Senior medical staff performance appraisal and support - literature review

Department of Health
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Purpose of this literature review

The purpose of this review is to inform the development of a process for senior medical staff in Victorian public health services to participate in formal performance systems and to identify what facilitators and barriers may exist to help or hinder the establishment of such arrangements.

To that end the literature review identifies key publications from the general literature relevant to performance review, management and appraisal, in particular as it relates to effective performance appraisal; goal setting; and the skills needed for performance management.

Evidence from medical journals about current trends in medical performance appraisal is presented along with information about multi-source feedback, practice and work assessment and self-assessment, which are tools that are gaining prominence in the related field of performance management of the medical profession.

Then follows a section on re-envisioning expectations about medical professionalism and accountability and the responsibilities of the profession in the context of external demands for more formal approaches to ensuring that doctors are able to provide safe medical care.

A summary is provided of relevant regulatory arrangements as they currently exist in Victoria, including the role of the Medical Practitioners Board of Victoria, the Specialist Medical Colleges and employing health services.

Information is provided about the current performance management arrangements for senior medical staff in the United Kingdom, United States, and in the Australian States of New South Wales, Queensland and Western Australia.

A summary is also presented of key legal and industrial matters that may impact upon the introduction of performance management and appraisal systems in Victorian public health services.

Finally, an analysis of the foregoing is presented to address the question of how senior medical staff performance review and management processes are best structured and undertaken and the barriers and facilitators that may impact on outcomes.

Introduction

In recent years, as a consequence of the uncovering of clinical governance failures interstate and overseas and also as a result of the continuing managerialist push into the public sector there has been a drive by government and consumer groups to increase regulation and oversight of the profession (Maynard & Bloor 2003). Medical practitioners, registration authorities, specialist colleges, health services and insurers in Australia and overseas are facing up to the challenge of ensuring public and government confidence that the members of the medical profession are competent and safe to provide care to their communities.

The medical profession holds a rare position characterised by high respect and community trust which is tied to significant professional and personal responsibility. This relationship is founded in the concept of professionalism, where society grants professions a monopoly over the use of
a body of knowledge and skills and allows autonomy through the privilege of self-regulation, for
which the profession guarantees competence, integrity and altruism (Cruess et al 2002). Therefore the profession has an obligation to set and maintain standards for education and training, entry into practice and provision of care, the extent of which is detailed in the **AMA Code of Ethics**, in the guidance of the Australian Medical Council, **Good Medical Practice: A Code of Conduct for Doctors in Australia** and in additional professional guidance promulgated by the Specialist Colleges.

Currently, senior medical practitioners working in public hospitals in Victoria are subject to three significant processes to determine their suitability to work:

- professional registration with the Medical Practitioners Board of Victoria;
- compliance with the continuing education and maintenance of standards requirements of a Specialist Medical College;
- work-based systems including employment contracts, credentialling, definition of scope of practice, clinical audit and quality assurance.

It is now proposed that additional developmental, review and support mechanisms for Victorian senior medical staff, which broadly represent generic management definitions of performance management, should also be introduced. However, as noted in the general management literature, performance management goes by many names, is defined in a variety of ways and includes an array of concepts (Behn 2002).

For the purpose of this paper, performance management is defined as:

‘…a process which contributes to the effective management of individuals and teams in order to achieve high levels of organisational performance. As such, it establishes shared understanding about what is to be achieved and an approach to leading and developing people which will ensure that it is achieved’ (Armstrong & Baron 2004). It also is a continuous leader-driven process which enables the performance of individuals and teams to align with established strategic goals (Aguinis & Pierce 2007; Nankervis & Compton 2006).

A key performance process is performance appraisal, which is defined as a ‘... positive process to give someone feedback on their performance, to chart their continuing progress, and to identify developmental needs. It is a forward-looking process essential for the developmental and educational planning needs of an individual’ (NHS 2006).

**Performance management**

Performance management is common practice in organisations (Gliddon 2004; Nankervis & Compton 2006), however too frequently performance management does not in fact enhance how individuals perform their work (Muras, Smith & Meyers 2008). This raises the question as to how to make the performance management process effective.

As an overarching concept, performance management is a process aimed at improving the performance of individuals, teams and organisations (Mwita 2000). According to the Australian Public Service Management Advisory Committee (2001) effective performance management can involve such elements as:

- clarification of performance objectives and expectations (i.e. tasks, outcomes, behaviours, values based systems, or a combination of these elements);
formal periodic performance appraisal of individuals or teams against the achievement of set objectives;

ongoing informal feedback on what is going well and what can be improved;

recognition and/or reward for performance;

capability building at the team and individual level;

coaching or other action to deal with developmental areas; and

development of particular capabilities linked with organisational business planning.

The literature indicates that effective performance management should include goal setting and formal performance appraisal as well as on-going informal feedback throughout the performance cycle. The key to achieving these outcomes is to include both formal and informal feedback loops so learning can be immediate. When leaders use informal and continuous positive feedback loops focussing on performance strengths, individual performance and organisational performance are enhanced (Vigoda-Gadot & Angert 2007).

However, notwithstanding these benefits the successful uptake in the public sector has been more muted, reasons for which include:

- practical – it may be that benefits of performance management, which is not necessarily a coherent set of proven ideas (Behn 2002) does not outweigh the costs (Wholey 1999); in addition there is the risk of unintended consequences (Smith 1995);

- managerial – performance management is difficult to do (Kettl 1997); it is no easy thing to improve performance and decision-making may be limited by financial or organisational restrictions (Behn 2002); and

- psychological – many attempts to measure performance are not necessarily positive (Julnes & Holzer 2001) and not unexpectedly create valid fears in the participants (Behn 2002).

**Effective performance appraisal techniques**

As identified above, formal periodic performance appraisal is considered a core component of performance systems. Appraisals are aimed at clarifying employees’ work objectives, identifying training needs and providing feedback in order that performance can be improved.

Generic management literature has identified that formal appraisal sessions should:

- Focus on performance strengths (CLC 2002), however if weaknesses need to be addressed, it is important that discussions are clearly focussed on specific suggestions for improvement or development, rather than simply telling the individual they did a ‘bad job’ or that they did something wrong (Locke & Latham 2007).

- Emphasise how an individual’s personality fits with the organisation (CLC 2002).
• Provide feedback from different sources (e.g. 360 degree feedback), as this helps increase the sense that the performance management process is fair in that it provides a broader view, not just the view of the direct manager (CLC 2004).

• Ensure that the employee has a clear understanding of expected performance standards (Bell & Kozlowski 2002):
  - If expected standards are not met adaptive guidance techniques can help the employee to come to their own realisation as to how personal development can occur (Bell & Kozlowski 2002).
  - Adaptive guidance is an evidence-based coaching technique that provides individuals with interpretive information to assist their personal learning process. It helps individuals interpret the meaning of their past performance and helps direct what they should focus on in order to enhance their skills in the future. As a result of adaptive guidance processes, individuals should be better equipped to make more effective learning choices and should be able to identify and direct their own learning (Bell & Kozlowski, 2002).

• Provide a clear link between the individual development plan and organisational goals and strategy (CLC 2002).

• Ensure there are sufficient levels of accountability and responsibility appropriate to the individual (CLC 2002).

• Have employees set their development plan in conjunction with their manager (Locke & Latham 2002). Goals should be written as behaviours which are specific, measurable, achievable, realistic and able to be tracked (Shaw 2004).

• Provide feedback from different sources as this helps increase the perceived level of fairness in the performance management process in that it provides a majority view, not just the view of the manager (CLC 2002).

• Discuss the long-term career-path of the employee within the organisation.

In order for the performance appraisal to be carried out effectively, research has determined that the following procedures should be in place (CLC 2002):

• Coaching and training in effective performance management for leaders, including how to have performance related conversations; effective goal setting techniques; and adaptive guidance coaching techniques.

• Grievance channels for performance review outcomes where the process yields results with which the employee strongly disagrees.

• At least one formal performance review each year, with informal reviews throughout the year with goal setting at the start of the cycle and a formal performance conversation at the end of the cycle.

• Fairness in any rating system so that performance standards are perceived as fair and linked to organisational success and strategy.
Goal setting as performance management

The outcome of an appraisal usually includes a personal development plan with some guidance as to the long-term career path and which also includes a number of agreed goals. Indeed, effective goal-setting is the most potent element of appraisal (Murphy & Cleveland 1995).

When set appropriately, goals can establish priorities, energise the individual, increase effort and determination, and promote action by drawing on past experience (Locke & Latham 2002). Effective goal setting has also been found to increase altruistic organisational citizenship behaviours that see the employee increase work commitment (Vigoda-Gadot & Angert 2007). The motivational effects of goals however can be affected by an individual’s level of commitment, the perceived importance of the goal, their self-belief about achievement of the goal, progress feedback, as well as task complexity (Latham, Borgogni & Petitta 2008).

Pioneering research conducted by Locke and Latham (2002) based on Goal Setting Theory (see Locke & Latham 1990) describes the characteristics required in order for a goal to influence an individual’s performance. This research has been replicated by subsequent studies in organisational settings (see Karakowski & Mann 2008; Locke & Latham 2007; Vigoda-Gadot & Angert 2007; Wegge, Bipp & Kleinbeck 2008). As such, goal-setting processes should include the following characteristics (Locke & Latham 2002):

- Goals should be set collaboratively between the manager and the individual rather than being assigned.
- Cognitive reasoning indicates that an individual’s participation in goal setting promotes their understanding through exchange of information and ideas on strategies to achieve the goal which then enhances self-belief that the goal can be achieved.
- Participation in goal-setting leads to more difficult goals than when they are assigned ((London, Mone & Scott 2004).
- If however a goal needs to be assigned, clear and understandable reasons behind the goal need to be given in order for performance to improve.
- The individual needs to be committed to achieving the goals which is helped by the individual being able to set or being involved in establishing their own goals which contributes to the ownership of the goal. Goal commitment has a strong, positive influence on performance (Klein et al 1999).
- Goals should be set at an appropriate level of difficulty.
  - If goals are too easy or too difficult they lose their motivational power.
  - If an employee does not have the self-efficacy or belief that they can achieve the goal, then motivation also falls away.
  - If employees are simply asked to ‘do their best’ there is insufficient guidance which allows for a wide range of views as to what constitutes effective performance, such that the actual performance of the individual may not improve.
The importance of attaining the goal by the individual and the potential impact they personally can have on the organisation should be understood.

Feedback on goal progress should be provided through clear performance metrics.

- The combination of goals plus feedback is more effective than goals alone.
- If individuals do not know how they are progressing it is difficult for them to know if they should, or how they should, adjust the level or direction of their effort.
- Progress feedback is often self-assessed, but is even more motivational when it comes from an external third party.
- Measurement of goal attainment can help maintain focus and motivation.

- Goals should be specific and time bound.
- There should be no more than 5-7 goals to achieve at any one time as more than this leads to goal diffusion and results in reduction of motivation and achievement of the goal (Shaw 2004).

Research looking at goal setting and performance management in the public sector found that goals are often lacking in clarity and are often open to a number of interpretations, which may be due to ‘fuzziness’ and ambiguity about strategic agency goals (Chun & Rainey 2005).

**Skills needed for performance management**

CLC (2002) research indicates that performance management is not an easy process to get right. Despite this being widely acknowledged it would seem that few seek ways to rectify this situation through offering training in the skills of effective performance management.

There are many elements of the manager-employee interaction that affect the outcomes of an employee’s performance. Elements that have a strongly positive impact on performance include: helping the employee to find solutions; helping the employee to find information, resources and technology; clear communication about expectations; the manager encouraging employees; the manager holding people accountable and measures performance. Frequent changes in assignments and projects have a significantly adverse impact on performance (CLC 2002).

As these interactions are so important for changing employee performance the manager driving the performance management process should be appropriately trained in such techniques. Research suggests that those in management or supervisory positions trained in goal setting are more effective at performance management than those who remain untrained (Ivancevich & Smith 1981). Individuals who are promoted to the level of manager because they are good at the technical aspects of their job may not automatically have the skills to become good managers of people.

A common mode of performance appraisal assigns ‘ratings’ to a set of pre-determined actions or outcomes, however neither this performance appraisal technique nor training in it are considered best practice as ratings are subjective and at risk of bias (Hedge & Kavanagh 1988). As there may be the risk of significant biases in ratings-based performance management processes, training in effective performance management is necessary for managers so they
avoid the common pitfalls such as the halo effect, central tendency and leniency (Viswesvaran, Schmidt & Ones 2005).

In order for the performance appraisal to be carried out effectively there should be coaching and training in effective performance management for appraisers including: how to have performance related conversations (see figure 1); effective goal setting techniques; and how to use adaptive guidance techniques which assist employees to learn how to guide their own development path (Bell & Kozlowski 2002).

**Figure 1: Maximum Impact on Performance through Formal Performance Management Conversations**

![Bar chart showing maximum impact on performance through formal performance management conversations.](image)

Whilst it is obviously important that managers are appropriately trained in effective performance management processes, it is equally important that the employee is trained in performance management also. As such, the employee should be trained in how to set goals, how to accept feedback and how to guide their own development. Research indicates that when an employee is trained in performance management: it increases belief in one’s own abilities and self-esteem (Gibson 2001); it increases the employee’s level of effectiveness (Gibson 2001); and helps individuals more effectively apply their skills to the job (Richman-Hirsch 2001). These findings together highlight the importance of firstly embedding an effective and motivational performance management process, and following through on this by training both the manager and the employee in how to make it as effective as possible.

