Professional Practice Review
Report and Recommendations
to Medical Council

Part I – Recruitment and Process
December 2007

Part II – Summary Data and Feedback
May 2008
Professional Practice Review
Report and Recommendations
to Medical Council

Part I – Recruitment and Process
December 2007
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Aim

In 2006, the Medical Council approved the piloting of a multi-source feedback (MSF) study of general practitioners as part of developing a professional competence programme for doctors.

The overall aim of the study was to promote quality improvement in individual medical practices and to foster a culture of continuous quality improvement in the profession.

The specific aim of the study was to pilot the use of MSF in an Irish context and secondly to examine the trends of the reports and look at feedback from doctors in a formative way.

Background

Multi-source feedback has been widely used in industry as an assessment tool for many years. More recently the tool has been adopted for use in the medical profession. At present the tool is used widely in Canada, USA and the UK. It is currently being piloted in New Zealand as a way of assessing and providing feedback to practising doctors from their patients and their peers. The tool is intended to be formative and allows doctors to identify their strengths and their weaknesses. Doctors can use their feedback for self-reflection and self-directed education and training.

There are many benefits to using multi-source feedback. It provides a valid source of feedback about individual performance and creates accountability to patients and colleagues. It encourages doctors to address weaknesses early before they develop into problems. It allows a doctor to confidentially compare results against regional, national and specialty specific trends. It gives feedback on individual rather than team performance. Multi-source feedback can complement tests of clinical and technical competence by measuring aspects of performance that cannot be easily assessed in other ways.

There are some key principles of MSF. In order for it to be effective it must compare like with like at specialty and national level. It must be valid, efficient, quick, easy-to-use, easy to analyse, and easy to interpret. In general, feedback should be anonymous and confidential.

There are many aspects of medical practice which are better assessed using MSF. Internationally the domains of good medical practice are well established. In general they are as follows:-

- Relating to Patients
- Clinical Skills
- Communication and Interpersonal Skills
- Collaboration and Teamwork
- Management (including self-management)
- Scholarship
- Professionalism

MSF has been shown to be particularly effective in measuring the following domains; Relating to Patients, Communication and Interpersonal Skills, Collaboration and Teamwork. MSF also assesses, to a lesser degree, measures of availability and emotional intelligence.
Methods

Stage 1  Preparation / Agreement with Pivotal Research

Research was conducted on similar MSF systems internationally, to determine whether any system in existence would be suitable for the Irish context. It was agreed that using an existing tool would be more efficient and beneficial rather than creating an original one for Ireland for the purposes of this pilot study. Having reviewed the information available, it was decided that the Canadian system “Physician Achievement Review (PAR)”, administered by Pivotal Research Inc., would be the most suitable.

Pivotal Research has considerable experience in administering the PAR program in Alberta, Nova Scotia and California and in New Zealand and proposed advising on and administering a similar program in Ireland. Following lengthy discussions and meetings, both in Ireland and Canada, an agreement was reached with Pivotal Research to administer the Irish Physician Achievement Review (IPAR) Pilot Study, locally named the Professional Practice Review (PPR) Pilot Study.

The first stage was to identify the similarities and differences in the Irish program as it compares to existing PAR programs in Alberta, Nova Scotia and California and New Zealand. It was agreed that, as this will be an online system, Pivotal would prepare a suitable database for the administration of the study. In addition, the material to be used, e.g. information letters and instructions, survey instruments, follow up correspondence etc. would be amended to suit the Irish context. In order to address any accessibility issues it was agreed that the patient feedback part of the review would be paper based and issued to the volunteer doctors by the Professional Competence Office Staff (project office).

The second stage was to agree the target sector of the profession to participate in the pilot study. It was agreed after liaison with Pivotal Research that the pilot study be conducted, in the first instance, in the largest specialty in the country. To this end, it was agreed that General Practitioners would be the most suitable group for this pilot study. The Irish College of General Practitioners (ICGP) and the Irish Medical Organisation (IMO) were approached and agreed to provide support and advice for the study.

The next stage was to develop the website and information documents to implement the program.

A Post Office Box was set up to receive the completed patient questionnaires in order to maintain confidentiality. The sealed patient questionnaires would then be forwarded to Pivotal Research for inclusion in the volunteers’ survey.

The fourth stage was to set up a Steering Group with general practitioner and patient group representatives. The Steering Group reviewed the developments within the study and provided information and advice on the survey instruments as well as the marketing strategies.
Stage 2  Pilot Study

1. Recruitment Strategy
The project office formulated a comprehensive recruitment strategy and adopted a professional approach to the recruitment process. There was high level support from both the IMO and the ICGP as well as patient representative groups, all of whom actively encouraged their members to participate. High profile general practitioners were recruited as volunteers, and monthly meetings were held to discuss the progress and the various approaches that were to be taken.

