

# Guide to the Revalidation of Occupational Physicians



*June 2010*

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## 1. Background

This document sets out the view of **The Faculty of Occupational Medicine (FOM)** in relation to revalidation, but it is an evolving area and it is current only as at the date in the page footer. The intention is to update the guide on a rolling basis, including changes to policy, information from pilots and feedback from members. New versions will be produced as required.

## 2. Definitions and descriptions

Revalidation is the process by which doctors will have to demonstrate to the General Medical Council (GMC) that they are up to date and fit to practise and that they are complying with the relevant professional standards. Revalidation, as originally described, had two elements: Relicensing and Recertification.

### Relicensing

From 16<sup>th</sup> November 2009, any doctor who wants to practise medicine in the UK will not only have to be registered with the GMC, but will also have to hold a licence to practise. All the professional activities that are currently restricted by law to doctors who are registered with the GMC will in future be restricted to doctors who hold a licence. These activities include prescribing, signing death and cremation certificates, and holding certain medical posts in the NHS and the independent sector.

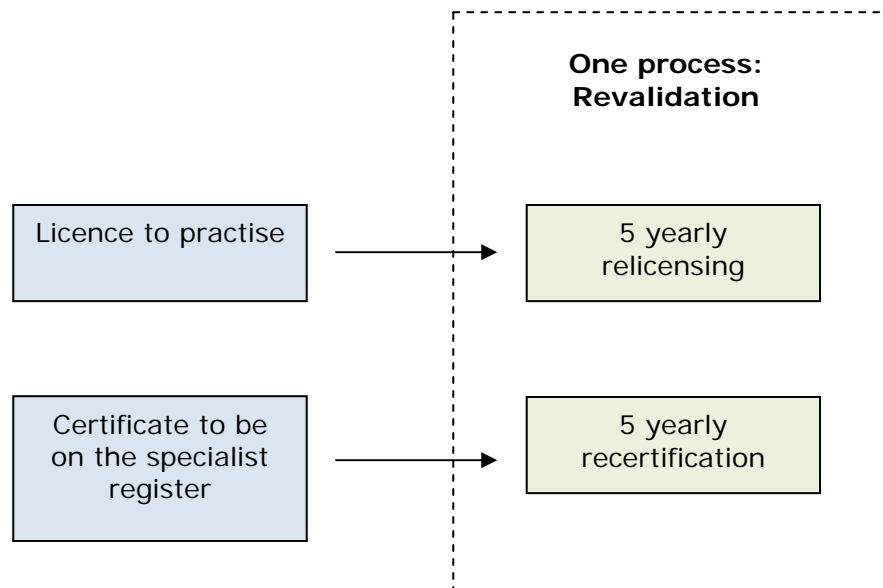
Further information about licensing, including whether you will need a licence, can be found on the GMC website - <http://www.gmc-uk.org/doctors/licensing/practice.asp>

The purpose of relicensing is to show that all doctors are practising in accordance with the generic standards of practice set by the GMC and based upon the GMC's guidance *Good Medical Practice*.

### Recertification

The purpose of recertification is to show that practising doctors who undertake specialist practice continue to meet the particular standards that apply to their medical specialty or area of practice. These specialty specific standards are set by the medical Royal Colleges and Faculties.

As development work on revalidation has progressed it has become increasingly obvious that the separation into two separate strands is unhelpful and revalidation should now be regarded as a single process or set of processes.



### **Aims of revalidation**

The Chief Medical Officer of England has identified **three main aims** of revalidation:

- To confirm that licensed doctors practise in accordance with the GMC's generic standards (*relicensure*);
- For doctors on the specialist register and GP register, to confirm that they meet the standards appropriate for their specialty (*recertification*) and;
- To identify for further investigation, and remediation, poor practice where local systems are either not robust enough to do this or do not exist.

The **objectives** in developing revalidation include:

- Recertification must command the confidence of patients, the public and the profession;
- Recertification should facilitate improved practice for all Members and Fellows;
- The process should identify those whose practice falls below acceptable standards and give advice and monitoring to allow recertification to be reconsidered. There should be early warning of potential failure so remedial action can be taken;
- The process should allow those who are working to College/Faculty standards to recertify without undue difficulty or stress;
- There must be equity across the specialty, independent of differing areas of practice, working environments and geographical location;
- Recertification should be affordable and flexible, starting simple to allow further development;
- The process should incorporate as far as possible information already being collected in clinical work and use existing tools and standards where available.

### 3. How will revalidation work?

#### **Standards for revalidation in occupational medicine**

The FOM has been working with the other Colleges and Faculties through the Academy of Medical Royal Colleges (AoMRC) on various aspects of revalidation in order to fulfil its responsibilities. The first step was to use the GMC's *Working Framework for Appraisal and Revalidation*<sup>1</sup>, which is based on *Good Medical Practice*, as a template to define standards and suggest supporting information for revalidation in occupational medicine. Fortunately, thanks to the proactive work of a number of far-sighted individuals from both the Faculty and the Society of Occupational Medicine (SOM), the foundations of this work had already been completed in providing guidance for appraisal. Bringing it up to date, in particular to reflect the requirements of *Good Occupational Medicine Practice*<sup>2</sup> and the new training curriculum, was therefore relatively straight forward and many members contributed feedback on earlier versions published on the Faculty website. The final version, which has now been approved by the GMC, incorporates standards for all 14 major medical specialties in a similar format<sup>3</sup>. There are a further five additional frameworks for non-clinical areas of practice: management, education, research, providing expert advice, and civil service and policy development for which GMC approval is still pending. Occupational physicians with a practice that extends beyond the purely clinical area will need to use these additional frameworks to inform their revalidation requirements.

The standards will be reviewed after completion of the piloting process and then subject to further regular review and update as a result of feedback from individual doctors, appraisers and responsible officers.

#### **A model for revalidation**

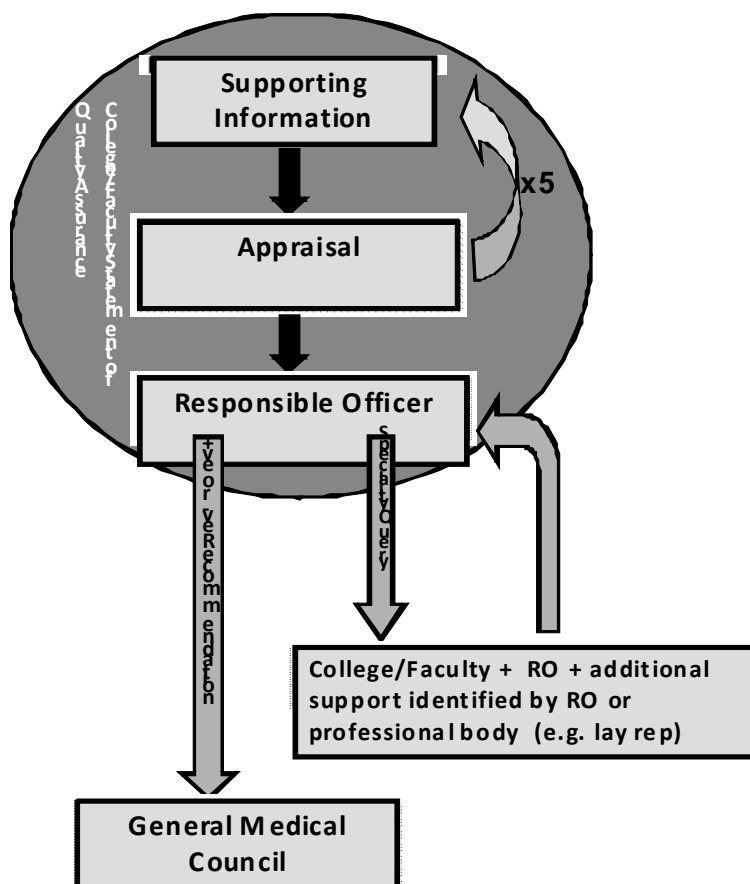
The AoMRC and GMC have together produced a generic model for revalidation which illustrates the process in outline. The model integrates relicensing and recertification as a single set of processes based around workplace appraisal. The outputs of appraisal are evaluated by the Responsible Officer in the doctor's healthcare organisation who makes a recommendation to the GMC regarding the doctor's suitability to be revalidated. In the vast majority of cases, the Responsible Officer will make a positive recommendation to the GMC, once in every five year revalidation cycle, which will result in relicensing of the individual doctor. If the Responsible Officer has queries about the specialty aspects of the doctor's work, advice will be taken from the Faculty, either centrally or through the appropriate Regional Specialty Adviser. The GMC would like the Faculty to have a role in quality assuring the whole process, though there is more work to be done in defining how it will be done and the resource implications.

