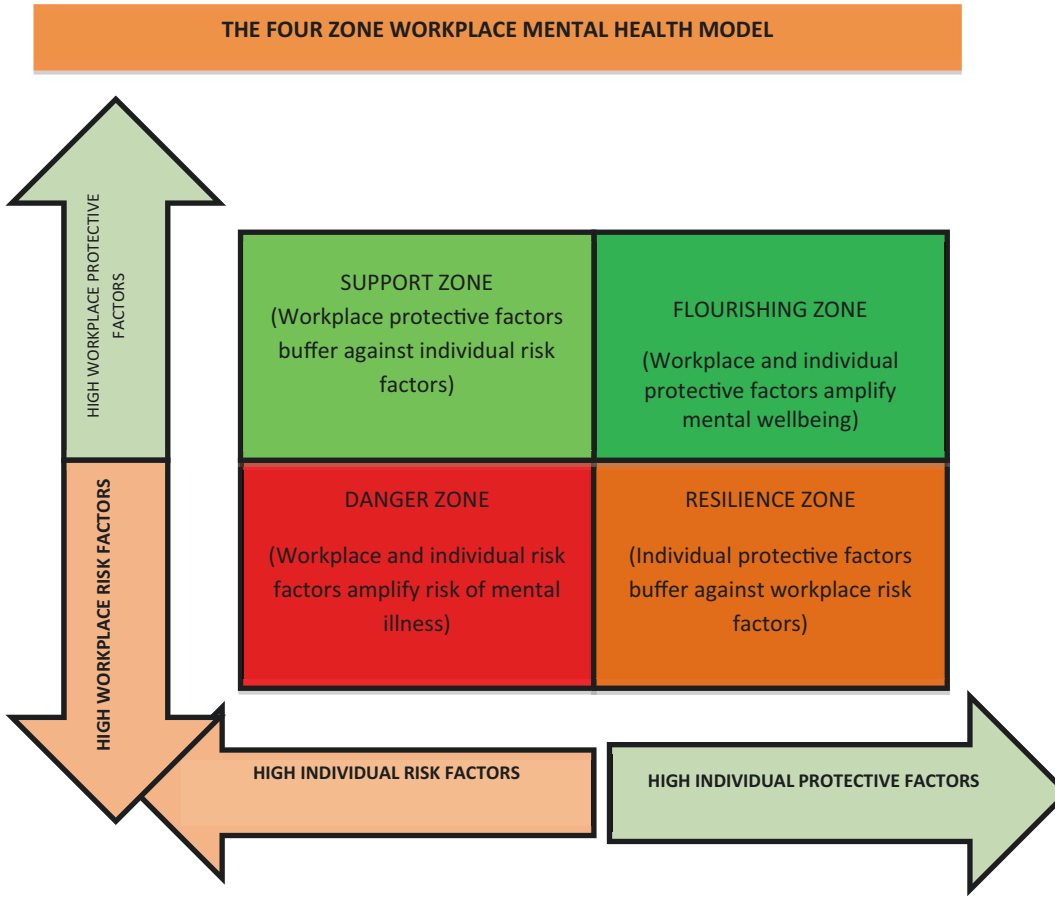

Fig. 4.1 The four-zone workplace mental health model (developed by author)

The workplace and individual factors can have an amplifying or buffering effect on the well-being of individuals. The Four Zone workplace mental health model, developed by the author, conceptualises the amplifying or buffering interaction between individual and workplace factors which can place an individual in one of the four zones described below (Fig. 4.1).

- Danger zone: Workplace risk factors add to individual risk factors and amplify the risk of mental illness.
- Resilience zone: Workplace risk factors are buffered by individual protective factors.
- Support zone: Workplace protective factors buffer against individual risk factors.
- Flourishing zone: Workplace protective factors add to individual protective factors to amplify mental well-being.

Worker well-being remains a shared responsibility of the individual worker and the organisation they work in. Individuals must take responsibility and accountability for recognising and addressing their personal risk factors and strengthening their protective factors. Some of these may be outside their control, but addressing life style factors, health concerns, unproductive behavioural patterns, personal relationships, and financial health may be some areas that could be modifiable.

Workplaces in turn should strive to keep workers in the Flourishing or Support zone and avoid

the Danger zone. It should also strive to ensure that individual protective factors in the Resilience zone are not overwhelmed by workplace risk factors tipping workers into the Danger zone.