**Summary of the above section**

In generic management literature definitional issues arise as to what is meant by performance management and performance review. However as an overarching concept, performance management is a process aimed at improving the performance of individuals, teams and organizations. Effective performance management can involve such elements as: goal setting, formal performance appraisal as well as on-going informal feedback throughout the performance cycle. There is strong evidence that good performance management increases employee attraction and retention, increases career optimisation, increases discretionary effort which can lead to increased productivity. However, the right environment and the commitment of the leadership of the organisation is needed to establish and maintain effective performance management systems to enable positive outcomes to be achieved on a regular and consistent basis.
Research has also identified how periodic formal appraisals should be undertaken and the skills needed by appraisers and appraisees. Goal setting is a key objective of performance appraisal and forms the focus of future personal, professional and organisational development.
Medical performance management and appraisal

The peer reviewed medical literature on performance management and appraisal to a large extent reflects the activity in key jurisdictions where new initiatives in the field are being developed and implemented. Consequently most of the literature about appraisal relates to the UK, where the government as employer has been instrumental in promoting change. In other jurisdictions such as the US where profession-driven initiatives such as Maintenance of Certification have been introduced, the research literature focuses on other instruments including multi-source feedback and performance and work assessment.

Consistent with evolving practice in the United Kingdom, Conlon (2003) identifies a number of components of medical performance systems:

- appraisal (appraisee centred) – involves reflection, is formative, developmental and confidential;
- assessment (personal) – involves measurement of targets/standards, audit, complaints and significant events;
- performance management (organisation) – involves comparison with others, with assessment against organisational agenda;
- revalidation (external/public) – involves licensing, is summative, with a public declaration of fitness of practice.

Performance management systems

An area of emerging research in the UK health sector attempts to link the sophistication of performance management systems to clinical outcomes. West and his colleagues (2002) found in the NHS considerable evidence that the extensiveness and sophistication of appraisal are linked to changes in individual performance, with appraisal systems, team work and the sophistication of training having the strongest relationship with lower patient mortality.

In a later study, based on 126 NHS hospitals, improved operational effectiveness, performance management and talent management were associated with lower rates of infection, lower readmission rates, more satisfied patients, more productive staff and better financial margins (Castro et al 2008). The researchers also found that hospitals with the greatest clinician participation in management scored about 50% higher on important drivers of performance than those with low levels of clinical leadership (Castro et al 2008).

Performance management needs to be embedded in an environment which encourages appropriate responses from managers (Smith & Goddard 2002). However, Smith (1995) has identified a number of barriers to effective performance management in health services:

- tunnel vision – focus on measured indicators, rather than other important, non-measurable indicators;
- measure fixation – effort is spent on meeting the measure rather than actually addressing the underlying issue;
• sub-optimisation – there is pursuit of narrow objectives rather than the overall priorities of the organisation;
• short-termism – where the long term consequences are not recognised;
• complacency – content with meeting middling performance;
• misrepresentation – where there is deliberate manipulation of data, results, and outcomes;
• misinterpretation – incorrect inferences about performance because of the difficulty of accounting for the full range of potential influences;
• gaming – where behaviour is altered so as to obtain strategic advantage;
• ossification – organisational paralysis brought about by an excessively rigid system of management.

**Appraisal**

It is observed that often appraisal in fact encompasses a combination of appraisal, assessment and performance management, but the greatest benefits accrue when it is limited to a structured process of facilitated self-reflection, which allows individuals to comprehensively review their professional activities and to identify areas of good performance and ones that need development (Conlon 2003). The two fundamental components of performance appraisal are therefore feedback on performance and objective setting (West 2002). In both general and medical management literature, appraisal is presented as a positive, self-reflective, non-punitive process. When appraisal is formative and educational it can become a powerful tool in personal development (Lakhani 2005). However, it can also be used for management-authorised summative assessment, the purpose of which relates to efficiency and resource use (Taylor et al 2002).

In the UK National Health Service formal performance appraisal is defined as a "... positive process to give someone feedback on their performance, to chart their continuing progress, and to identify developmental needs. It is a forward-looking process essential for the developmental and educational planning needs of an individual" (NHS 2006). In the NHS a formal appraisal meeting, which usually occurs on an annual basis, is structured around documentation prepared in advance by the appraiser and includes: reference to previous years goals and objectives; information about clinical work, administrative load, teaching, research; participation in audit, quality assurance and CPD; and information about relationship with colleagues and patients.

Positive drivers of appraisal include the use of personal development plans as a vehicle for life-long planning, processes that are consistent with organisational cultural change such as clinical governance and confidential arrangements which are consistent with a learning, not a shaming, culture (Conlon 2003).

A survey of three years of appraisal experience of Scottish general practitioners found that 47% of respondents had altered their educational activity, 33% had undertaken additional education as a result of the appraisal and 13% felt it had impacted their career development. However by third year only 41% reported appraisal was valuable or extremely valuable, down from 47% in the first year. The authors concluded that there is a clear requirement to ensure appraisal...
becomes relevant for all participants (Colthart et al 2008). A study of Welsh general practitioners found concerns about: the time spent on appraisal; questions about probity and health; links to revalidation; and summative rather than formative assessment (Lewis et al 2003).

Effective implementation of appraisal and feedback systems for medical practitioners requires the right environment, which includes:

- trained and skilled appraisers;
- properly resourced process, with protected time and appropriate remuneration for participating;
- support for the individual to fulfil his or her action plan;
- being seen to use appraisal outcomes to inform organisation strategy;
- useful evaluation of the appraisal system, and improving the process as it develops (Conlon 2003).

**Multi-source feedback**

Multi-source (360 degree) feedback (MSF) is the structured evaluation of performance through review by peers, other members of the clinical team and patients (Epstein 2007). MSF along with performance appraisal will be used in the UK to determine eligibility for re-licensing. It is asserted that medical knowledge as assessed by medical score is no longer a good predictor of individual performance, humanistic qualities and communication skills, so structured evaluation of performance through peer review and MSF is being introduced (Abdulla 2008).

Research shows that it is feasible to obtain assessment from professional colleagues about clinical performance in communication skills and humanistic qualities (Ramsay et al 1993). The most common changes were in relation to patient and team communication; the least common changes were in clinical competence (Sargeant et al 2007). MSF is not a replacement for audit when clinical outcomes need to be assessed but when interpersonal communication, professionalism, or teamwork behaviours need to be assessed it is one of the better tools available (Lockyer 2003). MSF is most effective when it includes narrative comments as well as statistical data, when the sources are recognised as credible, when the feedback is framed constructively, and when the entire process is accompanied by good mentoring and feedback (Norcini 2003b). Participants who responded negatively to feedback were not inclined to use it for practice improvement. Reactions were influenced by perceptions of accuracy, credibility and usefulness of feedback. Factors shaping these perceptions included: recruiting credible reviewers; ability of reviewers to make objective assessments; use of the assessment tool; and the specificity of the feedback (Sargeant et al 2005).

A systematic review of 64 articles observed 6 different methods of evaluating performance: simulated patients; video observation; direct observation; peer assessment; audit of medical records, and portfolio of appraisal. The review concluded that peer assessment is the most feasible method in terms of costs and time, it also noted that little psychometric assessment of the instruments has been undertaken so far, nor was the effectiveness of formative assessments well understood (Overeem 2007).
The validity of MSF and peer feedback, will be influenced by an extensive body of work on accountability (Lerner & Tetlock 1999). Accountable individuals, who are accountable in the sense that they must justify their views, feel pressured to please those being reviewed, so in the context of MSF there is a risk that this will lead to inflated ratings (Roch & McNall 2007).

**Practice and work assessment**

Practice and work performance assessment is the quantitative assessment of performance based on rates at which patients of doctors experience certain outcomes of care and/or the rates at which physicians adhere to evidence-based processes of care during practice (Landon et al 2003). Performance assessment is one of the four pillars upon which Maintenance of Certification in the USA is built. There are a number of substantial problems with assessment of outcomes: the patient’s outcome must be attributable solely to the doctor’s actions; patients with the same conditions will vary in complexity, as statistical adjustment is not completely effective; there is unevenness in case mix between doctors so comparison against set standards is problematic; the number of patients needs to be statistically significant which limits assessment to the most common conditions (Norcini 2003a); there is lack of evidence based measures for many specialties; and there is often no definition of thresholds of acceptable care (Landon et al 2003). There is also a risk that comparative measures, such as morbidity and mortality, can be over-interpreted which can lead to ill-considered performance management programs, which divert attention from genuine improvement strategies to superficial solutions (Lilford et al 2004). Overall the assessment of medical practitioners’ performance at work is considered to be in its infancy (Norcini 2005).

**Feedback**

Feedback, whether or not part of a formal appraisal system, can be used to communicate an individual’s performance in relation to a standard of behaviour or professional practice, with various bases for feedback including professional judgment, a local standard, evaluations, report cards and rankings. There is strong evidence that feedback on an individual’s performance is associated with improvements in performance and a reduction in errors across all employment sectors (Ilgen et al 1979). There is also information about the impact of feedback on specific changes to clinical practice. A systematic review (studies related to prescribing, referrals for diagnostics, management of common conditions) on assessment and feedback on medical practitioners’ clinical performance found it can change performance when provided systematically over multiple years by authoritative, credible sources. The effects of formal assessment and feedback on medical practitioner performance are influenced by the source and duration of feedback (Veloski et al 2006). A Cochrane Review of 118 studies reported that audit and feedback can be effective in improving clinical practice, however when it is effective, the effects are generally small to moderate. The relative effectiveness is likely to be greater when baseline compliance is low and when feedback is delivered more intensively (Jamtveldt et al 2006). Canadian general practitioners also report that private feedback they received was valuable and necessary part of medical professionalism; however they were reluctant to share this information with their patients (Rowan et al 2006). Other factors, such as practitioner’s active involvement in the process, the amount of information reported, the timing and amount of feedback, and other concurrent interventions, such as education, guidelines, reminder systems and incentives, also appear to be important, though their impact is not well documented (Veloski et al 2006).

**Self-assessment**

Self-assessment of knowledge is essential to the practice of medicine and self-directed life-long learning (Antonelli 1997). It is needed to assess specific learning needs and to choose
educational activities to meet these needs (Davis et al 2006). Self-assessment may be linked to assessment of competency and formal appraisal and be potentially useful in surveillance and demonstrating particular skills or it may emphasise a developmental approach which encourages personal and professional growth (Brown et al 1997). In Australia participation in continuing education usually involves significant self-assessment activities. A systematic review of the accuracy of self-assessment found that the preponderance of evidence suggests that medical practitioners have a limited ability to accurately self-assess (Davis et al 2006). The worst accuracy for self-assessment was amongst doctors who were the least skilled and those who were the most confident. (Davis et al 2006).

Alignment of individual performance goals and organisational strategic goals

A key objective of appraisal is to align performance and development goals of individuals with the strategic goals of the organisation. For this to occur there must be knowledge and understanding of the goals along with a trust in health service management and a willingness of the individual to engage with management in identifying and exploiting strategic opportunities, however culturally, clinical care and organisational leadership are different. The administrative focus is systems-oriented, collective and proactive, whereas clinicians are first and foremost accountable for treating individual patients (McAlearney et al 2005). This disjunction impacts opportunities for alignment. In addition the basis of the health service strategy may be far from clear-cut (Tuomela 2005) which will also make alignment more difficult.

Research also indicates that 70% of Australian medical specialists were unaware of their employers' organisational goals and hospital management infrequently followed clinician advice. Consequently, there is low level of congruence between the personal goals of individual medical specialists and organisational goals (Perkins et al 1997). Elsewhere, research demonstrates high level of doctor discontent with the doctor-manager relationship due to decreased clinical autonomy and reduced medical dominance (Davies & Harrison 2003) and also indicates that most health professionals (87%) believe that hospital administration is ineffective (Vlastarakos & Nikolopulos 2007), so garnering clinician support for alignment of personal and organisational goals under these conditions may also be constrained.

Further, organisations which wish to extend performance management systems to additional staff face difficulties caused by decentralised operational arrangements, lack of cohesion of performance metrics, uncertainty about what to measure and dispersed IT infrastructure (Lohman et al 2002).

Requirements to make performance management & appraisal systems work

The establishment and maintenance of an effective system of performance management and appraisal will likely rise and fall on the level of trust each party has with the system and with each other. Trust builds up over time after repeated interactions by parties in a relationship (Ring & Van de Ven 1992) and represents a willingness to accept vulnerability based upon expectations about positive behaviour from the other party (Hutt et al 2000). Trust is beneficial for organisations and as a basis for organisational relationships as it is potentially more cost-effective than detailed contracting and costly performance monitoring (Maynard & Bloor 2003).

However, consistent and marked differences as to how medical practitioners and health service management evaluate aspects of system reform and change are likely to militate against the development of trust. Medical clinicians, medical managers and general managers have distinct profession-based conceptions of clinical work. In a large multinational survey, medical clinicians held strongly individual rather than systemised views of clinical work and were equivocal about
the importance of the real cost of care and transparent accountability, whereas medical managers whilst supporting an individual view about clinical care recognised the value of financial realism and accountability. General managers supported systematised clinical work, financial realism and transparent accountability (Degeling et al 2003). These results confirm that differing professional cultures contribute to tensions between doctors and managers (Edwards & Marshall 2003).