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<sup>1</sup> [http://www.gmc-uk.org/about/reform/gmp\\_framework.asp](http://www.gmc-uk.org/about/reform/gmp_framework.asp)

<sup>2</sup> <http://www.facocmed.ac.uk/library/docs/pubgompmay08.pdf>

<sup>3</sup> [http://www.gmc-uk.org/static/documents/content/Revalidation\\_way\\_ahead\\_annex2.pdf](http://www.gmc-uk.org/static/documents/content/Revalidation_way_ahead_annex2.pdf)



## Appraisal

Appraisal is the cornerstone of medical revalidation and must therefore be delivered to a consistently high standard and be quality assured. The NHS Revalidation Support Team (RST) has revised existing guidance on appraisal to make it suitable for revalidation and produced *Assuring the Quality of Medical Appraisal for Revalidation (AQMAR)*<sup>4</sup>. The intention is for the broadly formative theme of appraisal to be retained, but additional judgements will be made about information on performance and whether the doctor is satisfactorily progressing towards revalidation. It is stressed that the responsibility for appraisal and revalidation lies with the individual doctor.

The AQMAR document is designed to provide guidance to all organisations wishing to provide medical appraisal. This includes traditional primary and secondary care organisations, but also independent sector organisations and other providers. Using checklists, organisations will be able to identify priorities for action and development. It has been used in NHS Trusts in England in 2009 as a base-lining exercise, with resulting development work supported locally by Strategic Health Authorities. This document should be seen as an aid to developing the systems needed to support appraisal and revalidation.

<sup>4</sup>[http://www.revalidationsupport.nhs.uk/Assuring\\_the\\_Quality\\_of\\_Medical\\_Appraisal\\_for\\_Revalidation.asp](http://www.revalidationsupport.nhs.uk/Assuring_the_Quality_of_Medical_Appraisal_for_Revalidation.asp)

Organisations outside the NHS that have their own systems of medical appraisal will be expected to conform to the AQMAR standard and the Faculty is working with the SOM to ensure that its Quality Assured Appraisal Scheme (QAAS) meets the same standard.

### **The Responsible Officer**

The role of Responsible Officer is a new one created under the provisions of the Health and Social Care Act 2008. There will be some differences to the role in the various countries of the United Kingdom; however, the Responsible Officer will generally be a senior doctor in a healthcare organisation, such as the Medical Director. For General Practitioners, the Responsible Officer will be from the primary care organisation on whose performers list they are included.

The Responsible Officer will have specific responsibilities relating to the evaluation of the fitness to practise of doctors connected with that organisation. Every licensed doctor will be linked with a named Responsible Officer. One of the Responsible Officer's key roles will be to recommend to the GMC whether or not a doctor should be revalidated.

Each designated organisation will have only one Responsible Officer though he or she may devolve some aspects of the wider role to a deputy. The Responsible Officer must have practical experience as a senior doctor and have a licence to practise. The Responsible Officer will be able to demonstrate evidence of continuing personal and professional development. Specifically, he or she must be able to demonstrate an ability to lead and manage change in complex healthcare organisations and have significant experience of medical management, including practical experience of performance management of colleagues, appraisal processes and audit.

It is likely that larger occupational health providers which can demonstrate adequate systems of clinical governance will be designated as organisations that will be required to appoint a Responsible Officer. Some designated organisations may elect to combine resources and appoint a single Responsible Officer to provide the function to multiple organisations. Doctors who do not work for an organisation designated under the regulations will need to identify an alternative Responsible Officer. This is entirely the responsibility of the individual doctor who will not be able to revalidate otherwise. The original Department of Health proposal was that Primary Care Trust (PCT) Responsible Officers would fulfil the function. That was felt by the Faculty to be unacceptable and as a result of negotiation with the Department of Health, the Faculty will be allowed to appoint its own Responsible Officer. Occupational physicians who do not have a relationship to a Responsible Officer through their employer will be able to access the Faculty appointed Responsible Officer. Details of how the scheme will work need to be developed further but it is currently envisaged that it will operate in much the same way as the SOM QAAS with individuals or their employer paying a fee for use of the service.

### **Continuing Professional Development (CPD)**

The Faculty has an established CPD scheme which has been updated to make it fit with revalidation by ensuring it conforms to an AoMRC framework for CPD that has been approved by the GMC. The overall requirement of 50 CPD credits (250 in a five year cycle) is unchanged, but there is added flexibility in how credits can be

accumulated, such as the addition of a new category of personal CPD, for example. Full details can be found on the Faculty website<sup>5</sup>. At the same time, funding has been provided by the AoMRC to develop an electronic CPD diary which will make recording, summarising and recording reflection more straight forward and remove the requirement to submit an annual paper summary. The requirement to retain supporting information from individual CPD activities remains unchanged because it will be needed for appraisal and to allow audit by the Faculty once every five years.

The electronic CPD diary will be available to members from summer 2010 (and to non-members on payment of a fee). The current paper version will run in parallel until December 2011 when it will cease. The revised CPD guidance, including elements such as personal CPD, will only apply to users of the electronic version. The CPD year for the electronic diary will run from 1<sup>st</sup> April.

#### **4. The supporting information required for revalidation**

The standards for revalidation in occupational medicine are owned by the GMC and can be viewed along with the standards for all 14 clinical specialties and five areas of non-clinical practice on the GMC website<sup>6</sup>. A more comprehensive version that incorporates the non-clinical areas into one document is included at Annex A to this handbook. The standards are divided into the four domains that the GMC has derived from *Good Medical Practice*. Under each domain there are three attributes, each accompanied by generic standards that apply to all doctors. To make them more relevant to occupational physicians, these have been converted into occupational medicine specific standards and for most of these there are corresponding possible sources of supporting information and evaluation. No doctor will be expected to provide supporting information for every single standard. Revalidation is related to the area in which a doctor works and the individual will need to decide which standards apply and, therefore, the corresponding examples of supporting evidence that are relevant to them. Similarly, as revalidation follows a five year cycle, not all forms of supporting information need to be included every year.

The vast majority of supporting information required for revalidation will be submitted through the appraisal process, and part of the Responsible Officer's role will be to ensure that the appraisal has been undertaken in accordance with the AQMAR standards. In most cases, this will require appraisal by another occupational physician.

