UK Fitness to Practise inquiries: Which types of doctors are under investigation and why?

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**Background:** Each year doctors in the UK are referred for Fitness to Practise (FtP) investigations for a wide a range of issues. Whilst not all investigations lead to further action it is well documented that certain types of doctors are more likely to be sanctioned if they face FtP investigations. This study sought to understand which types of doctors were referred for FtP inquiries and whether they were complained against for particular reasons.

**Method:** A retrospective cohort analysis of complaints for performance in FtP from 2008 till 2017 was undertaken. We analysed sources of complaints and allegations types against the demographic characteristics of doctors. Allegation types included clinical care, teamwork and probity, amongst others. Enquiries were provided by other doctors, employers, public organisations and patients.

**Results:** Over half of all complaints (1844) were made against male doctors. Males were more likely than females to be complained about by patients and for issues linked to maintaining trust, while females were more often complained against by the organisations and for safety issues. It is also noticed that other characteristics, such as doctors age, region of primary medical qualification, etc. are also important factors when analysing the differences in the enquiry and allegation type.

**Discussion & Conclusion:** The findings demonstrate the patterns within the data for FtP investigations. Certain groups were more likely to be reported than others by allegation type. Generally, males are more often subjected to FtP investigations and are more often referred for trust issues.

**Take-home message:** The findings inform policy makers, educationalists and practitioners about the most commonly identified characteristics of those who are reported for FtP issues. This information can be used to guide processes to help alleviate and tackle issues at an earlier stage.
**10H3 (1274)**

**Box ticking and Olympic High Jumping – How do Physicians accept their national Physician Validation System?**

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**Background:** National physician validation systems aim to periodically appraise physicians’ competence, and to ensure lifelong learning. These systems’ effectiveness, however, is determined by physicians’ perceptions about the system and resulting acceptance and commitment. We therefore aimed to explore physicians’ perceptions and self-reported acceptance of different physician validation systems in Europe.

**Method:** Using a constructivist grounded-theory approach, we conducted semi-structured interviews with 32 respiratory specialists from countries with validation systems that differed with respect to requirements, procedures and consequences: mandatory revalidation (UK); mandatory, credit-based continuing professional development (Germany), and recommended annual dialogues (Denmark). We analysed interview data per country, focusing on factors influencing physicians’ perceptions.

**Results:** Although our interviewees unanimously approved of having some validation system in place to stimulate continuing professional development and to evaluate competence, they challenged the practical implementation of these systems. Differences across countries resulted from an interaction between the individual, specific features of the system and the context. Factors influencing acceptance were assessment authenticity, and alignment of requirements with clinical practice. Other important aspects were physicians’ beliefs about learning, perceived autonomy, coordinated and organisational support along with trust in the system.

**Discussion & Conclusions:** Acceptance levels determine any system’s effectiveness. National physician validation systems therefore need to be carefully designed and integrated into clinical practice to effectively support lifelong learning and competence assessment. Findings resonate with assessment research, showing that assessment culture and assessment embedding in learning and work affect assessment acceptance and outcome.

**Take-home message:** National physician validation systems designed to foster continuing professional development and to assess performance for accountability purposes profit from offering activities which the individual can integrate into daily work. This can help to align individual goals with the system’s intended goal to safeguard quality of care. Engaging physicians as key stakeholders to design more authentic physician validation systems might enhance their acceptance and commitment.

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**10H4 (2521)**

**CPD Accreditation Surveyor Training: The Qatar Experience**

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**Background:** To ensure the sustainability of the CME/CPD accreditation system and expansion in number of QCHP accredited CPD Provider organizations in the State of Qatar, CPD accreditation surveyor training was conducted during and after implementation of National CPD Accreditation system for State of Qatar Health-system.

**Method:** Selected surveyors from various healthcare organizations with background knowledge of workplace, time-management, and quality-assurance were trained by QCHP partners, Royal College Canada International (RCCI) for its pilot project. The training was on reviewing documentation, being objective, analytical, investigative, and observant which are crucial characteristics of an ideal surveyor. A report-writing element was included for objective reporting of findings with appropriate recommendations to participating CPD Provider organization and CPD Accreditation committee for decision-making process. The pilot review was conducted in teams of three surveyors, two local and one from RCCI to test the application of established processes in November-2015 prior to launching of the system. A feedback from surveyors was collected to reflect on training for further improvements.

**Results:** The trained surveyor workforce helps maintain and measure effectiveness of accreditation standards and an opportunity to assess efficiency of governance model, administration support strategies, and decision process in ‘real time’.

**Discussion:** Credible surveyor must display team-work, objectivity and balance in applying standards at high level, effective interpersonal skills and in-depth knowledge of accreditation standards, policies and contextual situations. A feedback from first batch of surveyors was analyzed for improvement in program and sessions like role-play and scenarios were included. The learning opportunities provided via face-to-face and self-directed-learning.
 ensured values, principles, standards, and requirements of CPD accreditation system were understood and applied in a consistent and fair manner. QCHP-AD independently conducted accreditation surveyor training in November-2017 to expand the pool of existing surveyors.

**Conclusion**: It is important to recruit and retain accreditation surveyors for sustainability of credible and valid CPD accreditation system that is internationally recognized and follows best practice. Conducting refresher-course and process-management is key to engaging surveyors in quality-improvement projects.

**Take-home message**: Effective accreditation Surveyor training programs are strategic human resource management to meet the needs of the CPD accreditation systems globally.