4.5.2 Mental Health and Well-being of Doctors

Despite being a highly paid and highly respected profession, the mental health and well-being of doctors has been of concern for some time now. The National Mental Health Survey of Australian Doctors and Medical Students found that doctors and medical students reported substantially higher rates of psychological distress and attempted suicide compared to both the Australian population and other Australian professionals [3]. Similar findings have been demonstrated around the world. In a large survey of American surgeons, Shanafelt et al. (2009) found that 40% reported symptoms of burnout and 30% screened positive for symptoms of depression [21]. Goldberg et al. (1995) found 60% Emergency Physicians reported moderate to high burnout [20]. In a systematic review of 15 studies, Thomas has found a high level of burnout in medical residents [22].

As described earlier in the chapter like any employees a doctor's performance is closely linked to their health and well-being. Poor mental health can impact on the doctor's ability to safely provide clinical care as well as contribute to inappropriate conduct and behaviour. In addition, stress related to poor working conditions, high workload and work-life conflict could cause job burnout that, in turn, can impact on performance. Therefore, providing an environment that promotes and protects health and well-being and prevents ill health is essential for ensuring a high-performing workforce that will then achieve the overall aim of providing safe and high-quality patient care.

Similar sentiments are also evident from other sources. In 2008, Donald Berwick and colleagues provided a framework for the delivery of high-value care in the USA, the Triple Aim, that is centred around three overarching goals: improving the individual experience of care, improving the health of populations, and reducing the per capita cost of healthcare [35]. Recently it has been suggested that the Triple Aim be broadened to a Quadruple Aim to include "improving the provider experience" as this is a key enabler of the first three goals. It is suggested that improving the provider experience so that they can find joy and meaning at work will lead to an engaged and productive workforce that is essential to realise the first three goals [36].

4.5.3 Creating a Mental Health and Well-being Strategy

All organisations should invest in creating a Mental Health and Well-being Strategy for their staff including doctors. Organisations like the World Health Organisation, European Network for Workplace Health Promotion (ENWHP) and Beyondblue have developed useful guidelines for this and readers are encouraged to explore these [37–39].

Some key learnings from these guides are that workplace mental health strategies should aim to:

4.5.4 Support Employees with Mental Illness

- Identify and support people with a mental illness including their return to work process.

4.5.5 Prevent Mental Illness in at Risk Employees

- Make it easy to seek help.
  - Creating a network of support people and programmes like the Employee Assistance, Peer Support.
  - Increase capability of all staff including supervisors and peers to recognise and assist individual in need of help.
- Raising awareness about mental illness.
- Reduce stigma about mental illness.

  - Talking openly about mental illness.
  - Sharing of stories by seniors about their success in managing mental illness.
  - Supporting employees with mental illness to remain in the workplace or successfully return to work following an absence due to mental illness.

4.5.6 Protect Mental Health of Healthy Employees

- Recognise and identify stressors in the content and context of work that play a part in decreasing well-being. Risks for doctors include:
  - Overwork.
  - Low recognition.
  - Poor relationship with superiors.
  - Sustained mental effort.
  - Low participation in decision making.
  - Competitive climate.
  - Information not clear.
  - Insufficient information to do work.
  - Role ambiguity or conflict.
  - Inequity.
  - Poor interpersonal relationships.
  - Poor working conditions.
  - Poor leadership and communication.
  - Conflicting home and work demands.
- Reduce the impact of these stressors by:
  - Reorganising poor work processes.
  - Increase control that doctors have over their work.
  - Include them in decision making and problem solving processes.
  - Balance effort and rewards.
  - Improve communication and feedback.
  - Clarify roles and expectations.
  - Ensure adequate training to perform the role.

4.5.7 Promote Mental Health and Well-being

- Create a positive workplace culture that helps doctors accomplish their professional and personal goals.
- Enable nurturing and high-quality relationships.
- Improve engagement in organisational decisions.
- Help them find meaning and purpose in their organisational roles.
- Make work environment pleasant.

In addition, doctors should be encouraged to take responsibility for their own mental health. In a thoughtful article, Hatem suggests that physicians should continually renew themselves and realise that they are not a limitless resource and to continually find joy and satisfaction in work, they need the time and effort to replenish what their profession takes out of them [40]. Shanafelt suggests personal wellness strategies like cultivating meaningful relationships, developing hobbies, participating in community, spiritual or religious activities and undertaking exercise and health-promoting activities could help in renewal and replenishment [41]. He also emphasises aligning personal and professional values and managing any conflict between them.

Figure 4.2 depicts a conceptual model developed by the author for a complete mental health strategy for a workplace.