Some elements of the supporting information merit further elaboration.

##### **Continuing Professional Development**

The portfolio for every appraisal should contain a CPD summary for the year and, once in every five years, the result of a Faculty CPD audit. The appraiser will want to have available the whole CPD folder, containing the evidence of attendance and of any reflective learning. Users of the Faculty on-line CPD diary will be able to print out a CPD summary and all their reflective notes for use in appraisal.

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<sup>5</sup> <http://www.facocmed.ac.uk/cpd/index.jsp>

<sup>6</sup> [http://www.gmc-uk.org/static/documents/content/Revalidation\\_way\\_ahead\\_annex2.pdf](http://www.gmc-uk.org/static/documents/content/Revalidation_way_ahead_annex2.pdf)

## **Clinical audit**

The information that doctors will need to provide for revalidation will be drawn largely from their actual practice. For occupational physicians with clinical responsibility, the information required will include evidence of participation in clinical audit and evidence that the doctor has both reflected and acted on the results of clinical audit. Examples of at least two completed clinical audits will be required in each revalidation cycle. The SOM is developing practical audit tools to aid occupational physicians who might have limited experience in this area.

## **Multi-source feedback**

Independent feedback from colleagues is seen as one of the important elements of revalidation. It is variously referred to as 360-degree or multi-source feedback (MSF).

The GMC has been developing colleague questionnaires for use within the revalidation process based on the standards contained in *Good Medical Practice*. Early research by Peninsula Medical School into the validity, reliability and practicality of the questionnaires has been encouraging and demonstrates that questionnaires have the potential to be a reliable means of collecting information regarding doctors' performance. More in-depth testing of the questionnaire tools across whole organisations and in different clinical settings is now taking place.

Some occupational physicians are already using various MSF systems available through commercial organisations. Others are managing their own paper-based systems, such as that available on the Faculty website for use in workplace-based assessment by specialty registrars<sup>7</sup>. Revalidation will require the use of MSF at least once in the revalidation cycle. The GMC questionnaire is available for use by doctors and employers through a commercial organisation that administers the questionnaires.<sup>8</sup>

## **Patient feedback**

Doctors in clinical practice are expected to obtain feedback from their patients. This may pose some challenges for occupational physicians whose recommendations are not always looked upon favourably by patients/clients. Nevertheless, it is important that we get the views of our patients on elements of our practice, such as communication skills, and there are many questionnaires available for doing so, including one available through the same GMC web page as MSF. Examples of at least one completed patient feedback survey will be required in each revalidation cycle. This is another area that the SOM is looking to develop specific support to occupational physicians.

## **Presenting the evidence**

There is an aspiration that the supporting information for revalidation should be held in an electronic portfolio, which will allow the doctor to provide a summary for the

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<sup>7</sup> [http://www.facocmed.ac.uk/library/docs/w\\_msfass.pdf](http://www.facocmed.ac.uk/library/docs/w_msfass.pdf)

<sup>8</sup> [http://www.gmc-uk.org/doctors/licensing/revalidation/multi\\_source\\_feedback\\_for\\_doctors.asp](http://www.gmc-uk.org/doctors/licensing/revalidation/multi_source_feedback_for_doctors.asp) and [http://www.gmc-uk.org/Draft\\_GMC\\_Colleague\\_Questionnaire.pdf\\_28205215.pdf](http://www.gmc-uk.org/Draft_GMC_Colleague_Questionnaire.pdf_28205215.pdf)

appraiser so that important issues can be identified and further detail accessed, if needed. It would form an electronic filing cabinet that would link to the specialty framework, categorising information under the correct domain. The Faculty has been working with a number of other colleges and faculties on developing an outline specification, and has been funded by the AoMRC to develop an appropriate tool. It is unlikely that revalidation will begin before such tools are available.

## 5. Occupational physicians in particular situations

Revalidation for occupational physicians who are employed in the UK by large, managed medical organisations, including the NHS, Armed Forces and large providers of occupational health services should be straightforward. You will have an annual appraisal within your own established, quality assured appraisal system by another occupational physician trained in appraisal, and your organisation's Responsible Officer will make the appropriate recommendation to the GMC. Occupational physicians in other settings may find revalidation more challenging and some additional guidance is offered below.

### **General practitioners with a special interest in occupational medicine**

General Practitioners (GPs) should refer to the detailed guidance on *GPs with Specialist Interest (GPwSI)* contained in the RCGP *Guide to the Revalidation of General Practitioners*<sup>9</sup>. Evidence Area 13 refers to the additional evidence required for GPs with areas of extended practice and is reproduced below for ease of reference:

*For clinical activities, including GPwSIs, the GP should describe in detail the role (in evidence area 1) and provide in this section of the portfolio evidence that satisfactorily answers the following three questions:*

- 1. How did you qualify to take on this role? This should include prior experience, education and qualifications.*
- 2. How do you keep up to date in this role? This should include reference to all education and refreshment undertaken for this role in the revalidation period, including any learning credits recorded in evidence area 6.*
- 3. How can you demonstrate that you are fit to practise in this role? This should include appropriate audits of care delivered, including reference to any audits in evidence areas 10 and 11, evidence from third-party observation of your work, and sign-off from an appropriate consultant/expert/colleague who knows your work.*

<sup>9</sup> [http://www.rcgp.org.uk/PDF/PDS\\_Guide\\_to\\_Revalidation\\_for\\_GPs.pdf](http://www.rcgp.org.uk/PDF/PDS_Guide_to_Revalidation_for_GPs.pdf)

Your appraisal should cover all your work, including your occupational medicine role, and your CPD should contain an appropriate proportion of occupational health, relative to the amount of time you spend in its practice. You will not be required to submit a separate CPD return to the Faculty and you do not need a separate appraisal, though you should try to ensure that your appraiser has experience in all aspects of your work if possible. If your GP appraiser or Responsible Officer has any queries relating to the specialist component of your work, these can be addressed to the appropriate Regional Specialty Adviser<sup>10</sup>.

### **Occupational physicians not on the Specialist Register**

Doctors who practise occupational medicine who have not successfully completed a formal training programme leading to specialist accreditation will not be able to recertify, but will still have to demonstrate that their practice complies with the specialty standards in order to revalidate. In addition to the appropriate examples of supporting information that are relevant to your practice, you will be expected to demonstrate how you are qualified to undertake your role, through formal qualification, other training or experience, and provide evidence that you have access to an appropriate level of specialist support.

### **Occupational physicians working in other clinical fields**

The Faculty is aware of a small number of specialist occupational physicians who retain some clinical responsibility in other specialties in which they have previously qualified, notably general practice. Assuming that most of your time is spent practising occupational medicine, the majority of your supporting information for revalidation must be derived from that area. However, you will also be required to demonstrate that you meet the standards for revalidation for the whole of your practice. Ideally, you would have a single appraisal by another doctor with the same spread of competence. In practice, this is unlikely to be achieved easily and, therefore, you will need to demonstrate that you are being appraised appropriately, either by having a single appraisal with appraisers from both specialty areas, or separate appraisals.