In addition, opposition by medical practitioners to a blind and unrelenting drive for throughput and cost efficiency at the expense of clinical priorities (Degeling et al 2000) and to management-oriented paperwork lacking in clinical significance provides grounds for resistance to change by the profession (Degeling et al 2003).

Proponents of performance management systems must therefore necessarily overcome a number of cultural hurdles to convince clinicians of its value. To build trust in the system performance management should be reliable, valid, acceptable, feasible and have some educational impact (McKinley et al 2001).

Another major issue will be concerns as to how performance information is collected, used and stored. For instance, in the UK general practitioners see benefit in formative assessment to guide education and professional development, its original use, but not if it is linked to formal revalidation, a later add-on (Boylan et al 2005). Trust in performance management and appraisal will, therefore, be dependent upon agreed collection and use protocols.

Managers need to build trust and interpersonal relationships, notwithstanding likely professional tensions, however trust is dependent upon meeting expectations and not reverting to opportunistic behaviour (Hutt et al 2002).

Key elements of good practice in the design and implementation of effective performance management practice include:

- alignment – where systems are based on an understanding of the mission, values, objectives, culture and history of the organisation;

- credibility – the Board, CEO and management demonstrate commitment to the process and engage and win the support of staff; the gap between rhetoric and reality is narrowed; and poor performance is addressed;

- integration – the performance system is part of the overall management structure of the organisation and there is a clear link between the responsibilities of the individual and the goals of the organisation (APSMAC 2001).

Further, the NHS (2005) has devised a framework for quality assurance for appraisal of doctors, which is based upon four high level indicators:

- organisational ethos – there is unequivocal commitment from the highest levels of the organisation to deliver a quality assured system of appraisal integrated with other quality systems;

- appraiser selection, skills and training – there is a process for selection of appraisers, whose skills are continually reviewed and developed;
appraisal discussion – the discussion is challenging and effective; it is informed by valid supporting evidence that reflects the breadth of the doctor’s practice and results in a personal development plan which prioritises the doctor’s development needs and helps to inform organisational strategy (Conlon 2003); and

systems and infrastructure – the supporting systems are effective and ensure that all doctors are supported and appraised annually.

Summary of the above section
The establishment and maintenance of an effective system of performance management and appraisal will likely rise and fall on the level of trust each party to the arrangement has with the system and with each other. However, consistent and marked differences as to how medical practitioners and health service management evaluate aspects of system reform and change are likely to militate against the development of trust.

Key elements of good practice in the design and implementation of effective performance management practice have been identified as have factors to ensure the quality of the appraisal process.

A number of components of medical performance systems exist, including: appraisal; MSF; practice and work assessment; feedback and self-assessment.

Effective implementation of appraisal and feedback systems for medical practitioners requires: trained and skilled appraisers; properly resourced process, with protected time and appropriate remuneration for participating; support for the individual to fulfil his or her action plan; being seen to use appraisal outcomes to inform organisational strategy; useful evaluation of the appraisal system, and improving the process as it develops (Conlon 2003).

Feedback on medical practitioner’s clinical performance can change performance when provided systematically over multiple years by authoritative, credible sources. Other factors, such as practitioner’s active involvement in the process, the amount of information reported, the timing and amount of feedback, and other concurrent interventions, such as education, guidelines, reminder systems and incentives, also appear to be important.

Research into MSF shows that reliable data can be generated with a reasonable number of respondents, and physicians will use the feedback to contemplate and initiate changes in practice. The most common changes were in relation to patient and team communication; the least common changes were in clinical competence.

Practice and work performance assessment has a number of substantial problems with assessment of outcomes and there is a danger that comparative measures, such as morbidity and mortality, can be over-interpreted which can lead to ill-considered performance management programs, which divert attention from genuine improvement strategies to superficial solutions (Lilford et al 2004).

Performance management systems need as a whole, as well as well its component parts, to be reliable, valid, acceptable, feasible and produce a meaningful and useful outcome.

In optimal circumstances the various components of medical performance systems can have a positive impact on clinical practice and personal and professional development, however such efforts can be de-railed if identified factors are not in place.
Medical professionalism, accountability and clinical engagement

Medical professionalism and professional accountability are two key concepts which can establish a place for performance management in contemporary medical practice.

Society grants professions a monopoly over the use of a body of knowledge and skills and allows autonomy through the privilege of self-regulation, for which the profession guarantees competence, integrity and altruism (Cruess et al 2002). The profession has an obligation to set and maintain standards for education and training, entry into practice and standards of practice. Society must be confident that as a profession medical practitioners are skilled, competent, respectful and honest and that they oversee a regulatory system to guarantee that this is indeed the outcome (Irvine 2004). The public reasonably expects that in a modern health service the competence and professionalism of all doctors should be a given, not an additional avoidable hazard (Irvine 2007).

A social system can be defined in part by its population, structure and mechanisms for maintaining these, of which accountability is one such mechanism (Frink et al 2008). Accountability is the adhesive that binds social systems together, because if individuals are not answerable for their behaviours and decisions there will be no shared expectations in the society or organisation. (Frink & Klimoski 1998). Under conditions of accountability individuals can be made to justify or explain their actions. Rules and standards for conduct are also developed, with performance evaluated relative to these standards.

In recent decades, as a result of well-publicised failures of clinical governance and reports of unacceptable levels of adverse events occurring during the provision of medical care, the public and government has lost some confidence in the medical profession’s capacity to self-regulate.

Apart from the poor clinical outcomes in paediatric cardiac surgery at the Royal Bristol Infirmary, the most startling finding of the Inquiry was the collective attitude of the medical staff to clinical audit, teamwork, consent, complaints about poor outcomes and whistleblowing. The medical profession looked reactive and protective with a laid-back approach to accountability and transparency (Irvine 2004).

The failure of the medical profession to regulate so as to guarantee competence and patient safety has impacted on societal attitudes to professionalism (Cruess et al 2002). In turn this has led to the development and imposition by government of additional oversight, incentives and regulation. However, economic incentives, technology and administrative control will not be an effective surrogate for a commitment to professionalism (Sullivan 1995).

In the current era the central theses of professionalism must be re-discovered and be embedded in explicit standards in medical education, registration and licensure, specialist certification and employment contracts (Irvine 2007). Medical practitioners need to accept that they should follow explicit professional standards of good medical practice and undertake continuing professional development (Irvine 2007).

The setting and maintenance of standards is of overriding importance, and issues such as recertification and revalidation are, without question, now regarded as professional obligations (Cruess 2002). Through revalidation medical practitioners become personally responsible for demonstrating that they remain fit to practise (Irvine 2007).
Surveys show that patients expect medical practitioners to undertake frequent review and testing and government is challenging the profession to show that it provides high-quality care. If the profession is to retain the prerogative of self-regulation it must demonstrate that such regulation is thorough and exacting (Brennan 2005). In addition accountability requires not only evaluation but also answerability for decisions, behaviours and outcomes (Frink et al 2008).

For the ideal of professionalism to survive medical practitioners must understand it and its role in the social contract. They must meet the obligations necessary to sustain professionalism and accountability and ensure that healthcare systems support professional behaviour (Cruess et al 2002).

In the 21st century, whilst the core precepts of professionalism remain the same, how society expects them to be reflected in practice has changed. A comprehensive suite of performance arrangements which requires the active participation of members of the profession need to be applied, but the question remains how this can best be achieved.

**Clinical engagement**

Internationally the concept of clinical engagement as a mechanism to encourage participation by members of the profession in change programs and the development of safe and effective health services has gained momentum. Research indicates that hospitals where clinicians are engaged in planning and decision making perform better than where this is not the case (Goldstein & Ward 2004).

Establishing clinical engagement relies on health services treating staff fairly and to engender in them confidence, pride and passion in the work of the health service. Reflecting these attributes clinical engagement can be defined as:

> ‘The active and positive contribution of doctors within their normal working roles to maintaining and enhancing the performance of the organization which itself recognizes this commitment in supporting and encouraging high quality care’ (Applied Research 2008).

Clearly to develop clinical engagement requires positive action from the health service to encourage appropriate actions by the clinician.

In the United States, the Institute for Healthcare Improvement has been instrumental in promoting the improvement of the quality of health care through the greater engagement of medical staff. To that end it has developed a framework for engaging medical practitioners in quality and safety (Reinersten et al 2007). The key elements of the framework, which require action by both the health service and doctors, are:

- Discover a common purpose
- improve patient outcomes;
- reduce hassles for doctors and don’t waste their time;
- understand the history and culture of the organization;
- Reframe values and beliefs
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- make doctors partners and promote both individual and system responsibility for quality;

- Segment the engagement plan
  - involve doctors where their efforts are mandatory or very important to the success of the project;
  - identify, educate and inform champions and leaders;

- Use ‘engaging’ improvement methods
  - use data effectively;
  - make the right thing easy to try and easy to do;

- Be courageous and be true to the agreed objectives

- Adopt an engaging style
  - involve doctors from the outset and make their involvement visible
  - choose messages and messengers carefully;
  - communicate candidly and often;
  - value doctors’ time (Reinersten et al 2007).

In the United Kingdom, the NHS Institute for Innovation and Improvement (2008) also identified how health service chief executives and senior management can also develop clinical engagement and in turn effect the successful application of the IHI framework. Chief executives and senior managers need to:

- meet informally for face-to-face meetings with senior doctors;
- have additional, regular meetings with the senior medical staff group;
- meet all new senior doctors as part of their induction and again in three months to canvass their views about service improvements;
- ensure senior doctors are involved in all aspects of management of the health service; and
- devote resources to develop new clinical leaders (NHS III 2008).
Regulatory arrangements for medical practitioners in Victoria

Medical practitioners in Victoria are subject to a number of processes, operated under the auspices of various authorities, which collectively provide an assessment of that person’s suitability to work as a registered medical practitioner.

Medical registration and specialist medical colleges

Professional registration is a legal process that bestows recognition of a minimum standard of training in a particular field. In Victoria, at least until the implementation of national registration arrangements, the Medical Practitioners Board of Victoria has the statutory authority established under the Health Professions Registration Act 2005 to protect the community, by ensuring medical practitioners maintain professional standards and practise ethically and competently. Specifically, the Board:

- decides who is qualified and fit to practise medicine in Victoria;
- registers medical practitioners;
- promotes good medical practice; and
- investigates complaints about doctors’ conduct, and concerns about their professional performance or their health if this is impacting on their ability to practise.

The Board has powers that enable it to work with medical practitioners who are performing unsatisfactorily in a constructive and non-disciplinary way. This investigative pathway is intended to support the profession to maintain high professional standards while the Board meets its responsibility to protect the public. The performance pathway helps medical practitioners avoid the Board’s disciplinary procedures and is designed to be flexible and to facilitate negotiation with the medical practitioner concerned.

These powers allow the Board to arrange for an independent peer assessment of medical practitioners who are believed to be performing unsatisfactorily, identify whether there are deficiencies in performance and if so, define the deficiencies. The doctor who is found to be performing unsatisfactorily will be encouraged to take remedial action in order to remain in safe, active and useful medical practice.

Medical practitioners must re-register each year, at which time the Board requires them to make a mandatory disclosure as to whether they have been: ordered by a court to pay damages or compensation of $20,000 or more; convicted of an indictable offence; or been investigated, had restrictions imposed upon their registration or been prohibited from practising by another medical registering authority. The Board also seeks information about continuing education undertaken in the previous year. The majority of registrants indicate that they have participated in education programs conducted by the Specialist Medical Colleges.

Specialist Medical Colleges have a number of key responsibilities including standard setting, training the next cohort of specialists, maintenance of professional standards and the provision of medical education for this purpose, assessment of international medical graduates and participation in assessment of performance. Failure by Fellows of the College to successfully complete continuing education requirements (often a triennial cycle) may cause their
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membership of the College to lapse, which has the further consequence of their patients being unable to access specialist rebates from Medicare.

A number of these Colleges have in place guidelines and policies which their members must follow. For example, the Royal Australasian College of Surgeons has a policy titled *Clinical Standards Review Policy*. This policy establishes a mechanism for Clinical Standards Reviews as a valuable means of maintaining standards for both individuals and surgical units. However, it does encourage Hospitals and Health Authorities to manage internally issues where the competence of a surgeon is in question either because of illness or poor performance. The development of a performance appraisal process may be a means of complementing the aims policies such as the Clinical Standards Review Policy.

**Victorian health services – credentialling, performance management and appraisal**

Credentialling is a formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes for the purpose of determining their competence and suitability to provide safe, high quality health care within the organisation. Definition of the scope of clinical practice, which follows credentialling, involves delineating the extent of an individual medical practitioner’s clinical practice based on the individual’s credentials, competence, performance and professional suitability and the needs and the capability of the organisation to support the medical practitioner’s scope of clinical practice. (DHS 2007).

Credentialling and defining the scope of clinical practice of the individual medical practitioner are the precursor to appointment to the health service and consequent provision of a contract, which defines the rights and obligations of each party.

In Victoria each health service must have in place policies and processes for credentialling and defining scope of clinical practice for all medical practitioners with independent responsibility for patient care.

All health services must have committees which are responsible for undertaking the process. Members of these committees must have relevant expertise for their role and must not have any conflicts of interest.

The application for specialist credentialing and scope of practice requires:

- a curriculum vitae including certified copies of original qualifications;
- a copy of current medical registration;
- a copy of current medical indemnity insurance certificate;
- applicant and contact details;
- confirmation of qualifications;
- training and clinical experience;
- clinical appointments;
- academic appointments and teaching experience;
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- evidence of participation in continuing education and professional development;
- evidence of participation in clinical and peer review;
- information about health status;
- a disclosure about disciplinary actions or criminal activity;
- the names of three referees;
- a series of undertakings including agreement to participate in annual performance appraisal.

