Appraisal, wellbeing, and pandemics: is a focus on wellbeing now warranted?

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INTRODUCTION

Appraisal, quiescent in the initial COVID-19 response in the UK, may restart in October, but differently. In early July, GPs in England were told of the intention: '... to re-purpose the appraisals process in the context of the pandemic ... to anchor the new approach around professional development and support, focusing on well-being as well as minimise the supporting information requirements.' 1

A few weeks later, the Interim Chief Medical Officer for Scotland wrote to Responsible Officers signalling change: 'In planning to recommence appraisals I would encourage you to work with your appraisers to ensure that forthcoming appraisals focus on the well-being of the doctor.' 2

Acknowledgement of the need to reduce the burden of the appraisal process is welcome; however, more needs to be done to also clarify its purpose and value. The evidence on the benefits of appraisal is limited and findings are mostly based on self-reported, subjective assessments, the results of which vary widely.3,4

Is this focus on doctors' wellbeing a sign of an emerging kinder, more informal, flexible, and supportive appraisal process? And can such a process meaningfully respond to the reported increasing levels of stress and burnout among doctors5 while fulfilling its regulatory role towards revalidation? We do not think so and urge caution.

WHAT IS WELLBEING?

First, what is wellbeing? It is a term often used to cover mental, physical, social, emotional, and financial states: 'While it [wellbeing] does include happiness, it also includes other things, such as how satisfied people are with their life as a whole, their sense of purpose, and how in control they feel.' 6

Wellbeing can mean different things to different people and can be influenced by external conditions (such as income, housing, and social networks) and internal resources (such as optimism, resilience, and self-esteem). A review identified 99 measures with 196 dimensions of wellbeing within them.7 While there is a role for health systems to consider the impacts of policy on staff health and morale,8 it is difficult to see how a brief, annual conversation with an appraiser can assist towards addressing such a multifaceted and complex issue.

This is especially challenging when the core purpose of appraisal is to revalidate. There is no other route to remaining on the UK medical register. Appraisers are clinicians trained on assessing progress towards revalidation; they are not the appraisees' doctor or counsellor. The main purpose of the appraisal meeting, as set out by the General Medical Council (GMC), does not include a discussion of wellbeing (the doctor is asked to confirm they have recourse to independent medical advice).9 A fundamental change in the nature, focus, and information being sought at appraisal should not be introduced without critical appraisal of the evidence, consideration of unintended harms, and careful consultation.

It is currently unclear what an appraisal focus on wellbeing will include, what information will be sought, and what actions the appraiser and appraisee will be expected to take. Links to potentially relevant resources may be recommended for the appraisee to access, but such resources are already available via a multitude of organisations including the Royal Medical Colleges and the British

Medical Association. There is a difference when one reacts to information that happens to be found (for example, difficult working conditions), and when one seeks and elicits information in a statutory meeting, which is necessary to attend in order to continue to work.

SUPPORT IN APPRAISAL

It can be reasonably assumed that answers that may suggest a safety issue may be escalated (the confidentiality of the appraisal process is not absolute); however, doctors are entitled to their own medical confidentiality and should not be pushed into a therapeutic relationship with an appraiser. If there is a need for psychological support or an occupational workplace assessment, these should be done in an appropriate venue with the resources and follow-up required. Appraisal cannot be relied on to replace regular assessments of doctors' working conditions, and appraisees and appraisers cannot be held responsible for accommodating unreasonable working practices.

If the aim of the proposed appraisal changes is to support colleagues who may have been working in stressful and extreme environments with potential associated distress, the bureaucracy of the appraisal should be removed or at least minimised without adding new and confusing elements to the process. Other means would be necessary to offer rapid, confidential, and effective support. As the letter from the Interim Chief Medical Officer for Scotland goes on: 'An accommodation will require to be made for the fact that doctors will have found it challenging to collect meaningful supporting information [...] while the GMC has also stated that they expect flexibility with regard to the submission of supporting information for appraisal purposes they have made it clear that consideration of the core GMC requirements, particularly with regard to patient safety issues, continues to be necessary ... ' 2

We should be under no illusions; appraisal is not a medical consultation, a coaching session, or an informal chat. Doctors at risk of burnout and in need of support should seek this in settings designed for this purpose. Any future initiatives on addressing doctors' wellbeing should consider the potential negative impact of bureaucratic processes imposed on them.

We urge caution on introducing appraisal with added dimensions at a time that may be one of the busiest in NHS history, and suggest that interrogating the nature and cost effectiveness of the existing process, and removing that which is ineffective, burdensome, and low value, may do rather more for the wellbeing of the UK's medical workforce.

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