### **Independent practitioners**

Independent practitioners will find some aspects of revalidation more challenging than those who are employed in a managed medical setting. The SOM QAAS has been put in place specifically to support doctors in your situation and the Faculty's Responsible Officer scheme will provide the final recommendation that you will need to revalidate for those who need to use it. The supporting information that you are able to provide will necessarily be limited: for example, you may have few colleagues to call upon for MSF purposes. These factors will be taken into account by your appraiser and Responsible Officer but the responsibility for demonstrating that you are fit to continue to practise rests firmly with the individual doctor and you may need to seek additional sources of supporting information from other areas of your practice. You should also make the most of opportunities provided by specialist societies, for example the regional audit groups that the SOM is encouraging.

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<sup>10</sup> <http://www.facocmed.ac.uk/library/index.jsp?ref=73>

## **Occupational physicians working abroad**

The GMC's FAQ deals specifically with the issues of doctors working overseas<sup>11</sup>. Many occupational physicians work for international organisations and will wish to maintain their certification, rather than re-establish their credentials on returning to the UK. They will need to satisfy the same standards of CPD and quality assured appraisal as those working in the UK, which poses a significant challenge; but they will have the advantage of access to the Faculty Responsible Officer scheme, if necessary.

## **Part-time doctors**

You should also refer to the GMC's FAQ<sup>11</sup>. In most respects, you will, for revalidation purposes, be treated no differently from a doctor working full-time. You will, for example, need to complete the same number of CPD credits.

## **6. Remediation**

Remediation is the support that needs to be made available to doctors who need it at any point in the revalidation cycle. It is a spectrum that has self-help and peer support at one end and National Clinical Assessment Service (NCAS) and the GMC at the other. Remedial support needs to be offered as early as possible when concerns are identified and should not wait for appraisal or responsible officer involvement. Many employers will have their own systems of support to doctors who are cause for concern. The SOM plans a road show to support the introduction of revalidation through sharing experience of the types of supporting information that have been found useful and by producing appropriate template policies that can be adapted by individual occupational physicians as part of their evidence. The Faculty Professional Development Sub-Committee will provide advice, as required, to individual requests for support, although, at this stage, it is envisaged to consist largely of signposting to the appropriate agency. Any additional substantial costs incurred in support of remediation will fall to the individual or their employer.

## **Support to Appraisers and Responsible Officers**

The Faculty has a network of Regional Specialty Advisers who are available to offer specialty specific advice to those appraisers or Responsible Officers who do not have an occupational health background<sup>12</sup>.

## **7. Timescale for the introduction of revalidation**

The GMC will decide when revalidation is to start, once it is satisfied that all standards and processes are in place and have been adequately piloted. The Faculty's aim is to be ready for that decision by 1<sup>st</sup> April 2011.

Revalidation will take place over a five year cycle. That is not to say that it is a single event that takes place once in every five years, rather it is a continuous process throughout the cycle that culminates in the re-issue of a licence to practise. Any concerns that arise during the cycle must be addressed at the time, not left until the end.

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<sup>11</sup> [http://www.gmc-uk.org/doctors/licensing/faq\\_revalidation\\_p4.asp](http://www.gmc-uk.org/doctors/licensing/faq_revalidation_p4.asp)

<sup>12</sup> [http://www.facocmed.ac.uk/library/docs/t08hb\\_6\\_rsas.doc](http://www.facocmed.ac.uk/library/docs/t08hb_6_rsas.doc)

The way in which the GMC will select doctors for revalidation within a five year period has yet to be decided and, during the first five years, the majority will be revalidated on the basis of supporting information covering less than five years of practice. Responsible Officers will need to make a judgement on the amount of supporting evidence appropriate to the period covered. For example, two iterations of MSF are required in five years. In the first year, few will have been able to organise one but by the end of the second year, all should have. By the end of year 4, all doctors should have had two. Previous evidence of participation in a quality assured medical appraisal process, particularly for those doctors whose revalidation takes place in the first few years, will help to reassure Responsible Officers of their commitment to a process of continuous improvement.

### **Pilot**

There is general agreement that all aspects of revalidation should be subject to piloting before it is finally introduced. Several pilots have already started in the NHS and some occupational physicians may have been included. The Faculty intends to conduct a specialty specific pilot during 2010 which will cover all sectors, including occupational physicians not on the specialist register, and all stages of the process. An application for funding to the AoMRC has been successful and the FOM is working with the Faculties of Pharmaceutical Medicine and Public Health, which have doctors working in similar situations, on a joint pilot project which should commence towards the end of 2010. The results will be used to refine the specialty standards and develop procedures within the Faculty for its role in the administration of revalidation.

## **8. Conclusion**

The intention is for this to remain a living document that will be responsive to feedback from individual occupational physicians, the piloting of revalidation and its eventual introduction. We welcome any comments which should be sent to:

[professionaldevelopment@facocmed.ac.uk](mailto:professionaldevelopment@facocmed.ac.uk)

## **Annex A - STANDARDS FOR REVALIDATION IN OCCUPATIONAL MEDICINE**

The generic standards are based on the General Medical Council's framework for appraisal and assessment, which apply to all doctors. They are followed by OM specific standards<sup>1</sup> which in some cases expand on the generic standards and in others define standards which are specific to doctors practising occupational medicine. They are accompanied by suggested examples of the sort of evidence that will help to demonstrate that continuous quality improvement is being achieved. None of them are mandatory and other kinds of evidence may be acceptable, depending on personal practice.

Numbers following the generic standards refer to paragraph numbers in GMP, except where preceded by MfD which refers to the GMC booklet *Management for Doctors*; or Research which refers to *Research: the role and responsibilities of doctors*.

The 'Leicester Statement' recommends the use of Structured Reflective Templates (SRT) to link the raw evidence of performance, which will frequently be provided on a team basis, to the behaviour and development needs of the individual doctor. The relevant SRT are referenced below where appropriate. The full document which includes the individual SRT can be found at:

<http://www.appraisalsupport.nhs.uk/files2/the%20leicester%20%20statement%20on%20evidence%20for%20appraisal.pdf>.

Other useful sources of supporting information for SOM members are available through the SOM website's Learning Zone (Tools for Appraisal).

<b>Domain 1 – Knowledge, Skills and Performance</b>		
<b>Attributes</b>	<b>Generic Standards</b>	
Maintain your professional performance	<p><b>All doctors</b></p> <ul style="list-style-type: none"> <li>• Maintain knowledge of the law and other regulation relevant to practice (13);</li> <li>• Keep knowledge and skills up to date (13);</li> <li>• Participate in professional development and educational activities (12);</li> <li>• Take part in regular and systematic audit (14).</li> </ul>	
	<b>OM Specific Standards</b>	<b>Possible Sources of Supporting Information</b>
<b>Occupational physicians should:</b>	<ul style="list-style-type: none"> <li>• Regularly review their training needs;</li> <li>• Keep their knowledge and skills up to date and appropriate for all areas of practice;</li> <li>• Participate in regular educational activities that maintain and further develop their competence and performance;</li> <li>• Keep abreast of clinical developments relevant to their practice;</li> <li>• Keep abreast of the changes in legislation and codes of practice that affect their practice;</li> <li>• Understand the professional and managerial obligations to participate in medical audit;</li> <li>• Be aware of a range of audit processes and demonstrate the skills required to conduct audit;</li> <li>• Take part in regular medical and clinical audit and respond to the results of audit to improve their own practice;</li> <li>• Respond constructively to the outcome of reviews, assessments and appraisals of their own performance;</li> <li>• Take part in confidential enquiries and adverse</li> </ul>	<ul style="list-style-type: none"> <li>• Participating in the Faculty's scheme for Continuing Professional Development (CPD)</li> <li>• Maintaining a folder of evidence on the activities undertaken (e.g. certificates of attendance, programmes from courses, and other proofs);</li> <li>• Maintaining a personal training plan and a training log to show sufficient training in fields relevant to the doctor's practice;</li> <li>• Personal Learning Structured Reflective Template (SRT);</li> <li>• A rolling audit plan that covers all of the relevant areas of a doctor's practice.</li> </ul> <p><b>Evaluation</b></p> <ul style="list-style-type: none"> <li>• Certificate of completion of CPD requirement;</li> <li>• Certificate of completion of CPD audit (once in every 5 years);</li> <li>• Record of the audits conducted as part of audit plan;</li> </ul>