Re-application encompasses the presentation of information that may have changed since the previous application. Medical practitioners working in hospitals are also expected to participate in clinical audit and other quality assurance programs (Victorian DHS 2007).

In addition to the successful introduction of credentialing a number of other factors have come into play which have encouraged discussion about the introduction of a performance system for senior medical practitioners working in Victorian health services. These additional factors are:

- a requirement in most senior medical practitioner contracts that annual participation in performance review should occur;
- recognition by health services of the need to improve engagement with senior medical practitioners in a mutually-agreed approach to the delivery of safe, high quality care;
- the requirement in the by-laws of some hospitals that the hospital has responsibility to oversight and monitor senior medical practitioner professional development; and
- an accreditation requirement for health services that performance management systems must be in place.

The performance system would provide guidance about performance and professional development in the period between formal credentialling and scope of clinical practice reviews, which occur every 3-5 years.
Overseas and interstate jurisdictions

As identified above, the policy guidance about performance review arrangements overseas and interstate reflects to a significant extent key government and professional imperatives. For example, the profession in the UK is still coming to grips with the criticisms levelled at it by Dame Janet Smith in the 5th Shipman Inquiry report, which generated much debate and analysis. Progress in the introduction of a new revalidation process reflects the intense scrutiny of these proposals. The structure of the new system also lends itself to the employment relation of doctors in the UK National Health Scheme whereas in the USA, the key focus has been on Specialist Board recertification, rather than the role of the doctor as employee.

In Australia explicit expectations about performance management which also encompasses an appraisal discussion are now in place in NSW and Queensland, whilst remaining embedded in the wider context of clinical governance, credentialling and definition of scope of practice.

Revalidation in the United Kingdom – re-licensing and recertification

The 5th Shipman Inquiry report, which was released in 2004, criticised the General Medical Council’s proposed reliance on appraisal alone for revalidation, as it would be ineffective for picking up poorly performing doctors. Subsequently, the Secretary of State for Health commissioned the Chief Medical Officer to undertake a review and report on what further measures were necessary to:

- strengthen procedures for assuring the safety of patients in situations where a doctor’s performance or conduct poses a risk to patient safety or the effective functioning of services;
- ensure the operation of an effective system of revalidation;
- modify the role, structure and functions of the GMC (NHS 2006).

The Chief Medical Officer reported in July 2006, which has now led to the government and the profession in the UK working toward the implementation of a comprehensive program for the regulation of the practice of medicine.

The first change in the second half of 2009 is the introduction by the General Medical Council (GMC) of a licence to practise. All doctors will be required by law to hold a licence if they wish to exercise the privileges currently reserved for registered medical practitioners, including prescribing medications and signing death certificates. A new system of revalidation that will require doctors to renew their licence to practise every five years will also be introduced.

Revalidation has three elements:

- Re-licensure to confirm that medical practitioners do practise in accordance with the General Medical Council’s generic standards set out in guidance established in Good Medical Practice.
- Recertification to confirm that medical practitioners on the GMC’s specialist register or GP register continue to meet the standards appropriate for their specialty.
Identification for further investigation and remediation of medical practitioners whose practice is impaired or may be impaired.

Re-licensing, which will occur at least every five years, will have three main elements:

- Participation in annual appraisal within the workplace based on the doctor’s folder of information about their practice, which could include information about appraisal, CPD, audit, teaching and training undertaken, understanding about changes to clinical practice, probity and health (UK DH 2006).

- Participation in an independent process for obtaining MSF from patients and colleagues.

- Secure confirmation from the ‘responsible officer’ (usually the Medical Director) in their local healthcare organisation that any concerns about their practice have been resolved. The Responsible Officer will provide a recommendation to the GMC, on the basis of which it makes a decision whether the doctor’s licence should be renewed.

The second element of revalidation is recertification, which will apply to those doctors who are on the GMC’s specialist register or GP register. These doctors will need to demonstrate, through recertification, that they continue to meet the particular standards that apply to their specialty or area of practice. The Academy of Medical Royal Colleges, the individual Colleges and specialist societies will have a key role in setting recertification standards and designing methods by which doctors will be evaluated. In its role of protecting the integrity of the medical register and revalidation, the GMC will have to agree the standards and method of evaluation (UK DH 2008).

**Annual performance appraisal in the United Kingdom – a requirement for re-licensing**

Appraisal was introduced in the UK for hospital consultants in 2001 and for general practitioners in 2002. It was established as a positive process to give feedback on past performance, to chart continuing process and identify development needs. Specifically, the aims of appraisal are to:

- set out personal and professional development needs and agree plans for these to be met;

- regularly review a doctor’s work and performance utilizing, where possible, relevant and appropriate comparative operational data from local, regional and national sources;

- consider the doctor’s contribution to the quality and improvement of services and priorities delivered locally;

- review the doctor’s participation in continuing education;

- optimise the use of skills and resources in seeking to achieve the delivery of general and personal medical services;

- identify the need for adequate resources to enable any service objectives in the agreed job plan to be met;

- provide an opportunity for doctors to discuss and seek support for their participation in activities for the wider NHS;
utilise the annual appraisal process and associated documentation to meet the requirements for GMC revalidation.

Annual appraisal within a five year cycle of review will help to assess progress to revalidation, with the opportunity to remedy potential problems at a local level.

There is support amongst general practitioners for the professional development aspects of appraisal, however there are concerns about it being linked to revalidation (Boylan et al 2005).

A review undertaken to inform the implementation of revalidation found, however, that appraisal was geographically patchy across the NHS and not fit for the purpose of re-licensing across the country as a whole. As current systems of appraisal reflected the diversity of practice settings and employment arrangements, it was deemed not feasible to impose a new standardised model (DH 2008). It was therefore determined that a standardised module derived from *Good Medical Practice* and agreed by the GMC will be included in all appraisal systems, while other aspects of appraisal will be a matter for local employers.

The GMC module covers the following domains of *Good Medical Practice*:

- **Knowledge, skills and performance**
  - maintain professional performance;
  - apply knowledge and experience in practice;
  - keep clear, accurate and legible records

- **Safety and quality**
  - systems to protect patients and improve outcomes;
  - response to risks to safety;
  - protect patients and colleagues from any risks posed by the doctor;

- **Communication, partnership and teamwork**
  - communicate effectively;
  - work constructively with colleagues and delegate effectively;
  - establish and maintain partnerships with patients;

- **Maintaining trust**
  - show respect for patients;
  - treat patients and colleagues fairly and without discrimination;
  - act with honesty and integrity.

The new model of revalidation will also establish that employment contracts require providers to undertake appraisal.
Under the new arrangements, it is proposed that in the first instance appraisal will provide a component of evidence in determining suitability for revalidation. The appraisal module will require the appraisers to make a judgement as to whether the appraisee has presented the agreed evidence required to support validation, has engaged with the appraisal and has produced a personal development plan relevant to their learning needs (UK DH 2008).

The current appraisal process, follows a tight formula, which requires appraisees to prepare an appraisal questionnaire to reflect and review on: critical incidents/significant events; audits; practice report or practice professional development plan; prescribing data, referral data and other aspects of practice performance; complaints or suggestions from patients; educational activities and learning needs including Personal Development Plan; any concerns about probity; any concerns about health and fitness to practice; teaching activities; research activities; management activities (UK DH 2007). Preparation of the questionnaire and reflection on the above issues leads to the development an appraisal statement, which forms the basis of the appraisal. Only the practitioner and the appraiser see the appraisal statement.

**Multi-source feedback – a requirement for re-licensing in the United Kingdom**

In 2005 the Federation of Royal Colleges of Physicians was resourced to develop, pilot and validate peer and patient MSF in the UK. The principle underpinning the project was that participation in the MSF process should affirm a doctor’s good medical practice.

The colleague MSF feedback questionnaire included the following fields:

- clinical assessment – diagnostic skills, performance of technical procedures;
- patient management – complex problems; appropriate use of resources;
- reliability – conscientious; available for advice when needed; time management;
- professional development – commitment to improved quality; keeps up-to-date;
- teaching and training – contributes to the education & supervision of students and junior colleagues;
- empathy & respect – polite and respectful to patients and colleagues; compassionate with patients and relatives;
- team player – values the skills and contributions of a multi-disciplinary team;
- leadership – takes leadership role when require and delegates appropriately.

The patient questionnaire addressed issues including whether:

- the doctor was polite and considerate; listened to the patient and gave the patient an opportunity to ask questions;
- the doctor explained things in an understandable way and involved the patient as much as he/she wanted in his/her care;
- the doctor respected the patient’s views;
the doctor asked the patient permission to undertake an examination and whether this was conducted with privacy and dignity;

the patient had confidence in the doctor and by the end of the consultation was better able to understand and/or manage their condition (Academy of Medical Royal Colleges 2007).

To achieve acceptable levels of reliability for MSF, a minimum of 8 colleague questionnaires and 22 patient questionnaires are required. Research also determined that the questionnaire offers a reliable basis for the assessment of professionalism. If used in the revalidation of a doctor’s registration, it would be capable of discriminating a range of professional performance among doctors, and potentially identify the minority whose practice requires greater scrutiny (Campbell et al 2008).

It has subsequently been decided in the UK that re-licensure will also encompass 360 degree or multi-source feedback. Key issues to be determined prior to the introduction will be:

- how the tools are administered;
- the principles and criteria that these feedback tools must meet in order to be acceptable for relicensure purposes;
- whether they can encompass the ‘whole practice’ of doctors who work in multiple sites;
- how information from MSF will be fed back to individual doctors; and
- whether MSF will be required for every appraisal, or only a proportion of them (UK DH 2008).

Responsible Officers and Appraisers

In England, the Responsible Officer will be a senior doctor in an organisation, typically designated as the Medical Director, who takes personal responsibility for: the employment of doctors; performance and conduct of doctors; annual appraisal and MSF; monitoring of clinical performance; handling complaints and collating information from various sources which may support a recommendation for revalidation (UK DH 2008). Each doctor in the UK will relate to one and only one Responsible Officer.

Appraisal, as it encompasses the whole of the UK medical workforce, both specialist and generalist, cannot only be performed by direct supervisors of doctors. Consequently, an approach of defining the attributes and requirements of the appraiser, rather than nominating a named post, has been used. Currently appraisers must: be on the GMC register; have been appraised themselves; have attended and completed training as an appraiser and be able to give constructive feedback to the appraisee; understand the content of the appraisal; undertake refresher programs for appraisers and attend relevant meetings. Appraisers are paid for undertaking this role (NHS 2006).

United States

In the United States, all medical practitioners must maintain licensure with a State registering authority. In addition they may also qualify as Board Certified, which is a voluntary process. Since 2002 all 24 member boards of American Board of Medical Specialties (ABMS) have
agreed to comparable standards of Maintenance of Certification (Cassel & Holmboe 2006). The new Maintenance of Certification (MOC) program represents a dramatic shift from how graduate medical education, initial certification in the medical specialties and recertification has been conducted (Batmangelich & Adamowski 2004).

All boards have agreed to issue time-limited certificates that necessitate subsequent recertification, usually at 10 years or less, with a more continuous process of accessing competence (Steinbrook 2005).

MOC includes four major components:

- professional standing, including an unrestricted license to practise medicine;
- lifelong learning and self-assessment in relevant clinical fields which requires undertaking education modules to qualify for continuing education points;
- demonstrated cognitive expertise with evidence including performance on standardised, monitored examination, which for instance in internal medicine, are three, two-hour tests on one day; and
- practice and work performance assessment such as medical care provided to patients for common problems, physician behaviour in communication and professionalism, which are compared with peers and national benchmarks (Miller 2005). This is the most controversial aspect of MOC, as it is difficult to measure; approaches differ amongst specialties (some more procedural than others); the general approach is critical self-assessment not inspection or regulation; and not statistically significant unless high volumes are involved (Steinbrook 2005).

**Canada**

Currently in Canada the processes for ensuring that physicians maintain their competence vary from province to province. For instance:

- 3 provinces (Saskatchewan, Ontario and Quebec) have mandated that physicians must participate in educational programs to maintain their licence to practice, the Australian equivalent of registration. This contains the right conceptual elements of maintaining competence, however as they are self-reporting they lack rigorous accountability (Levinson 2008);
- 2 provinces (Alberta and Nova Scotia) require physicians to participate in review processes in which they are offered feedback from patients and peers about their performance.

In 1999 the College of Physicians and Surgeons of Alberta, the statutory registration body for medical practitioners in that Province adopted a multisource feedback system for all medical practitioners, the Physician Achievement Review (PAR) program. Review of the program indicates that general competencies of physicians and general practitioners can be assessed by medical peers, co-workers and patients and MSF can be a feasible means of assessing the competencies of practising surgeons in communication, interpersonal skills, collegiality and professionalism (Violato, Lockyer & Fidler 2003).

Currently, every specialist and general practitioner in Alberta is reviewed every five years, so 20% of all registrants are reviewed each year. Each doctor asks 8 medical colleagues, 8 non-
medical co-workers and 25 patients to complete the relevant questionnaire. Specialty specific questionnaires have been developed for colleagues to complete (CPSA 2009). Overall, even though PAR operates as a quality improvement program about 4% of doctors are flagged as a result of the program and undergo a formal peer review of their practice (Theman, Oetter & Kendel 2009).