Interviews were conducted in the local, national and trade press releases in conjunction with the media strategy (see below).

The project office devised an e-mail recruitment campaign. Efforts were made to e-mail individual doctors and invite them to participate. E-mails were sourced using a broad range of directories, registers and internet sources and GPs were circulated on a two monthly basis to recruit volunteers.

2. Media Strategy
To support the recruitment strategy a media campaign was developed. The aim of the campaign was to market the study, inform the profession and encourage volunteers to register their interest. Advertisements were published in national newspapers as well as relevant medical publications.

Press releases were also issued to the national media outlining the pilot study and calling for volunteers.

To launch the PPR Pilot Study formally, a high profile media event was held in Dublin. Media representatives were invited from the national and medical press. The event was supported by the President, Vice President and members of the Medical Council.

Throughout the pilot study, press releases were issued on a continuous basis updating the public and the profession on progress of the study, and encouraging GPs to continue to volunteer.

3. There were four sections of the assessment process
  ◆ Medical Colleagues
  ◆ Non-Medical Colleagues
  ◆ Self-Assessment
  ◆ Patients

Volunteers were requested to supply the names and e-mail addresses for eight medical and eight non-medical colleagues who they would like to involve in the review process. Volunteers were advised that choosing a cross section of nominees would provide more credible and informed feedback. An information leaflet on potential types of nominees was circulated to all volunteers. Volunteers were advised to ask nominees’ permission to take part and confirm their e-mail addresses, prior to forwarding nominee details to Pivotal Research. It was acknowledged that the volunteer would receive an e-mail from Pivotal Research with a registered link and log-in details to complete the on-line self assessment questionnaire.

A patient pack consisting of 1 poster, 1 leaflet holder, 25 information leaflets, 25 coded questionnaires and envelopes, a prepaid envelope for their return and instructions / guidelines to run the day was sent to each volunteer. Volunteers were advised that choosing patients randomly would give the best results.

A helpline number was set up in the project office to aid volunteers with any queries / difficulties they may have encountered.

See flowchart Professional Practice Review Pilot Study How does it Work?
Professional Practice Review Pilot Study
How does it work?

Volunteer contacts office by post, e-mail or phone to register for pilot study

Volunteer is sent a confirmation e-mail and his/her details sent to Pivotal Research

Volunteer is issued a registration link + Patient pack sent to volunteers practice

Volunteer completes on-line self assessment questionnaire & nominates colleagues + Volunteer conducts patient questionnaires on a selected day

Medical & non-medical colleagues are issued link and complete on-line survey + Patient questionnaires returned and forwarded to Pivotal Research

Pivotal Research evaluate all questionnaires

Confidential report issued electronically directly to volunteer
4. Follow-up Strategy

The follow-up strategy included weekly reviews of the volunteer list.

- On receipt of patient questionnaires the database was updated and relevant documentation forwarded to Pivotal Research.
- On receipt of confirmation from Pivotal Research that a volunteer had completed each category of the process, volunteers were removed from follow-up lists.

The project team reviewed the data and estimated time-lines for start to completion of study. When non-responders came to the attention of the project office, a strategic reminder plan was devised.

- Volunteers were sent weekly reminders via e-mail.
- Volunteers were sent monthly reminders via regular post.

Initially it was agreed with Pivotal Research that nominees would be reminded on a three-weekly basis. However, following an analysis of the response rate, it was agreed that a weekly reminder would be sent from Pivotal Research to non-respondent nominees. Non respondent volunteers also received follow-up calls from Pivotal Research and the project office.

In the last month of the study the project office devised a strategy to prompt volunteers to complete the study.

- Weekly status updates were requested from Pivotal Research.
- Volunteers were advised on what was outstanding in each category and encouraged to prompt their nominees to complete reviews and submit patient questionnaires for final analysis.

Fortnightly conference calls took place between the project office and Pivotal Research to review the status of the study and to determine different avenues to increase productivity of volunteers and non-respondent nominees.

See flowchart Guidelines – Follow up Strategy
Guidelines – Follow up Strategy

Project office and Pivotal Research review statistics & form reminder strategy

Pivotal Research send weekly e-mail reminders to nominees

Project office send weekly e-mail reminders to volunteers

Project office request weekly update status report from Pivotal Research and review statistics

Project office issue e-mail to volunteer outlining outstanding information to prompt a response

Project office & Pivotal Research devise strategy for follow up calls to non-respondent volunteers to prompt completion or part completion of pilot study

Final e-mail reminder sent to volunteers to advise closing date of study and submission of data for analysis
Results

Recruitment

A total of **181** applicants registered their interest in the PPR on the online site.