	<p>event recognition and reporting organised by appropriate professional bodies; and also investigations of untoward incidents, injuries, adverse health outcomes, and dangerous occurrences in the workplaces for which they have responsibility.</p>	<ul style="list-style-type: none"> <li>Record of the satisfactory completion of all remedial actions recommended as part of such audits.</li> </ul>
<b>Additional comments:</b>	<ul style="list-style-type: none"> <li>Keep documentary evidence of meeting the national minimum annual target of CPD (50 hours per year averaged over a five-year cycle - i.e. about 1 hour per week). This should be in a balance appropriate to the work role;</li> <li>The easiest route is to join in the Faculty's scheme and follow its rules (detailed guidance can be found by following links for CPD at <a href="http://www.facoccmmed.ac.uk">www.facoccmmed.ac.uk</a>). Participants who submit annual returns will receive certificates to confirm this; periodically the Faculty will conduct a formal audit of their records, and then supply an audit certificate;</li> <li>The scheme also encourages appraisal of CPD activities. It recommends that, where possible the appraiser should countersign annual returns before they are submitted to the Faculty, as confirmation of local review;</li> <li>Occupational physicians should audit their professional activities. They should aim, over a five-year period, to conduct at least two audits in areas relevant to their work and demonstrate how the results have been used to assess (and if necessary improve) standards;</li> <li>They should be able to produce records to show that audit is occurring and that they are assessing their performance against an explicit and reasonable standard (Guidelines set by the Faculty, other Royal Colleges and specialist societies can be used to provide a benchmark where they exist);</li> <li>For audit, consult the AoMRC document: Clinical Audit and Revalidation Report and Recommendations - <a href="http://www.aomrc.org.uk/publications/reports-guidance.html">http://www.aomrc.org.uk/publications/reports-guidance.html</a></li> </ul>	
<b>Attributes</b>	<b>Generic Standards</b>	
Apply knowledge and experience to practice	<p><b>All doctors</b></p> <ul style="list-style-type: none"> <li>Recognise and work within the limits of your competence (3a)</li> </ul> <p><b>Doctors with management, teaching or research roles</b></p>	

	<ul style="list-style-type: none"> <li>• Follow appropriate national research governance guidelines (71);</li> <li>• Apply the skills, attitudes and practice of a competent teacher/trainer (16);</li> <li>• Work effectively as a manager (MfD 12,17).</li> </ul> <p><b>Doctors with clinical roles</b></p> <ul style="list-style-type: none"> <li>• Adequately assess the patient's conditions(2a);</li> <li>• Provide or arrange advice, investigations or treatment where necessary (2b);</li> <li>• Prescribe drugs or treatment, including repeat prescriptions, safely and appropriately (3b);</li> <li>• Provide effective treatments based on the best available evidence (3c);</li> <li>• Take steps to alleviate pain and distress whether or not a cure may be possible (3d);</li> <li>• Consult colleagues, or refer patients to colleagues, when this is in the patient's best interests (2c, 3a, 3i, 54,55);</li> <li>• Support patients in caring for themselves (21e).</li> </ul>	
	<p><b>OM Specific Standards</b>  <i>Occupational physicians will usually work in one of three basic settings - with individuals, with groups of people and with organisations.</i></p>	<p><b>Possible Sources of Supporting Information</b></p>
<p><b>Occupational physicians should:</b></p>	<p><b>Working with individual patients</b>  <i>Many occupational physicians use the term 'client', 'employee', or 'worker', rather than 'patient', to emphasise a relationship that is frequently non-therapeutic and with the intent of keeping workers healthy.</i></p> <ul style="list-style-type: none"> <li>• Make an adequate assessment of the patient's health status (by history, physical examination, clinical procedures and relevant tests);</li> <li>• Make an adequate assessment of the patients occupational health needs (by occupational history, physical examination, clinical procedures and relevant tests);</li> <li>• Obtain or arrange for additional medical or</li> </ul>	<ul style="list-style-type: none"> <li>• Records of audits of clinical activity covering:             <ul style="list-style-type: none"> <li>– Reviews of clinical notes</li> <li>– Reviews of letters of referral</li> <li>– Reviews of the written procedures supporting clinical activity</li> <li>– Reviews of patient feedback including complaints</li> <li>– SRT audit</li> </ul> </li> <li>• Minutes of meetings at which clinical audit was conducted or personal clinical performance was reviewed;</li> <li>• Any routine indicators of performance - e.g. evidence to show compliance with medical policies or protocols; or that personal development plan objectives have been met;</li> </ul>

	<p>paramedical information from specialists or relevant therapists;</p> <ul style="list-style-type: none"> <li>• Make a functional assessment of the patient's physical and psychological capability for his job (or the job he might be asked to do);</li> <li>• Make an assessment of the impact of a patient's work on their health;</li> <li>• Make an assessment of the risk a patient's health or fitness poses to the safety of themselves and others;</li> <li>• Provide patients with information on their health, its occupational impact, and the steps needed to control and reduce their personal risks;</li> <li>• Provide advice on the relevant options for treatment, rehabilitation, and redeployment;</li> <li>• Advise on the short and long-term modifications to a patient's work dictated by their state of health;</li> <li>• Involve other health and occupational health professionals where appropriate, including the patient's general practitioner</li> <li>• Work within their limits.</li> </ul>	<ul style="list-style-type: none"> <li>• Records of any lessons learned from dealing with patients or participation in critical reviews for this purpose;</li> <li>• Adherence to guidelines (e.g. GMC confidentiality);</li> <li>• Case Review SRT (2 per year).</li> </ul> <p><b>Evaluation</b></p> <ul style="list-style-type: none"> <li>• Records of any audits conducted</li> </ul>
<p><b>Occupational physicians should:</b></p>	<p><b>Working with groups of patients</b></p> <ul style="list-style-type: none"> <li>• Understand the nature of the hazards in the workplace settings for which they are responsible;</li> <li>• Assess the risks to the health in these settings (including risks to employees, contractors, temps, agency staff and members of the public) by:             <ul style="list-style-type: none"> <li>- ensuring appropriate data are collected</li> <li>- adopting a structured approach to site visits - to observe hazards, and</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Written reports by the doctor following site visits to workplaces;</li> <li>• The findings of studies into the health of working groups for which the doctor has responsibility</li> <li>• Policies which the doctor follows that relate to the health of working groups, (including, for example, their rationale and the basis on which they have been constructed and are assessed);</li> <li>• Reviews of existing, or newly designed,</li> </ul>