Given the variation in requirements across the country there have been calls for the provincial Colleges to implement a consistent program of revalidation for all physicians. This should include a rigorous, external assessment of physician competence and evidence as to the actual ability of physicians to implement quality of care in their practice, rather than relying exclusively on self-assessment (Levinson 2008).

Such a change would be consistent with the position of the Federation of Medical Regulatory Authorities of Canada (2007), which determined that the maintenance of certification programs of the College of Family Physicians of Canada and the Royal College of Physicians & Surgeons of Canada require their members to participate in and document their continuing professional development activities, but there is lack evidence of whether physicians put their knowledge and skills into practice.

Consequently FMRAC (2007) recommended that all licensed physicians in Canada must participate in a recognised revalidation process in which they demonstrate their commitment to continued competent performance in a framework that is fair, relevant, inclusive, transparent and formative, with revalidation being a constructive educational quality assurance process, independent and distinct from the disciplinary processes of the regulatory authorities.

**Continental Europe**

In Austria, Germany and Spain recertification and quality of care is promoted through continuing education, whereas in Belgium, France and The Netherlands peer review is also incorporated (Merkur et al 2008).

**New South Wales**

New South Wales Health has in place a policy directive (PD2005_498) which establishes a policy for the implementation of performance review for visiting medical officers.

The policy establishes that public health organisations have a responsibility to ensure that:

- health care is delivered in a way which minimises the risk of harm to patients;
- there are systems in place for measuring and routinely reporting on the safety and the quality of the care provided;
- all who work within the organisation participate in improving the quality of the care provided
- visiting practitioners meet the performance requirements for delivering the services they are contracted to provide.

The policy, *Performance Review of Visiting Practitioners: Policy for implementation* (2005) outlines the components of a performance review system for all visiting practitioners and provides a structure to give transparency and fairness in the performance review process.
Performance review records also provide a basis for objective assessment in any subsequent appointment and/or clinical privileging process.

The objectives of the NSW performance review are to:

- enhance professional development by providing regular feedback about performance and identifying appropriate development opportunities;
- provide an opportunity for candid two-way feedback where all aspects of performance are assessed;
- assist in ensuring that each visiting medical officer meets his/her contractual obligations in a competent manner that meets the expectations of the public health organisation;
- review quality assurance, quality improvement and clinical risk management activities and ensure that relevant activities for the following year are established;
- vary the contracts (in accordance with contract provisions) or agreements;
- where appropriate, update targets and performance criteria;
- assist in the early identification and management of any unsatisfactory practice or performance;
- identify opportunities for the public health organisation to support the practitioner in maintaining and improving performance.

The supervisor of the visiting medical officer, who is the medical person administratively responsible for the practitioner, undertakes the review on behalf of the employing organisation.

To facilitate the performance review process, model service contracts for VMOs contain a specific requirement to participate in the performance review system.

Unless the public health organisation or the VMO requests more frequent meetings, a performance review occurs at least once a year.

All parties sign off the record of review and plan for future activities. These reviews are part of the overall performance review process.

**Queensland**

The Queensland Government has recently promulgated a new Performance Appraisal & Development (PAD) policy (G9, July 2008). The Policy applies to all Queensland Health employees. The purpose of the policy is to enhance work performance and career development by: clarifying performance expectations of employees; ensuring feedback and guidance on performance; and collaboratively identifying learning and development needs and activities.

Employees and managers are required to:

- Participate in the PAD process twice a year for existing employees and within three months of commencing for new employees.
Develop a PAD plan or formally document a discussion about performance goals, corporate values, learning strategies and actions required to obtain new skills or develop existing skills for the current position. The PAD plan or discussion must be consistent with District/Divisional Strategic Plans and the Queensland Health Strategic Plan.

Conduct a performance appraisal meeting to assess previous performance and clarify the employee’s role. For clinicians and managers this will involve reflection on their own performance and provision of data to support their self-assessment across a range of relevant dimensions of performance.

Participate in ongoing management of workplace performance including work allocation, coaching and regular feedback discussions.

If necessary, manage unsatisfactory performance in accordance with the Performance Improvement policy.

Record on the appropriate form that the PAD process has been completed for each employee.

The PAD Plan is to encompass the range of dimensions and performance indicators in the role description.

The Plan should also refer to:

- service objectives which links organisational and departmental objectives to staff performance;
- interpersonal objectives such as professionalism, teamwork, accountability;
- technical objectives the evaluation of which may be supported by Credentialing and Scope of Practice processes when they are in place for a specific professional group, as well as clinical audit processes;
- ethical principles as outlined in the Code of Conduct;
- Queensland Health Values of caring for people, leadership, respect and integrity;
- developmental needs including developmental aspects of the role (e.g. their own learning needs, participation in teaching and/or research).

All managers are required to conduct a mid cycle and annual review of all staff.

**Western Australia**

In Western Australia a number of related processes and policies are in place to ensure the quality of care provided in public hospitals. These include:

- clinical governance;
- recruitment, selection, appointment and engagement;
- credentialling and defining scope of practice; and
Clinical governance brings together activities that promote, review, measure and monitor the quality of patient care in order for health care to improve. It is defined as “a systematic and integrated approach to assurance and review of clinical responsibility and accountability that improves quality and safety resulting in optimal patient outcomes”. A Clinical Governance Framework for WA Health has been developed based on the following four key components, known as Pillars:

- consumer value;
- clinical performance and evaluation;
- clinical risk; and
- professional development and management.

Credentialling and defining the scope of clinical practice fall within ‘professional development and management’ and provide the health care facility with a level of confidence that staff have adequate skill, experience and knowledge to undertake the responsibilities of the position.

Recruitment, selection and appointment focus on the employment of ‘the most suitable and available applicant on the basis of merit, equity and probity.’ The Department of Health’s Recruitment, Selection and Appointment Policy outlines the relevant standards, policies, legislation and guidelines that govern these processes for WA Health. The terms and conditions that apply to the employment of salaried medical practitioners are set out in the Department of Health Medical Practitioners AMA Industrial Agreements.

Non-salaried medical practitioners are appointed through a Contract of Service to provide services for monetary remuneration for or on behalf of a particular public health care facility. Non-salaried medical practitioners practise in accordance with the conditions specified in their Contract of Service or the Medical Services Agreement and the principles and processes detailed in the MOU as applicable to the relevant health care facility.

Credentialling and defining the scope of clinical practice occurs as part of the employment/engagement processes.

In WA there are three steps in credentialing and definition of the scope of clinical practice for medical practitioners.

The first two steps, as part of initial credentialing:

- in which verification of credentials is undertaken; and
- the scope of clinical practice is defined;

are completed prior to appointment.

The third step re-credentialling, occurs every 3-5 years, where there is formal review of credentials and scope of practice to confirm the medical practitioner has maintained his or her qualifications, skills and competencies.
Performance Review aims to provide a regular opportunity for two-way feedback between the employer and medical practitioner to discuss:

- job performance requirements;
- past performance including clinical practice, clinical governance activities and professional development; and
- future opportunities including professional development opportunities, potential for increased responsibility, and health care facility support to assist the medical practitioner to maintain and improve performance.

The Office of Public Sector Standards Commission requires that performance of all public sector employees must be fairly assessed, on a routine basis, ‘to achieve the work-related requirements of the public sector body while paying proper regard to employee interests’. The Department of Health Medical Practitioners AMA Industrial Agreements state that medical practitioners will be subject to regular performance review, and that this should be completed through a positive approach directed towards an individual’s skills and competencies.
Industrial and legal issues

General considerations

In general terms, the engagement of senior medical practitioners by Victorian public hospitals differs depending upon whether the public hospital is a metropolitan, large regional or rural hospital.

Whereas rural hospitals mostly engage their senior medical practitioners (perhaps other than directors of medical services) as independent contractors, metropolitan and large regional hospitals tend to engage senior medical practitioners as employees.

For the purposes of this review, there has not been consideration as to whether or not those employees engaged by rural hospitals are genuine independent contractors as this is outside the scope of the project. However, the distinction between a senior medical practitioner engaged as an employee as opposed to an independent contractor will be fundamental to many of the legal issues that impact on the management of the senior medical practitioners including discipline, termination and natural justice in the context of those issues and performance management. It may also be relevant to the type of performance support and management systems developed.

Rural hospitals that engage their senior medical practitioners as independent contractors refer to them as visiting medical officers (VMOs). In the metropolitan and large regional hospitals, the senior medical practitioners are engaged typically on either a full-time or part-time basis. Perhaps paradoxically, those engaged on a part-time basis are also referred to as VMOs, although they would be regarded as employees rather than independent contractors.

That difference needs to be kept in mind.

Manner of engagement

All the senior medical practitioners, whether engaged at metropolitan or rural hospitals, will have their engagement governed by a contract. In the case of metropolitan and large regional hospitals engaging medical practitioners as employees, that contract will be a contract of employment. In the case of rural hospitals, it will simply be an independent contract. These contracts may or may not be in writing. Generally there will have written contracts.

Metropolitan and large regional hospitals typically engage senior medical practitioners under written contracts which contain common terms of employment such as those relating to the duties, hours of work, remuneration and termination of employment. They will also generally contain terms specific to medical practitioners such as private practice arrangements and insurance issues. In some cases they may also contain references to matters of credentialing although typically these would simply be governed by relevant policies or by-laws (whether incorporated into the contract or not).

Rural hospitals will engage their VMOs under more basic contracts which will also commonly contain terms relating to hours, private practice, patient admission matters, invoicing and so forth.
Industrial instruments applicable to senior medical practitioners

Senior medical practitioners engaged in metropolitan and large regional hospitals have their employment terms and conditions governed by industrial instruments such as certified agreements (or workplace agreements as they are currently known) and awards.

For example, full-time medical specialists have their employment governed by the Hospital Specialists and Medical Administrator's Award 2002 (the Award). However, VMOs engaged in metropolitan and large regional hospitals (i.e. part-time employees) are not governed by that award or any other award as it only applies to full-time staff.

A number of metropolitan and large regional hospitals have certified agreements relating to their VMOs (both senior and otherwise).

There are also a large number of metropolitan and large regional hospitals which have independently entered into certified agreements covering medical specialists.

Where the Award or certified agreement (or workplace agreement) governs the employment of a medical specialist, it has the effect of setting minimum terms and conditions of employment in respect of the subject matter contained in those awards or agreements. The hospitals will not, therefore, be able to provide benefits which are less than those contained in the applicable award or agreement. They can of course provide enhanced benefits over and above those contained in the awards or agreements.

Interaction between contracts of employment and industrial instruments

Contracts of employment are typically used by hospitals to achieve two aims. Firstly, to provide any enhanced benefits over and above the applicable award or industrial agreement. Secondly, to set out terms and conditions (or other benefits) not contained in the awards or industrial agreements. Examples of this are more detailed termination provisions, requirements to comply with hospital by-laws and policy and more detailed provisions relating to the practitioner's duties and responsibilities.

Rural VMOs and industrial instruments

VMOs engaged by rural hospitals will not be covered by any awards or industrial agreements as awards and industrial agreements can only apply to employees, not independent contractors. Their terms and conditions will simply be set by the terms of their contract of engagement, whether written, oral or through implied terms or a combination of those.

Performance management and rural VMOs

Whilst performance support and management systems are typically associated with employees, there is no reason why independent contractors cannot also be subject to a performance management and support system.

However, one of the risks of using a performance management and support system for independent contractors VMOs is that it may give rise to arguments that the VMOs are not truly

1 See attachment 1

2 See attachment 2
independent contractors but are, or have become, employees. This is because one of the factors that a court or tribunal will consider in respect of that issue is the level of control exercised by a principal (or employer) over the contractor. The more control that is exercised by the principal over the independent contractor, the more likely it is that there will be a finding that the contractor is indeed an employee rather than an independent contractor. Therefore care needs to be taken when considering the issue of a performance management system for VMOs engaged by rural hospitals (or any other medical specialists engaged as independent contractors) to avoid a finding that they are in fact employees.

Attachment 3 contains a list of some industrial agreements and the clauses that may impact on performance support and management.

**Performance management and industrial instruments**

There are no provisions relating to performance management and support in the Award. Therefore, the Award will not impact directly upon performance management and support systems for senior medical practitioners.

The industrial agreements may contain clauses dealing with performance review, performance management or performance support. Where they do not, then hospitals can lawfully introduce a performance management and support system without being in breach of provisions in the relevant industrial agreement. The qualification however is that in such performance support management systems still need to be consistent with other provisions in the relevant industrial agreements (and contracts of employment) that may potentially impact. Such provisions might include termination of employment provisions, discipline provisions, duties and responsibilities of senior medical specialists. In addition, dispute resolution clauses in industrial agreements (which relate to disputes or grievances senior medical specialists may have in the workplace) may impact upon any performance supporting management system (see the table in Attachment 3 for clauses in various industrial agreements that may be impacted by a performance support and management system).

**Case law**

Performance by management and performance review will, as a general rule, only become litigious where it leads to discipline of the employee or the termination of the employment. Therefore, there is no case law specifically on performance management and support systems.

Performance management and support systems become relevant as part of the rubric of factors that a court or tribunal will consider when assessing whether a doctor’s dismissal, suspension or other disciplinary action taken has been warranted.

As a matter of logic, it follows that the more robust the performance management support system has been, the higher the chances of an employer defending any disciplinary action taken against an employee (including their suspension or dismissal), at least in the case where performance issues are in question.