4.5.8 Conclusion

As providers of healthcare and as healers of humankind, physicians are a very valuable resource for society. It is, therefore, not surprising that physician mental health and burnout and its personal and public health consequences is a major concern for the profession and the public they undertake to care for. The current discourse on mental health and burnout is limited to its identification and management and focuses on eliminating the negative. While this is extremely important, institutions that employ physicians must also promote their well-being by creating a work environment that fosters positive experiences and actively cares for their well-being.

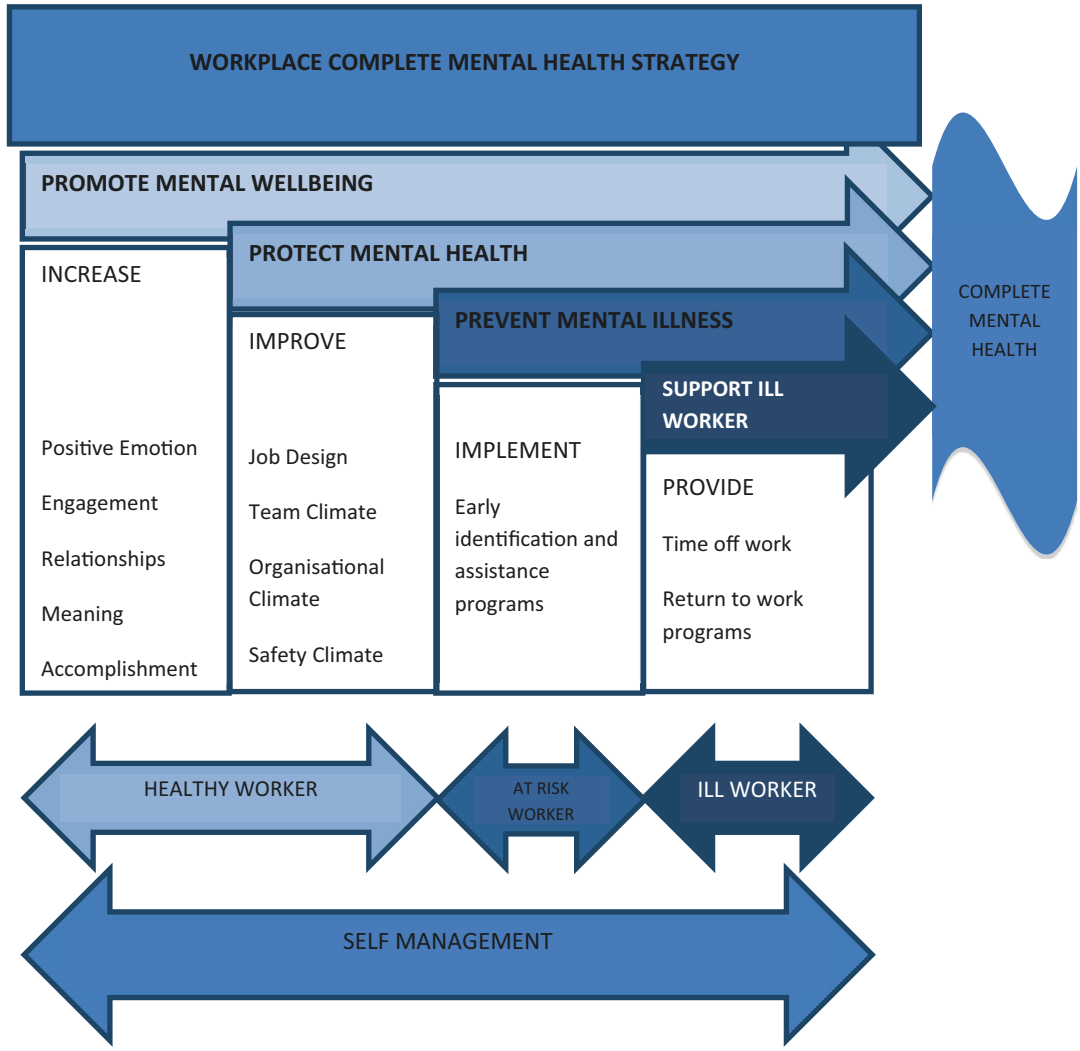

Fig. 4.2 Workplace complete mental health strategy

4.5.9 Reflections

Medical workforce management is a core skill of a medical administrator. This chapter provided a basic outline of five key aspects of this important topic. It is acknowledged that most of the material is relevant to hospital-based practice only. It does not cover broader topics on medical workforce strategy and planning, medical education and training, industrial relations and regulation of the medical workforce.

