

Improving clinical performance in the GCC: what could we be doing?

Editorial

Chris Roberts

In a modern society all doctors have a duty of care in dealing with their patients, their fellow professionals, and also themselves. How can organizations such as the Committee for Training and CME/CPD¹ be sure that doctors within the GCC countries are performing to the highest standards in discharging that duty of care? A recent and extensive review arising from the 10th Cambridge Conference of medical educators highlighted several problems with existing conceptual frameworks for assessing the performance of doctors. The major problem is finding suitable tools which can consistently rate doctors on meaningful measures of their performance in a way which is credible both to doctors and the public.² The working environment of our hospitals and community clinics requires that doctors are not only competent clinically, but are able to work in teams, to undertake a management role, to undertake continuing professional development (CPD), and ensure their own good health, each of which will have its own impact on individual performance.

There are however, a number of assessment tools which show promise in assessing whether working doctors have such capabilities. CME/CPD institutions should consider these as part of their armory to both encourage doctors to perform to their true potential, and to record that evidence for further scrutiny. It must be remembered that in measuring clinical performance, no one single assessment format is able to assess all aspects of performance.³ Performance assessment tools can be used alone or in combination formatively where participating doctors can receive vital feedback on their own performance. They can be part of summative procedures where, for example, a training

council might wish to accredit a doctor in training as having achieved a satisfactory level of competence. Any summative assessments used for high stakes decision-making, for example progression in training or fitness to practice, should have a high degree of validity and reliability in the context in which they are performed.

There are two broad classes of approach in assessing the clinical performance of the day-to-day working of doctors. The first approach is the reflective portfolio, derived from adult learning theories. The second is derived from measurement theory, for example the Mini-Clinical Evaluation Exercise (Mini-Cex) and Multi-Source Feedback (MSF). I will illustrate some of the features of these tools in the context of improving clinical performance.

Portfolios

The main use of portfolios in medical education has been for formative assessment, as a means of encouraging reflection on a doctor's daily practice. In some UK programs, portfolios have been used for the formative assessment of General Practitioners (GPs) engaged in CPD, with a view to improving or maintaining their performance through experiential learning and reflection. Learning support for the doctors can vary from none, to face-to-face meetings with a GP tutor, small group learning approaches with the tutor acting as a co-mentor, and a range of self-administered educational tools. Portfolio content typically includes patient-focused critical incidents, audits, critical reading, and feedback from patients and peers on topics ranging from single in-depth studies to a broad spread of clinical material.⁴ Latterly such portfolios have been linked to an annual mandatory appraisal by a fellow GP. The most valued part of such assessment is the personalized feedback. Similar portfolio schemes are available for public health doctors.⁵

Prof. Chris Roberts, Sydney, NSW, Australia.

Correspondence: Prof. Chris Roberts, Associate Dean (Education), Centre for Innovation in Professional Health Education and Research, Faculty of Medicine (A27), Edward Ford Building, University of Sydney, NSW 2006, Australia. Tel: 61 2 9036 9453; Fax: 61 2 9351 6646; email: chris.roberts@med.usyd.edu.au

It has been the General Medical Council's (GMC) intention to use the evidence from these portfolios designed for formative purposes for revalidation of GPs every five years, ultimately determining their fitness to practice. In such a context, the issues of reliability and validity of the assessment methods become very important. In measuring performance, portfolio-based assessment tools focus doctors and their assessors, and can produce moderately reliable assessment results. For example, in higher specialist training in pediatrics, four independent ratings of a portfolio by assessors would be needed.⁶ In UK general practice, where the purpose of the portfolio was to determine the quality of continuing professional development in pursuit of better clinical performance, similar results were achieved.⁴

Whilst reflective portfolios attract much interest in CPD circles, there are a number of downsides to them. There are problems in ensuring the material (evidence) in the portfolio is attributable to the person submitting it. This requires a policing role of the training councils. There are also concerns about the cost and feasibility of implementing a full portfolio system across the wide range of doctors involved in clinical practice with the potential of generating a huge volume of assessable material for a limited number of those providing CPD services.

Mini-Cex

The purpose of the Mini-Cex is to allow an examiner to observe usually a trainee doctor with a patient in any setting whether at the bedside, in the clinic or out in the community.⁷ The trainee performs a focused task, for example, taking a history from a patient with abdominal pain. A more experienced doctor scores the activity using a structured checklist, and then gives feedback in a process which takes 15-20 minutes.

Several encounters are expected over the course of a clinical placement. In any assessment system examiners can be inconsistent when rating trainees. Trainees can be good on one case but not the next. This is known as content specificity. By having multiple encounters these inconsistencies are averaged out and a robust measure of the trainees' performance can result. Research suggests that as few as four or five observed encounters can

give a very good indication of the capability of a doctor. Where a doctor is not performing well further testing is undertaken to be more certain. It is reasonable to modify the structured checklist so that it matches the particular outcomes of a clinical training program. Although originally developed in the US on training doctors similar systems have been used within the GMC.⁸ Such systems evaluate well for both trainees and teachers, and are highly suitable for the modern clinical learning environment in that doctors should be able to spare 20 minutes for their duty of teaching.

Multi Source Feedback

The principles of multi-source feedback (MSF), sometimes called 360 degree appraisal, are very similar to the Mini-Cex I have just described. The major difference is that the Mini-Cex is focused on an individual task and assessments are collected severally over time by different observers on differing tasks. MSF is a consensus view of many peers on a range of attributes, and repeated at intervals throughout the year. MSF has been used for some time in medicine for example in the US⁹ and Australia.¹⁰

Archer et al¹¹ have devised a system within the UK, which is undergoing extensive piloting for the doctors in their first two years post qualifying and is a good example of this type of assessment in action. The views of a range of colleagues (usually 12) are collected using structured rating forms, as well as the perceptions of the trainee themselves. The structured checklist has been adapted from the principles of the GMC's Good Medical Practice,¹² and includes items covering: good clinical care, maintaining good medical practice, teaching and training, and relationships with patients.

The forms are collated using scanning software for efficiency and the results used to make a judgment about performance. Trainees need to achieve a minimum score for their supervisors to be confident they are satisfactory. Those scoring below this level need more detailed investigation by their supervisors as to why they are underperforming. The process assumes that the rater has both observed the competence in question and can make a judgment about its quality. There is a potential for supervisors to give feedback focusing on those areas identified as weak and creating

focused learning opportunities to remedy them. This may form the basis of a portfolio.

Conclusions

The educational impact of assessments on the CPD of specialist doctors and those in training should not be underestimated. The Committee for Training and CME/CPD desires that doctors improve their clinical performance through CPD,¹ and assessment is one way of driving that learning.¹³ The challenge for clinical educators is to provide the assessments that can be applied in the modern busy workplace, and will drive any doctor's CPD in the direction of improved patient care. Whilst formative feedback is essential for the individual doctor, the Committee and the CME/CPD program directors have to assure that all doctors are performing to the highest standards. There are many practical and technical difficulties which are yet to be resolved in implementing such a system. One such difficulty is determining how we integrate the range of tools into a comprehensive program, which supports the development of the many doctors doing a good job and yet identifies the few who need greater attention as to why they are underperforming.

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