Perhaps the best example of this can be found in a 1997 decision of the Australian Industrial Relations Commission regarding an employee who was dismissed for performance issues\(^3\). In considering whether or not the dismissal of the employee was harsh, unjust or unreasonable,

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\(^3\) Davie v Qantas Australian Holidays (19/11/97, Print 6791).
the Commission specifically referred to the fact that there was considerable evidence lead by
the employer that the employee in question had been given 3 ½ years of training, counselling
and monitoring in order to be able to produce a consistent level of performance. A lot of time
and attention was given to the employee by management representatives to help the employee
achieve consistent standards of performance. This weighed heavily on the decision to find that
the dismissal was fair.

It should also be noted that in recent years there has been considerable development of the
implied term of trust and confidence that is owed by an employer to its employees. As part of
that implied term, an employer has an obligation to treat the employee in a fair and reasonable
manner during the employment. No doubt performance management and support systems will
be factors that will be raised by both employees and their employers to support an argument
that the term has been breached (or not breached) as the case may be.

**Anti-discrimination legislation**

Anti-discrimination legislation potentially will have a greater impact on the development of a
performance support and management system than, say, unfair dismissal laws. This is
because at both a federal and state level, discrimination laws apply not only to the termination
of employment but also during the employment. The discrimination legislation will apply to,
amongst other things, unfair treatment of employees based on one of the protected
discriminatory attributes. Therefore, a performance management and support system which
discriminates against those with protected attributes will risk raising discrimination claims. It
may even do so if the performance support and management system does not appropriately
take into account those protected attributes, certainly in its implementation. For example,
indirect discrimination may occur where an employee's particular protected attribute have not
been properly considered or accommodated when offering performance support or
management.

**Natural justice**

Natural justice will generally apply to decisions which are made by an employer in the
employment setting. It would be most relevant where a dismissal occurs. Natural justice has
less of a role to play in actions or events which do not give rise to or lead to a termination of
employment. Nevertheless, a sound performance support and management system can be an
element of natural justice where a dismissal occurs and compliance with natural justice in terms
of a performance support and management process may become relevant in such a process.

For a detailed discussion of natural justice see Attachment 4.
The rationale for involving senior medical staff in formal performance systems

It is undoubtedly true that senior medical staff in Victorian public health services are already subject to a range of regulatory and oversight arrangements, including those imposed by the Medical Board, indemnity insurers, specialist colleges and employing health services. The most recent development in this regard has been the introduction of mandatory credentialling and scope of practice review, which entails the preparation of an extensive portfolio of personal and professional information, including evidence about registration, insurance and participation in continuing professional development. It is likely that credentialling will be a useful process for the doctor and the health service. It has the additional benefit of linking information from the Medical Board, the college and insurers, however this may occur only every five years.

In other Australian jurisdictions such as Queensland and New South Wales, and in the United Kingdom, senior medical staff who work in the public hospital system, in addition to similar requirements as exist in Victoria, must also participate in annual or 6-monthly performance review processes which include face-to-face discussions with their clinical supervisor. It needs to be acknowledged that these three jurisdictions have has very significant medical scandals which have shaken the confidence of the government, the health bureaucracy, the community and the medical profession in the regulation and oversight of the profession. These policies therefore tend to reflect the context in which they were introduced, although the Queensland policy attempts to establish a program of both formal performance conversations directed at professional and personal development and informal feedback, consistent with modern general performance management practice.

Notwithstanding that Victoria has not been subject to the direct fall-out from a major failure of clinical governance the consequences of problems elsewhere are felt here. As a profession, there is an obligation to be accountable to the community and ensure that explicit standards are met. Systematic performance management programs established in non-medical settings, when supported and resourced, can provide guidance as to how the community can be reassured that professional performance is indeed under continuing review.

The extensive body of literature on generic performance management identifies the requirements for effective programs. These include: ongoing informal feedback; formal periodic appraisal sessions in which performance is reviewed and goals are set; and capability development and coaching to achieve personal, team and organizational objectives. There is also good evidence as how to maximise the effectiveness of appraisal sessions and how goals should be set. It is also clear that both those who appraise and who are themselves appraised benefit from education and training as to how to get the most of the appraisal.

Clearly unless there is organisational and senior management commitment to establishing and maintaining effective performance management systems which can be demonstrated by: the organisational culture; use of skilled appraisers; an informed, valid appraisal which addresses development needs; and appropriate resourcing; then it is unlikely that any performance system will achieve meaningful ongoing improvements.

In light of community expectations, overseas and interstate activity and an understanding as to how performance management systems can work, it is reasonable that such arrangements are introduced into Victoria for senior medical staff.
What are the barriers to participation?

The barriers to willing participation in performance management relate to trust, resourcing and value.

Trust

Unless medical staff have trust in the performance system and appraisal process it is unlikely that any benefits will accrue to the individual or the organisation as a result of its implementation. Trust issues to be addressed include:

- What is actually proposed; what does performance management and appraisal mean?
- Where do the new arrangements fit with existing regulatory and organisational oversight requirements?
- Is it intended to be punitive or supportive?
- How will it impact the employment contract?
- How will data and information be collected, used and stored?
- What recourse will be available if the process is felt to be unsatisfactory?

Resourcing

Senior medical staff in Victorian hospitals often have significant clinical, research, teaching and administrative responsibilities, which typically fully occupy their remunerated work. The introduction of new performance arrangements over and above existing requirements raises questions about the resources available to ensure meaningful participation. More specifically:

- What preparation will be needed for performance review and appraisal, in particular what information will need to be collected and prepared for formal appraisal sessions?
- Will appraisers and those appraised be provided with training to ensure that appraisal sessions are well-structured and effective?
- Will the participants in appraisal be remunerated for this effort, as occurs in the UK?

Value

Senior medical staff are keen that activities they undertake have some value either to them, their patients or the health service. They will need to be assured that:

- performance appraisal and support is not merely a tick-box episode to meet employment requirements;
- their goals and objectives are of value to them and the health service;
- where necessary, resources are available to meet their goals and objectives;
annual performance appraisals remain meaningful and are not subject to diminishing returns.

**What may facilitate participation?**

Extensive literature on generic performance systems provides guidance as to the factors that can facilitate effective arrangements. In addition, there is a developing body of research which points to the value of clinical engagement and clinical leadership in management in improving quality of care.

Core to the successful deployment of performance systems are high-level organisational issues. There needs to be an alignment of performance systems with organisational mission and integration with the management structure so that there is a link between individual goals and organisational objectives.

The performance system must be seen to be credible by having the participation and support of senior management and clinicians, which can be further demonstrated by providing the systems, structure and resourcing to support its operation.

With respect to appraisal sessions: there need to be trained and skilled appraisers; the process needs to be properly resourced; the appraised needs to be supported to fulfil his or her goals which must fit with overall organisational strategy; and the system needs to be evaluated on a routine basis.

Overall the performance system and its component systems must be reliable, valid, accepted, feasible and achieve some positive outcomes.
References


Applied Research Ltd (2008), Enhancing Medical Engagement in Leadership: developing the medical engagement scale.


Behn R. The psychological barriers to performance management or why isn’t everyone jumping on the performance-management bandwagon? Public Performance & Management Review 2002; 26:5-25


Boylan O, Bradley T, McKnight A. GP perceptions of appraisal: professional development, performance management, or both? Br J Gen Pract 2005; 55:544-545


Cassel C, Holmboe E. Credentialing and Public Accountability, A central role for Board certification. JAMA 2006; 295:939-940

Castro P, Dorgan S, Richardson B. A healthier health care system for the United Kingdom. The McKinsey Quarterly 2008; February


Colthart M, Cameron N, McKinstry B, Blaney D. What do doctors really think about the relevance and impact of GP appraisal 3 years on? A survey of Scottish GPs. Br J Gen Pract 2008; 58:82-87


Cruess S, Johnston S, Cruess R. Professionalism for medicine: opportunities and obligations. MJA 2002; 177:208-211


Davis D, Mazmanian P, Fordis M et al. Accuracy pf physician self-assessment compared with observed measures of competence, a systematic review. JAMA 2006; 296:1094-1102


Federation of Medical Regulatory Authorities of Canada, Physician revalidation, maintaining competence and performance (Position Paper) 2007


Irvine D. Everyone is entitled to a good doctor. *MJA* 2007; 186:256-261.


Levinson W. Revalidation of physicians in Canada: are we passing the test? *CMAJ* 2008; 179:979-980.


Lockyer J. Multisource feedback in the assessment of physician competencies. *J Contin Educ Health Prof* 2003; 23:4-12


McAlearney, Scheck A, Fisher D, Heiser K, Robbins D, Kelleher K. Developing effective physician leaders: changing cultures and transforming organizations. *Hospital Topics* 2005; 83(2)


Miller S, American Board of Medical Specialties and repositioning for excellence in lifelong learning: maintenance of certification. *J Contin Educ Health Prof* 2005; 25:151-156


Perkins R, Petrie K, Alley P. Health service reform: the perceptions of medical specialists in Australia (NSW), the United Kingdom and New Zealand. *MJA* 1997; 167:201-204


Shaw, K. Changing the goal setting process at Microsoft. *Academy of Management Executive* 2004, 11: 139-142.


United Kingdom Department of Health (2006), *Appraisal questions and Answers – NHS consultants* 
http://www.dh.gov.uk/en/Managingyourorganisation/Humanresourcesandtraining/EducationTrainingandDevelopment/Appraisals/DH_4080338

United Kingdom Department of Health (2007), *Questions and Answers - Toolkit for English GPs,* 
http://www.dh.gov.uk/en/Managingyourorganisation/Humanresourcesandtraining/EducationTrainingandDevelopment/Appraisals/DH_4080424


Victorian Department of Human Services (DHS) (2007), Credentialling and defining the scope of clinical practice for medical practitioners in Victorian health services – a policy handbook 


Attachment 1 - Certified agreements covering VMOs

AMA - Ballarat Health Services Visiting Medical Officers Agreement 2003

AMA Southern Health Visiting Medical Officers Certified Agreement 2000 - 2003

AMA Southern Health Visiting Medical Officers’ Certified Agreement 2002

Bayside Health and Australian Medical Association Visiting Medical Officers Agreement 2003

Bendigo Health Care Group and the Australian Medical Association (Vic) Limited (Visiting Medical Officers) Enterprise Agreement 2000

Eastern Health - AMA Visiting Medical Officers Agreement 2005

Mildura Base Hospital Visiting Medical Officers Certified Agreement 2000

St Vincent's Hospital (Melbourne) Limited Senior Medical Staff (Visiting Medical Officers) Certified Agreement 1999

St. Vincent's Health (Melbourne) Senior Medical Staff (Visiting Medical Officers) Certified Agreement 2003
Attachment 2 - Certified agreements covering medical specialists

AMA Calvary Health Care Bethlehem (Medical Specialists) Certified Agreement 2003

AMA Peninsula Health (Senior Medical Specialists) Certified Agreement 2002

AMA Peter MacCallum Cancer Centre Senior Medical Specialists Certified Agreement 2002-2005

AMA Royal Victorian Eye and Ear Hospital [Senior Medical Specialists] Certified Agreement 2004

AMA Women’s and Children’s Health [Senior Medical Specialists] Certified Agreement 2003

AMA, Skin and Cancer Foundation Inc (Medical Specialists) Certified Agreement 2001

Barwon Health Visiting Medical Specialists’ Certified Agreement 1997

Barwon Health Visiting Medical Specialists’ Certified Agreement 2003

Eastern Health - AMA Full Time Medical Specialists Certified Agreement 2005

Peninsula Health Care Network (Full Time Medical Specialists & Medical Administrators) Certified Agreement 1997

St Vincent's Health (Melbourne) Limited Fulltime Medical Specialists (Anaesthetists) Certified Agreement 2004

St Vincent's Health (Melbourne) Medical Specialists (Pathologists) Certified Agreement 2003

St Vincent's Hospital (Melbourne) Limited (Full Time Medical Specialists - Anaesthetists) Certified Agreement 2001

St Vincent's Hospital (Melbourne) Limited (Fulltime Medical Specialists - Anaesthetists) Certified Agreement 1997
The AMA - Australian Red Cross Blood Service - Victoria Medical Officers and Medical Specialists Certified Agreement 2004

Western Health (Full-time Medical Specialists - Anaesthetists/Intensivists) Certified Agreement 2000

Western Hospital (Full Time Medical Specialists - Anaesthetists/Intensivists) Certified Agreement 1997

Western Hospital (Full Time Medical Specialists - Anaesthetists/Intensivists) Revised Remuneration Certified Agreement 1998
### Attachment 3 - Relevant clauses in industrial agreements

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<tr>
<td><strong>Name</strong></td>
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<tr>
<td>Eastern Health - AMA Full time</td>
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<td>Medical Specialists Certified</td>
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<td>Agreement 2005</td>
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<td>AMA Royal Victorian Eye and Ear</td>
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<td>Hospital [Senior Medical</td>
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<td>Specialists] Certified</td>
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**Senior medical staff performance appraisal and support - literature review**
<table>
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<tr>
<th>Agreement Description</th>
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<tbody>
<tr>
<td>AMA Peninsula Health [Senior Medical Specialists] Certified Agreement 2002</td>
<td>• This applies to all employees who are employed in either a full-time or visiting capacity as Medical Specialists, Clinical Academics and Medical Administrators.</td>
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<td></td>
<td>• Clause 21 - Termination of Employment</td>
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<td>• Clause 50 - Continuous Improvement</td>
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<td>AMA Southern Health Full Time Specialists Certified Agreement 2002</td>
<td>• This applies to full time Medical Specialists.</td>
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<td></td>
<td>• Clause 15 - Termination of Employment</td>
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<tr>
<td>Bayside Health - Full Time Hospital Specialists and Medical Administrators Agreement 2004</td>
<td>• This applies to Full Time Hospital Specialists and Medical Administrators.</td>
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<td>• Clause 14 - Performance Review</td>
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<td>• Clause 27 - Termination of Employment</td>
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<td>Australian Medical Association and Melbourne Health Hospital Specialists Agreement 2002</td>
<td>• Clause 16 - Performance Review</td>
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<td>• Clause 17 - Continuous Improvement</td>
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<td>• Clause 24 - Termination of Employment</td>
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<td>Australian Medical Association and Western Health Hospital Specialists Agreement 2002</td>
<td>• Clause 16 - Performance Review</td>
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<td>• Clause 17 - Continuous Improvement</td>
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<td>• Clause 24 - Termination of Employment</td>
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<td>• &quot;Western Health (Specialist Emergency Physicians) Certified Agreement 2005</td>
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### AWARDS

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<tr>
<td>Hospital Specialists and Medical Administrators Award 2002</td>
<td>• This applies to AMA, its practitioners and members, the ASMPF, its practitioners and members, and employers set out in Schedule 1.</td>
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<td>• Clause 11 - Termination of Employment</td>
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Attachment 4 - Natural justice issues

What is natural justice?