Doctors are leaders of healthcare teams, and their leadership impacts on the performance of the team and the outcomes the team achieves. They are highly trained and the most expensive labour category in health services. In addition, they also control a large part of the health expenditure with their decision making including admitting and discharging patients, treatment decisions including procedures, medications and devices and decisions about the setting of care. Therefore, it is critical that health services

employ or contract well-trained doctors who are equipped to provide high-quality care and ensure that their work environment, education, training, continued professional development and well-being are supported throughout their employment.

This chapter has provided the reader with basic information about the key aspects of medical workforce management compiled from my own training, practice and experience.

The section on Credentialling and Defining Scope of Clinical Practice took the reader through the policy framework, governance systems and operational processes required to ensure that an organisation fulfils its obligation to ensure that professionals employed to provide healthcare are competent and work within their approved scope of practice. It will assist medical administrators in setting up governance systems for this in their organisations. It is important that adequate resources are allocated to ensure that the system and processes are sustainable. Medical Administrators must scrutinise the integrity of the processes personally and ensure that scrupulous documentation is maintained. Ensure that doctors are given adequate time to submit the extensive suite of documents but are clear that they will not be able to commence their employment until all documentation is complete.

The section on Performance Enhancement informed readers about the importance of continuously supporting and developing the medical workforce to achieve their personal and professional goals and realise their full potential. In practice, this area is still developing, and there is variability in the uptake of this concept among doctors. Doctors see this as a management task to be done between a manager and an employee. Even where unit-based structures exist, the relationship between the medical head and other doctors may still be peer-based, and having a peer review your performance may not sit comfortably with both the Head and the reviewer or reviewee. While most organisations require annual performance reviews of their medical staff, these are done inconsistently and may be a tick-box exercise rather than a meaningful developmental conversation that mutually benefits the medical staff member and the organisation. Readers are encouraged to give more thought and attention to this important aspect of medical workforce management to get the best out of the medical workforce.

The section on Performance Management stepped the reader through the complex process of managing performance that does not meet the expected standard. This is made more difficult than it should be as expectations of required standards are not made clear from the start. Medical Administrators must spend time and thought in ensuring that standards of competence and behaviour are clearly understood by all and that medical staff and medical leaders are held accountable for upholding those standards. It is critical that performance issues are identified early and managed expediently and consistently following the principles of procedural fairness and natural justice. Medical leaders must be trained in giving feedback and the art of having difficult conversations and supported by the organisation when required to manage the performance of their medical staff.

For a long time, the medical profession has normalised and tolerated the disruptive workplace behaviour of their colleagues. However, this culture is changing fast, and there is a growing understanding that inappropriate workplace behaviour is a risk to patient and staff safety, undermines the morale of the workforce, increases turnover and decreases productivity. In addition, organisations are required by legislation to ensure a safe working environment which makes effective management of such behaviour essential. Medical administrators must ensure that standards of behaviour are crystal clear, are role modelled by medical leaders, and any breach is managed effectively. Addressing underlying factors that trigger disruptive behaviour is also critical to ensure a lasting change.

Managing Health and Well-being of Doctors is an important area; this section introduced some original concepts that the author has developed. Readers will be aware of the growing concern about the well-being of doctors and the high rates

of anxiety, depression and suicide in the medical profession. A lot of factors that affect well-being are personal to an individual and outside the control of an organisation. However, in today's work culture where the boundaries between work and life are blurred, the workplace must recognise personal factors that may affect well-being and put in place supports in the workplace to help individuals while they are dealing with these issues. The Four Zone Workplace Mental Health model helps conceptualise the buffering and amplifying effect of individual and workplace risk factors and protective factors. By minimising workplace risk factors, Medical Administrators can help reduce the impact of risks that the individual brings with themselves. The Complete Mental Health Strategy framework provides a comprehensive overview of what is required to ensure that any such strategy meets the requirement of ill workers, at-risk workers and healthy workers. Most workplaces implement systems like Employee Assistance Programs to support injured or ill workers. However, most workers are healthy, and their mental health must be protected from the day-to-day risks and frustrations inherent in large and complex health systems. In addition, the workplace must provide conditions promoting mental health so workers can flourish and realise their full potential. The ideal workplace should be a place that gives workers joy and meaning, where they make long-lasting, nurturing and supportive relationships, feel engaged in their day-to-day work and go home with a feeling of accomplishment every day. Working towards such a workplace will not only improve the ensure that medical staff feel good and function well, it will also help Medical Administrators to improve their own sense of well-being.

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