	<p>workplace practices and behaviours.</p> <ul style="list-style-type: none"> <li>• Maintain adequate records of such data collection, site visits and assessments;</li> <li>• Advise on the measures required to control the health and safety risks arising from work activities;</li> <li>• Design and implement an effective programme of health surveillance where indicated, involving managers and patients' representatives in the process;</li> <li>• Plan and organise for the health and safety needs of employees, including their need for health and safety training;</li> <li>• You should encourage patients and the public to take an interest in their health and to take action to improve and maintain it. This may include advising patients on the effects of their life choices on their health and well-being and the possible outcomes of their treatments.</li> </ul>	<p>programmes of health surveillance related to the doctor's practice, (including, for example, their rationale and the basis on which they have been constructed and are assessed);</p> <ul style="list-style-type: none"> <li>• Periodic reports by the doctor to management on the health of working groups;</li> <li>• Minutes of reviews related to clinical governance, including any information on resulting changes in practice;</li> <li>• Examples of health promotional material used in the workplace.</li> </ul> <p><b>Evaluation</b></p> <ul style="list-style-type: none"> <li>• Demonstration that improvements have taken place as a result of such activities.</li> </ul>
<p><b>Occupational physicians should:</b></p>	<p><b>Working with organisations</b></p> <ul style="list-style-type: none"> <li>• Be able to understand how their organisation works in terms of: its structures, reporting lines, and business cycles; the personnel, representatives, and colleagues most closely connected with health and safety; and the working groups with special needs;</li> <li>• Ensure that the operation of their occupational medical service remains independent of, although not isolated from, the business it serves;</li> <li>• Ensure that patients remain at the core of the service;</li> <li>• Know the main management processes, data and quality systems relevant to occupational</li> </ul>	<ul style="list-style-type: none"> <li>• Health plans or business plans prepared by the doctor and which relate to health issues within their organisation;</li> <li>• Examples of evidence based-company advice that the doctor has given, or employs, in their dealings with managers;</li> <li>• Examples of correspondence with managers or presentations to managers, illustrating the clarity and relevance with which the doctor communicates on health matters;</li> <li>• Feedback from managers on the quality of the services a doctor provides and the employer's satisfaction with service level agreements;</li> <li>• Written protocols that describe the purpose of</li> </ul>

	<p>medical practice - e.g. policies on sickness absence, rehabilitation and ill-health retirement; and relevant performance indicators;</p> <ul style="list-style-type: none"> <li>• Be able to advise on the data an organisation needs to collect to assess its occupational health performance and requirements;</li> <li>• Be able to analyse and interpret the significance of such data;</li> <li>• Be able to report on it in ways that are accessible to managers, placing it within a business framework and also providing the medico-legal context;</li> <li>• Have a range of influencing styles that reflect the difference between medical and managerial concerns.</li> </ul>	<p>the occupational health service and outline its policies and arrangements - including the issues of patients' rights, professional standards and ethics, and policies of communication;</p> <ul style="list-style-type: none"> <li>• Evidence to show the safeguards and arrangements to preserve confidential clinical records.</li> </ul> <p><b>Evaluation</b></p> <ul style="list-style-type: none"> <li>• Letters can be evaluated using a standard tool such as the Sheffield Assessment Instrument for Letters (SAIL(OH))</li> </ul>
<p><b>Additional comments:</b></p>	<ul style="list-style-type: none"> <li>• Occupational physicians who care for patients should monitor their own clinical performance regularly through audit and structured peer-review with colleagues;</li> <li>• Assessment should occur against an explicit standard and any faults or concerns should be addressed;</li> <li>• Clinical notes and letters of referral to professional colleagues should make clear the current medical and occupational health needs of the patient;</li> <li>• The clinical notes they make should be legible and clear;</li> <li>• Letters to managers should enable them to understand the rationale for the advice given and (in so far as it relates to an individual) the occupational health needs of the patient;</li> <li>• Where appropriate occupational physicians should participate in clinical governance schemes.</li> </ul>	

Attributes	Generic Standards	
Keep clear, accurate and legible records	<p><b>All doctors</b></p> <ul style="list-style-type: none"> <li>• Keep clear, accurate and legible records (3f);</li> <li>• Make records at the same time as the events you are recording or as soon as possible afterwards (3f).</li> </ul> <p><b>Doctors with clinical roles</b></p> <ul style="list-style-type: none"> <li>• Record clinical findings, decisions, information given to patients, drugs prescribed and other information or treatment (3f)</li> </ul>	
	OM Specific Standards	Possible Sources of Supporting Information
<p><b>Occupational physicians should:</b></p>	<ul style="list-style-type: none"> <li>• Keep a clear, accurate, and contemporaneous patient record that details the clinical findings, the results of tests, reports given and received, decisions made and advice given to patients and others, and relevant details of treatments, and referrals;</li> <li>• You must ensure the confidentiality of the medical records you hold on patients. You must also ensure that team members understand and respect the requirement to preserve confidentiality of information held on patients. You must: <ul style="list-style-type: none"> <li>– ensure that medical records are stored and transferred safely and securely</li> <li>– protect against improper or accidental disclosures</li> <li>– ensure compliance with all relevant legislation (e.g. Access to Medical Reports Act 1988, Access to Health Records Act 1990, Data Protection Act 1998)</li> <li>– keep personal information, including medical information, confidential, releasing such information only with the individual’s informed</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Practice protocols that incorporate Faculty and GMC guidance</li> </ul> <p><b>Evaluation</b></p>

	consent or when required by law or overriding public interest	
<b>Additional comments:</b>	Health data that are required e.g.; as part of a health surveillance programme or to make decisions of health and safety policy should be suitably anonymised, to ensure that the details of named individuals cannot be identified.	

<b>Domain 2 – Safety and Quality</b>		
<b>Attributes</b>	<b>Generic Standards</b>	
Put into effect systems to protect patients and improve care	<p><b>All doctors</b></p> <ul style="list-style-type: none"> <li>• Respond constructively to the outcome of audit, appraisals and performance reviews (14e);</li> <li>• Take part in systems of quality assurance and quality improvement (14);</li> <li>• Comply with risk management and clinical governance procedures;</li> <li>• Co-operate with legitimate requests for information from organisations monitoring public health (14i);</li> <li>• Provide information for confidential inquiries, significant event reporting (14g).</li> </ul> <p><b>Doctors with management roles</b></p> <ul style="list-style-type: none"> <li>• Make sure that all staff for whose performance you are responsible, including locums and students, are properly supervised (17);</li> <li>• Ensure systems are in place for colleagues to raise concerns about risks to patients (45).</li> </ul> <p><b>Doctors with clinical roles</b></p> <ul style="list-style-type: none"> <li>• Report suspected adverse drug reactions (14h);</li> <li>• Ensure arrangements are made for the continuing care of the patient where necessary (40, 48).</li> </ul>	
	<b>OM Specific Standards</b>	<b>Possible Sources of Supporting Information</b>
<b>Occupational physicians should:</b>	<ul style="list-style-type: none"> <li>• Ensure that patients remain at the core of the service;</li> <li>• Ensure that team members work within their limitations; and that systems are in place to monitor and assist their performance and to support and train them;</li> <li>• Ensure that there is a proper reporting structure for professional activity.</li> </ul>	<ul style="list-style-type: none"> <li>• Organisational ‘wiring diagram’ showing clear lines of responsibility;</li> <li>• Significant Event Audit SRT.</li> </ul> <p><b>Evaluation</b></p>
<b>Additional comments:</b>	<ul style="list-style-type: none"> <li>• Occupational health services may be multi-disciplinary. Other professionals may include occupational health nurses, physiotherapists, counsellors and safety advisors. In delegating within the team, occupational physicians are still responsible for the overall occupational medical care of the patient. You must only delegate professional tasks to those who are specifically trained and competent to perform the task in question.</li> </ul>	