**10H5 (428)**
**Care Under Pressure: a realist review of interventions to tackle doctors’ mental ill-health**

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**Background**: Mental ill-health is prevalent across all groups of healthcare professionals and its high incidence is of great concern in the UK and elsewhere (1, 2). Doctors-in-training are affected both directly (e.g. by becoming ill themselves), and indirectly, by this problem (e.g. through colleagues becoming ill). Medical education is important because the ‘culture of medicine’ probably influences how all doctors deal with ill-health. The aim of this National Institute of Health Research-funded project is to improve our understanding of how, why and in what contexts mental health services and support interventions can be designed, to minimise the negative impacts of providing care on doctors’ mental ill-health. Although there is a large literature on interventions that offer support, advice and/or treatment to medical students and sick doctors, the evidence has not been synthesised in a way that takes account of the complexity and heterogeneity of these interventions, and the many dimensions of the problem.

**Method**: This research is a realist review of interventions to tackle doctors’ mental ill-health and its impacts on the clinical workforce and patient care, drawing on diverse literature sources. Stakeholder perspectives (e.g. doctors who have experienced mental ill-health, medical educators, representatives of patients and public, policy makers, charities) were incorporated through a stakeholder group.

**Results**: Our programme theory about why doctors develop mental ill-health, and why some strategies to reduce mental ill-health are more effective than others, will be presented. The focus will be on implications relevant to medical education and training.

**Discussion & Conclusions**: The insights gained through this research shed light into individual, organisational and socio-cultural aspects that contribute to the development of mental ill-health in doctors. Medical education and training is identified as a key component. The recommendations from this project support the tailoring, implementation, monitoring and evaluation of contextually-sensitive strategies to tackle mental ill-health and its impacts.

**Take-home message**: Realist review is particularly well suited to the exploration of complex problems such as the development of mental ill-health in doctors. Medical education and training is an important aspect of the problem – and therefore also of the solution.

**10H6 (530)**
**Do I know how my CPD might change practice? Development of a tool to code the behaviour change techniques in training courses**

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**Background**: Health professional education is often an intervention to change practice, but the behaviour change content is rarely systematically studied. Educators report that behavioural science is inaccessible. There are over 50 theories of behaviour change and a recent taxonomy of techniques to change behaviour found 93 techniques in 16 domains. The breadth of theories and techniques may need adjustment if educators are to use them to study the content of training and impact on the learner and their practice. We aimed to develop and refine a tool, using the BCT taxonomy (v1), with relevant examples, which health professional educators could use to describe the content of their courses.

**Method**: Two psychologists observed three medical CPD courses over seven days. The BCT taxonomy (v1) was used to live-code BCTs i.e., observing and coding in real time; inter-rater reliability was assessed. A pilot e-tool contained observed BCTs with relevant examples. Six behaviour change consultants commented on its comprehensiveness and suggested revisions. Three psychologists then formally rated examples (20% were double-rated) regarding accuracy, clarity, distinctiveness from other BCTs and generalisability to other behaviours. The tool was subsequently refined.

**Results**: Live coding inter-rater agreement was high (Cohen’s Kappa 0.75-0.89; PABAK 0.81-0.92). Forty-one BCTs were coded by at least one observer; behaviour change consultants suggested two more to enhance comprehensiveness. The pilot e-tool contained 43 BCTs with 86 examples. Thirty-seven examples were altered following recommendations; raters subsequently judged that 63/86 met all four example criteria (inter-rater agreement was 92%). The final e-tool contains 43 BCTs and 72 examples.

**Discussion & Conclusions**: A training version of the behaviour change technique taxonomy was systematically developed and refined to assist educators in
understanding the behaviour change content of education. It had high inter-rater reliability when used by psychologists. The e-tool should now be piloted by non-psychologist health professional educators in a wider range of courses.

**Take-home messages:** CPD contains many techniques to change practice. These can be 'live-coded'. Coding the techniques allows them to be systematically varied and studied to understand how to optimise CPD to make practice change more likely.

**10H7 (1043)**  
How does the education of health and social care staff lead to patient benefit: a realist synthesis?

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**Background:** The aim of the research was to answer the question: How does education and training of health and social care staff lead to patient benefit? We explored this question using a realist synthesis approach which lends itself to explaining complex interventions. Our theoretical approach was initially developed following the work of Kirwan and Birchall (2006) and Kirwan (2009).

**Method:** We conducted a systematic search of the literature to identify educational interventions with health and social care personnel and included the databases: Embase, Social Services Abstracts, PsycINFO, CINAHL, and Social Care Online. Search terms referred to three conceptual areas: education and training; patient outcomes; and health and social care occupations. Over 24000 articles involving education and patient outcomes were identified, after reading titles and abstracts this number reduced to 1149 and following full paper review to 465. The final model draws on 50 key papers that contained in depth process information. We identified the context (C), mechanisms (M) and outcome (O) variables in each paper and used Realist And Meta-narrative Evidence Syntheses: Evolving Standards (RAMESES) to guide the approach.

**Results:** Our model starts with when the organisation recognises the learning need and the intervention (focused on patients) is put in place. This is followed by individual motivation to learn before they attend the training and is followed by the educational intervention where the learner acquires knowledge and skills and ends with the learner both wanting to and being facilitated to transfer the learning to patients. The relationships between the contexts, mechanisms, and outcomes for each stage of the model was coded and tabulated for all included papers and informed the model. Cases studies were used to fill any gaps in the model and revise and strengthen it.

**Discussion & Conclusion:** The programme theory presented illustrates how and why interventions lead to patient benefit (or fail to), enabling those implementing educational interventions to identify the key features required to support transfer of learning to patients.

**Take-home message:** A model has been developed and tested, and illustrates how education of the healthcare team can reach and benefit patients.