

## Minutes of Trainers' Workshop meeting 17/9/08

### Business

- **Innovative trainees:** Richard Wilson thinks it would be better if they did 3m in GP for 4d/week, then 3m in hospital full-time, as he finds 2d/week for 6m unsatisfactory, eg. they take a long while to settle in & get the hang of the computer etc. This led to discussion of the objectives of the innovative GP attachments. *Idea after the meeting: maybe these posts could be a good topic for a future meeting?*
- **F2 education supervision:** Anthony Ojo has been asked to do this. We remembered discussions with Pam Wright last year & said he needn't (& shouldn't) do it. Unsure who he should tell: he'll ask Pam.

### Multisource feedback [MSF]

Jane Owens spoke about this [see below for her notes] & then led discussion about it. A few points from the discussion:

#### **Giving out the forms**

- would it be better not to allow the trainee to choose their raters?
- would it be better to use the same raters on the 2nd MSF or different?
- both questions academic in all except v large practices

#### **Filling in the forms**

- comments are much more useful than scores
- raters need to be taught what sort of comments are useful, in general descriptive rather than evaluative & specific rather than general.
- raters need to be clear about what the question means: examples may help, as provided with the nMRCGP forms

#### **Using the forms to give feedback**

- how the info is used by the trainer to give feedback seems likely to make a big difference to the usefulness of the whole exercise
- therefore we need to learn to do it well – but maybe should be ok simply applying general principles on feedback?

#### **Effectiveness in promoting reflection & change**

- though Jane reported scanty evidence for effectiveness & some against, Richard had an anecdote demonstrating that MSF can help a trainee to make important changes.
- we anticipate that it will be a good way to bring attitudinal problems etc to a trainee's attention; much less useful for the problem-free majority.

#### **Possible improvements to the MSF tools in current use**

- make comments compulsory
- do away with scores?
- stop attempting to assess clinical behaviour in this way.

## **Jane's talk**

Talk on MSF for trainers

MSF is part of the work based assessment of the nMRCGP. It does not have a pass/fail mark. Trainers are required to discuss the results with their registrars and by implication at least it is a formative tool.

You have all by now I think have seen the nMRCGP MSF tool. For those who haven't it consists of two questions:

Please provide your assessment of this doctor's overall professional behaviour.

Please provide your assessment of this doctor's overall clinical performance.

When I first saw this my reaction was "How can that produce any useful information" and I set out to try and find out how we have ended up with such a minimal questionnaire. I may, eventually have some thoughts on whether I think it produces any educational impact.

MSF started in industry, as a tool to assess managers and try and improve productivity. It has some evidence for success in this context though the gains are small and take some time to show.

It was first used in Canada and the United States as part of the assessment of qualified doctors for re-validation or their equivalent. The Canadians used quite long forms with separate formats for patients, professional colleagues and attached staff. The Americans, on the whole, went for simpler documents. Some people call this process a 360 degree assessment. In general practice I don't think you can call an assessment 360 degree unless you involve the patients. While registrars do also use patient satisfaction survey it is not really tied closely to the MSF forms so I think they are best considered separately.

Much of the research on MSF has concentrated on reliability and validity. Reliability seems good with most tools. If you give the same form to different people or, as was tried in the UK to the same people about 2 weeks after the first round, you get the same result give or take. In general if you use a shorter form you need more people to give a reliable sample; if you use a longer form you can get away with fewer assessors though you still should have a minimum of 4 and ideally 6. This evidence comes from Scotland where in small hospitals some trainees had difficulty getting 10 or so assessors originally thought necessary.

Validity is more difficult. It raises the question of what you are trying to assess. The test can only be valid if it accurately assesses what you want it to assess. The early US and Canadian forms were based on the competencies and models that their licensing authorities determined. SPRAT, which is the first British written MSF, was based on the GMC model of a good practitioner.

However when the statisticians are let loose with the results they find that the various questions correlate with each other and using factor analysis they find that the various tools are measuring only interpersonal, communication, professionalism and teamwork behaviour. Almost all the studies suggest that these tools are poor at assessing clinical behaviour and there are better tools eg audit for assessing that behaviour.

Unfortunately this is not reflected in the practice in the country. MMC suggests using miniPAT which includes clinical questions. Some deaneries however use TAB which does not assess clinical behaviour. The nMRCGP tries to do clinical behaviour.

This tool is called a feedback tool so how is the feedback managed. Best practice on feedback suggests it should be specific, requested by the ratee, prompt and delivered in a constructive atmosphere. Does the nMRCGP tool enable us as trainers to do this? First there is the problem with numerical or qualitative feedback. The nMRCGP gives a score to 2 decimal places and a comparison against the local and national averages. However it is difficult to give any constructive feedback on this without comments to illustrate how behaviour might improve. Some forms eg the original TAB when put in computerised form will not allow the form to be filed if a score is below acceptable without a comment. There is though no way of monitoring the quality of the comments eg “poor communication with staff”; does this relate to written or verbal communication; is it a reflection on the trainee or the organisation of the practice and the channels for communication? The American study that first developed a very short questionnaire took a couple of cycles to educate the raters into giving useful comments. Perhaps we will notice the same.

The nMRCGP tool went down the path of minimalism it is reported to minimise the “halo” effect. This is a reported phenomenon that the rater decides early on in the rating process whether or not they think the doctor is OK or not and scores them accordingly rather than considering each question independently.

As assessment is supposed to drive learning what is the evidence with MSF? Unfortunately it is rather poor. Looking at miniPAT and TAB in hospitals, supervisors, in general, did not find that the tool told them anything they did not know. Feedback times were between 5 and 20 minutes. One study with TAB failed to show that trainees had planned any learning objectives from the experience. The Canadian experience is rather better but still mixed. Those who got poor assessments fell into two almost equal groups, half ignored the whole thing and said that the assessors didn't really know what they were doing. The other half did make plans to change behaviour in the areas shown to be less than satisfactory. A 5 year follow up showed a small amount of change. The original papers with surgeons suggested that up to 70% planned to make changes but nobody has been able to demonstrate such profound changes.

I love general practice in the UK. It is capable at its best of getting on and doing the job. A recent example of this being computerisation; the systems originated in general practice and continue to be developed there. So with MSF. There are lots of tools being used but unfortunately little formal assessment of their usefulness though this may come. The powers that be decided earlier this year that MSF will be part of the re-validation process. There has been a trial of a tool for all “senior doctors” but the results in general practice were disappointing. Locally we have 2 tools suggested by EQUIP. There are lots more out there and I have some here. Watch this space.

Jane's email about references

Various people asked for references but I can't remember exactly what was requested.

The paper assessing MSF for the Academy of Medical Royal Colleges by Lucy

Mackillop (2007) is available at

[www.360clinical.com/pdf/Lucy\\_Mackillop\\_Report.pdf](http://www.360clinical.com/pdf/Lucy_Mackillop_Report.pdf)

Equip has 2 MSF tools on the web site.

SPRAT came with our original documentation about nMRCGP.

The American tool is available at

[www.abim.org](http://www.abim.org)

Mini PAT and TAB were available on the Modernising Medical Careers web site

but I,m not sure if they still are there after a recent rewrite.

References for reliabilty, validity, educational impact etc I can give if

people are interested.

Let me know if you want more.