Attributes	Generic Standards	
Respond to risks to safety	<p><b>All doctors</b></p> <ul style="list-style-type: none"> <li>• Report risks in the health care environment to your employing or contracting bodies (6);</li> <li>• Safeguard and protect the health and well-being of vulnerable people, including children and the elderly and those with learning disabilities (26,28);</li> <li>• Take action where there is evidence that a colleague's conduct, performance or health may be putting patients at risk (43,44).</li> </ul> <p><b>Doctors with clinical roles</b></p> <ul style="list-style-type: none"> <li>• Respond promptly to risks posed by patients;</li> <li>• Follow infection control procedures and regulations.</li> </ul>	
	OM Specific Standards	Possible Sources of Supporting Information
<b>Occupational physicians should:</b>	<ul style="list-style-type: none"> <li>• Accord high priority to the health and safety of individuals in the workplace that the doctor is responsible for;</li> <li>• Follow safe working practices and working methods which conform to the requirements of health and safety legislation.</li> </ul>	<b>Evaluation</b>
<b>Additional comments:</b>		

<b>Attributes</b>	<b>Generic Standards</b>	
Protect patients and colleagues from any risk posed by your health	<b>All doctors</b> <ul style="list-style-type: none"> <li>• Make arrangements for accessing independent medical advice when necessary (77);</li> <li>• Be immunised against common serious communicable diseases where vaccines are available (78).</li> </ul>	
	<b>OM Specific Standards</b>	<b>Possible Sources of Supporting Information</b>
<b>Occupational physicians should:</b>		<ul style="list-style-type: none"> <li>• Copies of relevant immunisation certificates;</li> <li>• Health SRT.</li> </ul> <b>Evaluation</b>
<b>Additional comments:</b>	Some doctors will have medical contraindications to immunisation which will need to be taken into account.	

<b>Domain 3 – Communication, Partnership and Teamwork</b>		
<b>Attributes</b>	<b>Generic Standards</b>	
Communicate effectively	<p><b>All doctors</b></p> <ul style="list-style-type: none"> <li>• Communicate effectively with colleagues within and outside the team (41b);</li> <li>• Explain to patients when something has gone wrong (30).</li> </ul> <p><b>Doctors with management roles</b></p> <ul style="list-style-type: none"> <li>• Encourage colleagues to contribute to discussions and to communicate effectively with each other (MfD 50);</li> </ul> <p><b>Doctors with clinical roles</b></p> <ul style="list-style-type: none"> <li>• Listen to patients and respect their views about their health (22 a 27a);</li> <li>• Give patients the information they need in order to make decisions about their care in a way they can understand (22b, 27);</li> <li>• Respond to patients' questions (22c, 27 b);</li> <li>• Keep patients informed about the progress of their care (22c);</li> <li>• Treat those close to the patient considerately (29);</li> <li>• Pass on information to colleagues involved in, or taking over, your patients' care (40, 51-53).</li> <li>•</li> </ul>	
	<b>OM Specific Standards</b>	<b>Possible Sources of Supporting Information</b>
<b>Occupational physicians should:</b>	<ul style="list-style-type: none"> <li>• Communicate effectively with colleagues and seek feedback from them on the Occupational physician's personal performance;</li> <li>• Communicate with human resources and line managers about the patient in an ethical and meaningful way, while maintaining the important requirement of medical confidentiality;</li> <li>• Provide additional sources of help for patients and effectively communicate such information to them.</li> </ul>	<ul style="list-style-type: none"> <li>• <i>Review of feedback on personal performance by colleagues, including Multi-source feedback (MSF);</i></li> <li>• <i>Surveys of patients and other consumers of the doctor's service;</i></li> <li>• Patient Survey SRT;</li> <li>• A written Patients Charter;</li> <li>• A written complaint procedure</li> <li>• Complaints SRT or Absence of Complaints SRT;</li> <li>• Examples of standard handouts and information sheets given to patients to aid communication.</li> </ul>

		<p><b>Evaluation</b></p> <ul style="list-style-type: none"> <li>• Records of complaints received and actions taken;</li> <li>• Record of written compliments received from patients or organisations.</li> </ul>
<p><b>Additional comments:</b></p>	<ul style="list-style-type: none"> <li>• The occupational physician must adopt the role of an independent adviser, prepared to communicate information to managers and workers alike. Similar general qualities will apply in effective communication with these other parties - for example: a willingness to listen to concerns, to keep managers updated on the progress of cases, and to share relevant information in ways that can be understood;</li> <li>• Clinical notes and letters of referral to professional colleagues should make clear the current medical and occupational health needs of the patient;</li> <li>• The clinical notes they make should be legible and clear;</li> <li>• Letters to managers should enable them to understand the rationale for the advice given and (in so far as it relates to an individual) the occupational health needs of the patient.</li> </ul>	

Attributes	Generic Standards	
Work constructively with colleagues and delegate effectively	<p><b>All doctors</b></p> <ul style="list-style-type: none"> <li>• Treat colleagues fairly and with respect (46);</li> <li>• Support colleagues who have problems with their performance, conduct or health (41d);</li> <li>• Act as a positive role model for colleagues (41);</li> <li>• Ensure colleagues to whom you delegate have appropriate qualifications, experience (54).</li> </ul> <p><b>Doctors with management roles</b></p> <ul style="list-style-type: none"> <li>• Provide effective leadership (MfD 50)</li> </ul>	
	OM Specific Standards	Possible Sources of Supporting Information
<b>Occupational physicians should:</b>	<ul style="list-style-type: none"> <li>• As a manager you must also provide an environment in which the general standards and obligations of Good Medical Practice can be met by the individuals and services that you manage. You must for example be satisfied that: <ul style="list-style-type: none"> <li>– clinical members of a team are registered with their respective regulatory bodies (e.g. doctors with the GMC, nurses with the NMC, physiotherapists with the Council for Professions Supplementary to Medicine);</li> <li>– fellow registered medical practitioners are aware of, and follow, the guidance of the GMC, and that colleagues from other professions follow the guidance of their own regulatory bodies;</li> <li>– all clinicians have suitable liability insurance or indemnity;</li> <li>– all occupational health team members recognise and work within their limitations;</li> <li>– all occupational health team members are appraised;</li> <li>– mechanisms are in place to identify the</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Evidence of a system that ensures that colleagues employed by the service are properly qualified, inducted, supervised, and trained; and that they understand the need to work within their professional limits and maintain medical confidentiality;</li> <li>• Written policy on dealing with conduct or performance issues in subordinates;</li> <li>• Evidence that the performance of subordinates for whom the doctor has management responsibilities is periodically appraised;</li> <li>• Record of undergoing training for this purpose;</li> <li>• Examples of well-constructed teaching materials, demonstrating relevance, clarity and up to date knowledge;</li> <li>• Evidence that the performance of junior colleagues is periodically appraised;</li> <li>• MSF SRT.</li> </ul> <p><b>Evaluation</b></p>