The principles of natural justice have evolved from the common law to ensure the fairness of the decision making power of courts and administrators.\(^4\)

The term natural justice is often used interchangeably with procedural fairness.\(^5\)

Not surprisingly, when courts have been asked to define the concept in a more detailed or specific way they have tended not to. Instead it has been said that whether natural justice, or sufficient fairness, in a procedure has been afforded in a given case will depend on the circumstances of the particular case and will vary from case to case.\(^6\)

Despite the courts' reluctance to apply a strict definition to natural justice it is clear that natural justice requires decision makers to act fairly and reasonably having regard to the particular circumstances and set of facts before them.

Natural justice’s application to the employer-employee relationship

It is a firmly established principle of both English and Commonwealth law that no man should be condemned unheard and that this principle is not confined to strictly legal tribunals but extends to every tribunal or body of persons invested with authority to adjudicate upon matters involving civil consequences to individuals.\(^7\)

Furthermore, in Stollery v Greyhound Racing Control Board BC7200110 (Stollery's case) Gibbs J considered whether the principles of natural justice apply equally to administrative bodies as they do to judicial tribunals. Gibbs considered that when an administrative body is adjudicating as to whether an individual should be terminated, "... it is making a decision which may have a serious effect on the rights and livelihood of the person whose conduct is called in question. Rules conferring jurisdiction of that kind must be construed as requiring that the proceedings should be carried on in accordance with the principles of natural justice, unless an intention to exclude those principles plainly appears."

This is authority for the fact that while the concept of natural justice has developed in the realm of public law, it's application into internal processes adopted by an employer in relation to its


\(^5\) Catanzariti. R., *Natural Justice; Application to Internal Employment Discipline Processes*, 29 November 2007, p. 3

\(^6\) Catanzariti. R., *Natural Justice; Application to Internal Employment Discipline Processes*, 29 November 2007, p. 3

\(^7\) Cooper v Wandsworth Board of Works (1863) 14 CBNS 180
employees certainly applies, however it is has been far more limited than in the public law arena.  

**Natural justice and consensual tribunals**

In *Sweeney v Committee of the South East Racing Association* (1985) ([Sweeney's case](https://www.bAILR.gov.au/flr/1985/75/191)) 75 FLR 191, the Supreme Court of the ACT made it clear that the application of the rules of natural justice depends upon whether the tribunal is statutory or consensual in origin.

In Sweeney's case Gallop J said "It is now well established that there is a different approach to the application of those rules depending upon whether the tribunal hearing the charges is statutory or consensual in origin …", "… in broad terms a more stringent test is applied to statutory tribunals than to consensual tribunals. To the statutory tribunal the law applies a test based on the appearance of fairness; a reasonable suspicion of unfairness generated in an assumed, informed observer is sufficient to nullify the proceedings. In the case of a consensual tribunal, however, the reality is considered; the question is whether in all the circumstances natural justice is done. There are differing standards of natural justice to be applied in the case of each different type of tribunal."

**When to apply natural justice**

It can be said that there are two questions to be asked when assessing the application of natural justice:

- Whether the rules of natural justice apply to the circumstances being examined; and
- If the rules are applicable, what is the content of the natural justice required.  

Below, we focus on the second point, that is, what formalities are necessary to satisfy the requirement of affording natural justice.

**Content of natural justice in employment situations**  

While all cases will be different depending on the circumstances, the English House of Lords decision in *Ridge v Baldwin* [1964] AC 40 at p.132 brings us closer to understanding how the concept of natural justice might apply in an employment situation. Lord Hodson observed:

"Three features of natural justice stand out - (1) the right to be heard by an unbiased tribunal; (2) the right to have notice of charges of misconduct; (3) the right to be heard in answer to those charges."

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8 Catanzariti, R., *Natural Justice; Application to Internal Employment Discipline Processes*, 29 November 2007, p. 2


10 Catanzariti. R., *Natural Justice; Application to Internal Employment Discipline Processes*, 29 November 2007, p. 4

From Ridge’s case we can see there are certain elements of natural justice that will be relevant in a disciplinary or grievance matter.

- **Firstly,** the individual or employee is entitled, in the case of a disciplinary matter, to know the allegations against them.

- **Secondly,** the individual or employee must have an opportunity to respond to the allegations that have been put; this is often referred to as the *hearing rule.* Being given an opportunity to respond means that the employee has an adequate opportunity to put forward his or her case, including any relevant material he or she thinks would be relevant to the making of the decision or the outcome of the proceeding.

- **Thirdly,** natural justice requires that the person conducting the hearing and/or making the decision should not have any vested interest in the matter; often referred to as the *rule against bias.* The decision maker must be free of actual bias or prejudgment, or the perception of prejudgment.

**Infinitely flexible concept**

Being a product of the common law, as opposed to some statutory provision, the rules of natural justice are infinitely flexible and capable of adaption to accommodate whatever set of factual circumstances is in issue. ¹²

This position has been consistently recognised by the courts and applies to all elements that constitute the content of natural justice.

**Infinitely flexible concept - judicial commentary**

In Stollery’s case the High Court heard an appeal from the Supreme Court of New South Wales that had rejected claims that Stollery (*the appellant*) had been denied natural justice when the Greyhound Racing Control Board (*the Board*) disqualified the appellant as a bookmaker registered with the Board.

The High Court overturned the decision of the Supreme Court and found that natural justice was denied to the appellant. In Stollery’s case, the same person who had initiated the complaint that was the subject of the disqualification, also was a member of the Board that deliberated and then made the ultimate decision to disqualify the appellant.

While the case does consider the application of the rule against bias, its commentary regarding the flexibility of natural justice is important now.

Barwick CJ said that “it is of the utmost importance that tribunals … conduct their proceedings with scrupulous adherence to the requirements of natural justice. What is required to satisfy these principles no doubt depends very largely on the nature of the matter in hand and the circumstances in which the hearing takes place.”

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Gibbs J agreed with Barwick CJ, but added “The principles of natural justice are not rigid or technical. The requirements of natural justice must depend on the circumstances of the case, the nature of the inquiry, the rules under which the tribunal is acting, the subject matter that is being dealt with, and so forth”: Russell v Duke of Norfolk (1949) 109 at p188.

The hearing rule

The essence of the hearing rule can be simply stated as that where the person whose rights, interests or legitimate expectations are likely to be affected by an administrative decision is given the chance to be heard before the decision is made.\(^{13}\)

Thus, the hearing rule incorporates into it this notion of being afforded an ‘… opportunity to be heard’, as incorporated in the words of section 41(2) of the Health Services Act 1988 (Vic).

Imprecision of the hearing rule

In applying the hearing rule, the difficulty comes in identifying what is actually required in the circumstances of a particular case. As per the judicially acknowledged flexibility of natural justice, discussed above, the hearing rule similarly must operate in a flexible fashion.

Writing extra-judicially, in 1986 Sir Gerard Brennan commented that '[T]he imprecision in the content of "natural justice" and the \textit{ex post facto} declaration of that content is one of the unresolved problems of administrative law and practice'.\(^{14}\) The words of Sir Gerard Brennan reflect the diversity of administrative contexts in which the hearing rule must be applied.

There is no universal standard, and the requirements of procedural fairness ‘depend on the circumstances of the case, the nature of the enquiry, the rules under which the tribunal is acting, the subject-matter that is being dealt with, and so forth …’.\(^{15}\)

Content of the hearing rule - minimum content required

The content of the hearing rule will to an extent depend on the circumstances of the particular case. A balancing act is needed between upholding the rights of individuals and ensuring requirements placed upon decision makers are not too onerous.\(^{16}\)

However, the minimum content required by the hearing rule can be considered to be:

1.1 To know the case against you:


\(^{16}\) Mason in Kioa
1.1.1 The person must be informed of the kind of matters the decision maker will take into account, but need not be informed of the precise nature.  

1.2 To be given an opportunity to respond:

1.2.1 The person needs to be given opportunity to respond to prejudicial matters raised or considered against them in making a decision - i.e. an opportunity to be heard.  

The case law considered below provides greater insight into the application of the hearing rule.

**Entitlement to legal representation**

Furthermore, the principles of natural justice often encapsulate an entitlement to legal representation.

However, it is considered that generally there is no absolute right to legal representation, but it may be considered necessary when factors such as the following are considered:

- Age of the person;
- Nature and seriousness of the allegation;
- Standard of education of the person;
- English speaking skills; and
- Confidence levels of the person.

**To know the case against you and the hearing rule**

*Shields v Chief Commissioner of Police [2008] VSC 2*

Appeal against decision of respondent Chief Commissioner of Police. Respondent found appellant police officer engaged in intimidating and persecutory conduct and conduct humiliating and degrading of women. Respondent relied on Ethical Standards Department (ESD) investigation report, various witness statements, email correspondence and a psychological report relating to alleged victims of appellant's conduct in making findings.

Respondent granted appellant access to documents relied on in making a decision but denied access to entirety of ESD files. Appellant made submissions in response to particularised allegations. Respondent dismissed appellant from employment and issued notice of dismissal.

Appellant submitted respondent breached rules of procedural fairness by denying access to ESD files and by procedures adopted for obtaining witness statements. Appellant sought orders quashing dismissal and requiring respondent to reconsider matter according to law. One question raised was whether the respondent breached rules of procedural fairness.

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17 Bond

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**Held, dismissing the appeal:** the respondent did not breach the rules of procedural fairness. There was no evidence that the undisclosed ESD files contained exculpatory material or that the appellant was treated unfairly during any ESD investigations. The procedures adopted by the respondent in relation to obtaining statements from witnesses were not unfair and the appellant was given a proper opportunity to be heard on the specified instances of misconduct.

**Weerappah v Nisselle [1999] VSC 249**

The plaintiff, while employed by the Alfred Hospital, received an electric shock and suffered injury. As a result, the plaintiff was awarded weekly compensation payments through the hospital's insurer. Sometime later, the plaintiff was advised that her weekly payments would cease. The plaintiff then exercised her right to an internal conciliation. As part of the conciliation a referral to the medical Panel was made.

Objecting to the hospital's decision to terminate payments, the plaintiff claimed there was a denial of procedural fairness because of:

(a) A denial of any opportunity to be heard on the form and content of the medical questions to be put to the medical Panel;

(b) A lack of notice of any reference to the medical Panel; and

(c) The denial of an opportunity to put forward material relating to the medical questions both as to their form and as to the merits of the matters referred to the medical Panel.

**Held:** The court determined that ground (b) was not made out as notice was received by the plaintiff. However, grounds (a) and (c) were made out.

In coming to this conclusion, Smith J said "... the first issue that should have arisen in the minds of the Panel, acting reasonably and fairly, was its inability to answer the questions. For, on the evidence before me, the papers submitted to them did not identify the injury for which compensation had been paid and to which the questions referred. In that situation, a body required to determine the questions would fail to give the parties natural justice if it proceeded without giving both parties the opportunity to be heard on the issue. To that extent, it should have invited submissions on the questions. In extending such an invitation to the parties, the plaintiff should have been invited to provide a history."

Furthermore, the Panel relied heavily on a video which the plaintiff had not led any evidence or commented on. Smith J said "It was evidence of a kind that a Panel should not consider acting upon without first inviting the parties to attend and comment or lead other evidence about it. In the absence of such an invitation, both parties were properly entitled to feel that they were denied natural justice ...." 

**Calleja v Franet Pty Ltd [1999] VSC 202**

In this case the appellant, Calleja, sought a review of a decision of a Medical Panel, appointed under the provisions of the Accident Compensation Act 1985. The appellant was employed as a process worker by the respondent. She was injured in the course of her employment and subsequently received weekly payments of compensation, on the expiration of which the insurer for the employer issued a notice of termination. The appellant disputed the termination. After conciliation failed, it was referred to a Medical Panel to determine.
The appellant sought a review of the Medical Panel's decision to terminate her upon certain grounds, including:

- The Medical Panel's finding regarding the appellant's mental symptoms which was made without any material to support it by the parties, and without giving the appellant any opportunity to respond to or be heard in relation to the finding.