	<p>educational and training needs of staff, as well as any deficiencies of performance;</p> <ul style="list-style-type: none"> <li>- There is sufficient opportunity and support for training;</li> <li>- Regular reviews and audit of the performance of the team are undertaken and any opportunities for improvement are addressed;</li> <li>- The principles of clinical governance are applied to the team's activities;</li> <li>- Systems are in place for dealing supportively with problems in the performance, conduct or health of team members;</li> <li>- Within the team, safe working practices are followed and working methods conform to the requirements of health and safety legislation;</li> <li>- There are adequate systems in place for investigating complaints promptly and fully;</li> <li>- There are adequate resources to support the services you contract to provide;</li> <li>- Each patient's care is properly co-ordinated and managed and that patients know whom to contact if they have questions or concerns.</li> </ul>	<ul style="list-style-type: none"> <li>• Evidence of participation in regular reviews and audit of the standards of team; performance, and where relevant a note of any remedial changes to improve performance;</li> <li>• Feedback on teaching the doctor has given.</li> </ul>
<p><b>Additional Comments:</b></p>		

Attributes	Generic Standards	
Establish and maintain partnerships with patients	<p><b>All doctors</b></p> <ul style="list-style-type: none"> <li>• Encourage patients to take an interest in their health and take action to improve and maintain it (4, 21f);</li> <li>• Be satisfied that you have consent or other valid authority before you undertake any examination or investigation, provide treatment or involve patients in teaching or research (36).</li> </ul>	
	OM Specific Standards	Possible Sources of Supporting Information
<b>Occupational physicians should:</b>	<ul style="list-style-type: none"> <li>• Follow written protocols in their practice that ensure the rights of patients are preserved including:                             <ul style="list-style-type: none"> <li>– obtaining informed consent whenever relevant;</li> <li>– explaining the possible outcomes that may follow a consultation;</li> <li>– ensuring that patients understand their rights when organising referrals or requesting medical information from other practitioners, and that they agree to the disclosure of their information;</li> <li>– observing the other rights of patients mentioned in the Faculty's guidance.<sup>3,4</sup></li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Audits of performance relating to informed consent, medical confidentiality, or the security of patient records.</li> </ul> <p><b>Evaluation</b></p>
<b>Additional comments:</b>		

<b>Domain 4 – Maintaining Trust</b>		
<b>Attributes</b>	<b>Generic Standards</b>	
Show respect for patients	<p><b>All doctors</b></p> <ul style="list-style-type: none"> <li>• Implement and comply with systems to protect patient confidentiality(37)</li> </ul> <p><b>Doctors with research roles</b></p> <ul style="list-style-type: none"> <li>• Respect the rights of patients participating in research (Research 2, 5)</li> </ul> <p><b>Doctors with clinical roles</b></p> <ul style="list-style-type: none"> <li>• Be polite, considerate and honest and respect patients’ dignity and privacy (21a, b, d)</li> <li>• Treat each patient fairly and as an individual (38-39, 21 c)</li> </ul>	
	<b>OM Specific Standards</b>	<b>Possible Sources of Supporting Information</b>
<b>Occupational physicians should:</b>	<ul style="list-style-type: none"> <li>• Actively seek feedback from patients on their performance;</li> <li>• Respect the right of workers to decline participation in a fitness assessment, teaching, or research;</li> <li>• Respect the right of a worker to enlist the help of an advocate such as an employee representative;</li> <li>• Respect the right of a worker to be fully involved in decisions about their care (including decisions of job placement and medical retirement); this does not imply a worker’s right to dictate the recommendation that a doctor wishes to make on job placement or medical retirement. Workers’ views should be taken into account and you should ensure that their views are recorded and considered in the final advice. Your advice, however, must represent an impartial opinion, based on medical evidence;</li> <li>• Respect the right of workers to have access to their medical records;</li> <li>• Respect the right of workers to a second opinion</li> </ul>	<ul style="list-style-type: none"> <li>• MSF;</li> <li>• Leaflets providing information to patients on the services available.</li> </ul> <p><b>Evaluation</b></p>

	where service arrangements allow this (and where arrangements do not include this provision, patients should be advised how they can obtain another opinion).	
<b>Additional comments:</b>		

Attributes	Generic Standards	
Treat patients and colleagues fairly and without discrimination	<p><b>All doctors</b></p> <ul style="list-style-type: none"> <li>• Be honest and objective when appraising or assessing colleagues and when writing references (18-19);</li> <li>• Respond promptly and fully to complaints (31).</li> </ul> <p><b>Doctors with clinical roles</b></p> <ul style="list-style-type: none"> <li>• Provide care on the basis of the patient's needs and the likely effect of treatment (7-10)</li> </ul>	
	OM Specific Standards	Possible Sources of Supporting Information
<b>Occupational physicians should:</b>	<ul style="list-style-type: none"> <li>• Treat colleagues fairly and not allow views they hold of a colleague's lifestyle, culture, beliefs, race, colour, sex, disability, sexuality, or age to prejudice the professional relationship between them;</li> <li>• Provide patients with a mechanism for raising objections or making complaints by maintaining a formal complaint procedure;</li> <li>• Provide honest and justifiable comments when providing references for colleagues or writing reports about them;</li> <li>• Be honest and objective when appraising or assessing the performance of colleagues they supervise or train;</li> <li>• Provide appropriate information regarding complaints procedures.</li> </ul>	<ul style="list-style-type: none"> <li>• Evidence of completion of equality and diversity training;</li> <li>• A published complaint procedure.</li> </ul>
<b>Additional comments:</b>		

Attributes	Generic Standards	
Act with honesty and integrity	<p><b>All doctors</b></p> <ul style="list-style-type: none"> <li>• Ensure you have adequate indemnity or insurance cover for your practice (34);</li> <li>• Be honest in financial and commercial dealings (73);</li> <li>• Ensure any published information about your services is factual and verifiable (60, 61);</li> <li>• Be honest in any formal statement or report, whether written or oral, making clear the limits of your knowledge or competence (63-65, 67-68).</li> </ul> <p><b>Doctors with research roles</b></p> <ul style="list-style-type: none"> <li>• Obtain appropriate ethical approval for research projects (Research 5);</li> <li>• Be honest in undertaking research and reporting research results (71 b);</li> <li>• Ensure that your research is audited regularly (Research 43);</li> </ul> <p><b>Doctors with clinical roles</b></p> <ul style="list-style-type: none"> <li>• Inform patients about any fees and charges before starting treatment (72a).</li> </ul>	
	OM Specific Standards	Possible Sources of Supporting Evaluation
<b>Occupational physicians should:</b>	<ul style="list-style-type: none"> <li>• Ensure that processes have been established to safeguard the ethical operation of the service and to avoid potential conflicts of interest;</li> <li>• You must not make unjustifiable claims about the quality of your services or convey an exaggerated impression of your effectiveness to employers; nor should you arouse ill-founded fear for the future health of their employees as a means of putting pressure on employers to use your service.</li> </ul>	<ul style="list-style-type: none"> <li>• Any published material advertising the service provided;</li> <li>• Probity SRT.</li> </ul> <p><b>Evaluation</b></p>
<b>Additional comments:</b>	<ul style="list-style-type: none"> <li>• Only doctors with postgraduate training in occupational medicine should describe themselves as occupational physicians; and they should only describe themselves as 'consultants' or 'specialists' in occupational medicine if they are eligible for inclusion on the specialist register established by the GMC under the European Specialist Medical Qualifications Order 1995.</li> </ul>	

**References:**

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2. The Faculty of Occupational Medicine, Royal College of Physicians. *Good Medical Practice for Occupational physicians*. London: Faculty of Occupational Medicine, 2001.
3. The Faculty of Occupational Medicine, Royal College of Physicians. *Guidance on Ethics for Occupational physicians* (Fifth edition). London: Faculty of Occupational Medicine, 1999.
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