**Held:** In finding that the Medical Panel failed to provide an adequate opportunity to be heard, Vincent J said "... the Panel was not entitled to find, without first giving her the opportunity to be heard, that the appellant's mental symptoms were related to the onset of menopause ... The obligation on the Panel to accord procedural fairness to Mrs Calleja necessitated that she be made aware that this, previously unsuggested, diagnosis had been made and that she be given an opportunity to respond to it."

Counsel for the respondent suggested that even if the Medical Panel had informed Mrs Calleja directly that her symptoms were due to menopause, she would not have been able to further assist them. Vincent J pointed out that proposition was beside the point.

Vincent J referred to Mason J in *Kioa v West* [1985] 159 CLR 550 at 552 who said "It is a fundamental rule of the common law doctrine of natural justice expressed in traditional terms that, generally speaking, when an order is to be made which will deprive a person of some right or interest or the legitimate expectation of a benefit, he is entitled to know the case sought to be made against him and to be given an opportunity of replying to it."

And at 585 "The critical question in most cases is not whether the principles of natural justice apply. It is: what does the duty to act fairly require in the circumstances of the particular case."

**Sydney United Football Club Pty Ltd v Soccer New South Wales Limited [2005] NSWSC 474**

A football match was played between the plaintiff and another side. The match was organised by the defendant. It was marred by disgraceful behaviour. The defendant determined that it warranted the punishment of the plaintiff, and so the board of directors of the defendant resolved to suspend the plaintiff from the competition. The defendant's decision was made by an Independent Panel of Inquiry. The plaintiff said that the decision to suspend it was vitiated by a denial of natural justice.

**Held:** The defendant's decision was voidable for denial of natural justice.

McDougall J first considered how the Panel made its decision. On that point, he found that the Panel had given the plaintiff natural justice. "The plaintiff was apprised of the terms of reference. It was given, and took, the opportunity to put its case. In the course of the interview, the members of the Panel raised their principal concerns ... and gave them the opportunity to comment. Before the panel finalised its report, it gave the plaintiff opportunity to comment of matters of concern. The plaintiff took this opportunity." "The Panel's process ... might not have achieved the level of comparative perfection of a civil trial, but that is not the test."

McDougall then considered the Board's actions once the Panel's report was provided to it. The defendant argued that the Board did not need to give the plaintiff another opportunity to be heard before it made its final determination, based on the Panel's report. However, McDougall said "... if the defendant wished to rely upon the report to support findings of breach against the plaintiff, it was incumbent on the defendant to provide the plaintiff with a copy of the report and..."
to tell the plaintiff what breaches … the defendant considered were made out … and to provide the plaintiff an opportunity to be heard on that question.”

Byrne v Law Institute of Victoria Pty Ltd [2005] VSC 509

In this case, Byrne (the plaintiff), a barrister and solicitor, sought judicial review of a decision made by a recognised professional association, namely the Law Institute of Victoria (LIV) (the defendant). The decision made by the LIV was made after an investigation of a complaint against the plaintiff.

Crucial to the case was how the LIV conducted its investigations into the complaint. The court found that in the LIV’s investigations it relied primarily on a set of papers which were pure conjecture. That investigation conducted by the LIV and the ultimate decision made was claimed, among other things, not to have afforded natural justice to the plaintiff.

**Held, granting the application for judicial review:** Gillard J said in relation to natural justice, “In my view a number of grounds of judicial review have been made out, namely the extremely irrational or illogical fact finding process employed in the circumstances, the failure to give effect to relevant evidence, the exercise of deciding a crucial fact on the papers without more, the inference that the plaintiff was not retained was not reasonably open, and finally a breach of natural justice, namely, that the determination process was unfair in all the circumstances … the procedure adopted and decision making process in those circumstances was unfair.” Furthermore Gillard J said the plaintiff “… should have been given the opportunity to be heard after the investigation was complete and before the decision was made ….”

Hedges v Australasian Conference Association Ltd [2003] NSWSC 1107

In this case the plaintiff, Dwayne Hedges, challenged a decision of the defendant, the Gosford Seventh Day Adventist Church (the Church) and its agents, debarring him from participating in the life of the Church. The plaintiff was a teacher at a School which was owned and operated by the Church.

The plaintiff received a letter from the Church requesting him to stand down temporarily from all Church office pending the outcome and report of an investigation being made in accordance with the allegations of child sexual abuse. The Church established a Professional Standards Committee (the Committee) to investigate further.

The plaintiff claimed, among other things, that the defendants failed to provide him with the precise details of the purported claims against him and that such actions were a denial of natural justice.

**Held:** In finding that there was a denial of natural justice, Young CJ said “Natural justice is usually a question of procedure. Different situations will give rise to requirements of satisfying the general principle of natural justice in different ways.”

The decision making process of the Committee was found to be fatally flawed for a number of reasons, including, but not limited to:

- The plaintiff was never informed of the precise charge against him;
• The plaintiff, who was not allowed legal representation at his "interview" and who was denied permission to tape it, was, despite his request, not given a transcript of his interview;

• Knowing that the plaintiff wished to make representations, the Committee did not give him a proper opportunity to do so;

• The Committee did not comply with the plaintiff's request for a transcript of his interview until after this decision to "convict" was made, and then did not provide a proper transcript; and

• The investigation was obviously amateurish and inadequate.

Young CJ went on to say "The Kafkaesque style of interrogation used by [the Committee] would prima facie run contrary to [the principles of natural justice]. This is really because the Church failed to realise there were three distinct stages involved in the process. The first stage is information gathering by the investigator to determine whether there is a case to be made of misconduct or whether the welfare of the Church requires that a person step down from office. The second stage is putting to the person against whom action is to be directed a clear statement of the matters he or she must answer. The third stage is the adjudication. The Church elided all three stages into one.

In concluding on natural justice, Young CJ said "I do not consider that the process did give the plaintiff a fair chance of knowing what exactly was alleged against him and an opportunity to answer."

Hart v Book Makers Revision Committee and Anor [1987] 9 NSWLR 713

The plaintiff, Hart, a registered bookmaker, failed to pay certain taxes owed in relation to his greyhound racing. The defendant, the Bookmaker's Revision Committee (the Committee), wrote to the plaintiff as a result stating that if he fell into arrears again, they would exercise their powers to remove his name from the register of bookmakers.

The plaintiff did fall into arrears again, and was called to attend a Committee meeting that was conducted to investigate the issue and determine a course of action. The plaintiff attended the meeting.

Four days after the meeting, the Committee informed the plaintiff that it had resolved to remove the plaintiff's name from the register of bookmakers.

The plaintiff alleged that the decision was voidable as it was not conducted in accordance with the rules of natural justice.

Held: The failure of the committee to inform the plaintiff of material it had in its possession that was relevant to the question of penalty amounted to a breach of the rules of natural justice even though the plaintiff was given the opportunity to address on the penalty.

The plaintiff was not given a proper opportunity to respond to material put before the committee in that he was never shown and was not aware of the existence of a briefing paper given to members of the committee.
A person before such a committee must be given a distinct opportunity to address all matters before it including the question of penalty. Such an opportunity requires that a person be informed of material relevant to any issue before the committee.

Baker v The University of Ballarat [2005] FCAFC 210

The appellant, Baker, was employed by the respondent, The University of Ballarat, as a senior lecturer, subject to a successful probationary period. After the initial probationary period, the University concluded that the appellant complete a further six month probation. Following the completion of that 'unsuccessful' probation period, the appellant was advised his employment was to be terminated.

The appellant's employment contract and the relevant enterprise bargaining agreement allowed the appellant to appeal the termination decision to an internal Appeal Committee. The Appellant then unsuccessfully appealed to the Federal Court.

Now the appellant appeals to the Full Court of the Federal Court on the grounds that, among other things, the appellant was denied natural justice when he was supplied by the defendant with a summary of certain memoranda relevant to his termination rather than the actual documents.

**Held:** Per Ryan and Marshall JJ, the failure to provide the appellant with the actual text of certain memoranda did not amount to a denial of natural justice as to invalidate the decision of the Appeal Committee.

The main reason for finding there was no denial of natural justice was that while the Appeal Committee did not provide the appellant with copies of the documents it intended to rely upon in making its decision, it did however provide the appellant with a detailed summary of those documents with descriptions as to the substance of each of those documents included.

Ryan J stated "In these circumstances, the appellant is confronted with a real difficulty in asserting that he was denied procedural fairness .... This is not a case like *Muin v Refugee Review Tribunal* (2002) 76 ALJR 966 where the appellant was arguably misled as to whether the appeal committee had before it, or would have regard to, particular documents. Rather, the appellant's complaint is that he was fully informed about the identity of the documents to which the Committee would have regard but was not himself supplied with copies or the actual text of those documents. Against that background, a denial of procedural fairness could only have occurred if the failure to give the appellant access to the actual text of the documents, as distinct from the summary described at [38] above, precluded him from making some submission or adducing some evidence which might have proved critical to the result reached by the Committee in conducting the rehearing of the question whether the appellant's probationary appointment should have been terminated." Ryan J held "... the appellant cannot reasonably complain that he was denied an opportunity to answer the material contained in the documents furnished by the Appeal Committee."

In coming to this conclusion regarding natural justice, Ryan J repeated the words of McHugh J in *Muin*, at 123: "What is required to discharge this duty depends on the circumstances of the particular case."
VAI v Forgie [2003] FCA 87

The Commissioner issued an amended notice of assessment to which the taxpayer unsuccessfully objected. The taxpayer appealed to the AAT. The Commissioner had provided to the taxpayer documents relevant to the taxpayer's case, in which the Commissioner had alleged fraud and evasion of tax. In appealing to the AAT, the taxpayer sought further particulars of documents relevant to the decision made, submitting that a denial of such was a denial of procedural fairness. The AAT denied that request.

Before the Federal Court, the taxpayer sought a review of the AAT's decision to deny further particulars.

**Held:** North J held that the Commissioner was not required to provide further particulars to the taxpayer and that there was no denial of natural justice.

His honour acknowledged that "As an allegation of fraud is a grave one, procedural fairness requires the Commissioner to make the applicant aware of the case against him".

His honour concluded that the Commissioner had sufficiently made the applicant aware of the case against him and further particulars need not be provided. However the applicant argued that because the Commissioner had come to a different conclusion of the matter in regards to the facts than he had, that he should be given further opportunity to be heard.

In response to this his honour said: "That there are alternative conclusions to be drawn from the same facts by the applicant and the Commissioner does not demonstrate that the taxpayer has been denied explanation of the case against him."

**Opportunity to be heard - how much time is required?**

Thames Magistrates' Court; Ex Parte Polemis [1974] 2 All ER 1219

The applicant was the master of a vessel which arrived at a birth in the London docks. Shortly after it was docked a large patch of oil appeared close to the vessel, in an area where oil had previously not been seen.

At 10.30 am on 11 July a summons was served on the applicant charging them with offences related to the oil leakage. The applicant's vessel was due to sail at 9.00 pm on 11 July. Between 10.30 am and 9.00 pm the applicant had to instruct lawyers, prepare a case and appear before a Magistrate that afternoon. The Magistrate heard the case and convicted the applicant.

The applicant later appealed on the grounds of a denial of natural justice.

**Held:** Natural justice was denied.

In so finding, Lord Widgery CJ said in relation to natural justice generally: "nothing is clearer today than that a breach of the rules of natural justice is said to occur if a party to proceedings, and more especially the defendant in a criminal case, is not given a reasonable chance to present his case. It is so elementary and so basic it hardly needs to be said."

As to the issue of the amount of time the applicant had to prepare, Lord Widgery CJ said: "... the defence were prejudiced because they were not given a fair and reasonable opportunity to
present their case to the court, and of course the opportunity to present a case to the court is not confined to being given an opportunity to stand up and say what you want to say; it necessarily extends to a reasonable opportunity to prepare your case before you are called on to present it. A mere allocation of court time is of no value if the party in question is deprived of the opportunity of getting his tackle in order and being able to present his case in the fullest sense."

Again, as with natural justice principles generally, the answer to how much time is required for preparing to respond to allegations etc, does depend very much on the circumstances. A reasonable period of time will be required. However, what is reasonable will depend upon:

- How serious the charges are (i.e. will they lead to potential termination of employment or are they of a criminal nature, e.g. fraud)?
- Is there a large amount of documentation relevant to the matter?
- Other circumstances (e.g. where the employee is not well).¹⁹

**Denial of adequate representation**

*Cains v Jenkins and Ors* [1979] 42 FLR 188

**Held:** there is no absolute right to representation even where livelihood is at stake. But that is not to say that in all cases the tribunal can refuse representation with impunity. The seriousness of the matter and the complexity of the issues, factual or legal, may be such that refusal would offend natural justice principals.

*Russell v Duke of Northfolk and Ors* [1949] 1 ALL ER 109

**Held:** cases dealing with a denial of representation do not have universal application to every kind of inquiry in every kind of domestic tribunal.

*McNab v Auburn Soccer Sports Club Limited* [1975] 1 NSWLR 54

**Held:** a court should not, except in the plainest circumstances, make a declaration that the tribunal would be in breach of the principals of natural justice if it did not permit legal representation. If the board observes the rules of natural justice, the plaintiff will be able to state his case without difficulty. If the board fails to do its duty, the plaintiff will have his remedy in this court.

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