Of these, **167** volunteers were eligible to participate in the pilot study.

The **14** volunteers who were not eligible were not eligible for the following reasons:-

- Not in general practice (10)
- Not in practice in Ireland (4)

Demographics

The eligible cohort consisted of **60 %** men and **40 %** women. The majority of volunteers came from Dublin, although they were reasonably evenly distributed throughout the country (see chart below).

Chart 1 – Volunteer Rate by location
The average graduation date was 1986, although all decades of graduation were represented.

Of the 167 eligible volunteers, 62 successfully completed all four sections of the study. A further 66 volunteers successfully completed one or more parts of the study, with 10 of this group awaiting 1 nominee response for a sufficient number of reviews to receive a complete report.

19 volunteers registered but did not complete any sections and are deemed non-responders for the purposes of the study.

20 volunteers voluntarily withdrew from the study after initial registration. Of the 20 volunteers who withdrew from the study, the following reasons were given for withdrawal:

- Not enough free time to participate (3)
- No access to internet (1)
- No access to medical / non-medical colleague e-mail addresses (1)
- Went on maternity leave (1)
- Working part-time did not have patient scope or numbers (2)
- Moved practice, had not built up patient relationships (1)
- Ill-health (1)
- Volunteered accidentally (3)
- Personal reasons (2)
- Undisclosed reasons (5)
In the second part of this study all 167 volunteers were asked for feedback regardless of the level of participation in the study.

As part of the follow-up strategy all volunteers were contacted on a regular basis including the non-responders, with appropriate prompts and reminders and phone calls where necessary.

Chart 4 - Participation Rates in the study

<table>
<thead>
<tr>
<th>Incomplete Reviews</th>
<th>Complete Reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>66</td>
<td>62</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did not complete any part</th>
<th>Withdrew from Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>20</td>
</tr>
</tbody>
</table>
Experience with the Online Questionnaires

The vast majority of volunteers had immediate access to internet and e-mail facilities. Others were assisted by the project office in setting up e-mail addresses as, although they had access to the web, some did not have e-mail addresses.

Other volunteers were functional beginners with the electronic system and had early difficulties with managing systems like spam filters. Technical difficulties such as problems with not receiving e-mails, recipients’ servers down, cookies, firewalls, e-mail address errors etc. were common and were dealt with on a case-by-case basis.

Some volunteers preferred to use practice e-mail addresses instead of personal addresses leading to potential issues with confidentiality. In some cases volunteers were assisted by their office staff in completing the online sections.

All volunteers were given written guidelines on appropriate nominees for each section. Some volunteers, especially those in isolated practices, had genuine difficulties sourcing appropriate nominees with current e-mail access. Of these, some volunteers withdrew from the process completely or partially completed the process.

Volunteers were advised to contact their nominees in advance with a phone call before their e-mail details were submitted. Despite this, nominees were sometimes unaware that they had been selected. Many did not see relevant e-mails, or deleted them inadvertently. This issue was raised at an early stage with Pivotal Research and it was agreed that there needed to be more recognition of Pivotal Research’s profile and their involvement in the study. Volunteers were advised of this by follow-up e-mails and phone calls.

Because of the confidential nature of the questionnaire, volunteers were unable to check which of their nominees had responded to their e-mail. Motivated volunteers felt that they were unable to control the response and in fact some volunteers were unable to complete a section despite their best efforts. This meant that some volunteers spent a lot of extra time on follow-up calls to nominees.

There were ongoing issues with nominees’ e-mail addresses, accounts, login details and spam filters, some of which were identified and sorted, but many of which could not be resolved.

Chart 5 – Types of queries received

The project office dealt with an enormous number of telephone and e-mail enquiries all of which were logged, many of which reflected the technical issues outlined above.
Experience with Patient Questionnaires

The vast majority of patient packs were returned without difficulty. In general the questionnaires were well received and were returned in a timely manner. Many volunteers felt the paper questionnaires caused them considerably less difficulty than the electronic questionnaires. Further feedback from the experience with the patient questionnaire is expected from the formal feedback process.

Informally, however, volunteers reported that the experience with the patient’s questionnaire was very positive. Over 3,000 patients volunteered in the process by filling out and returning questionnaires.
Preliminary Discussion

This was a very challenging study that received mixed reactions from the profession, but was warmly welcomed by the public and patients. Buy-in and recruitment were a constant challenge and our target numbers of 200 were not reached. However we were satisfied with the numbers that did enrol and were able to develop statistical norms within that group. Many volunteers reported difficulties with persuading peers to participate and spent an inordinate amount of time following up on those that did not return their questionnaires in time. Others seemed to have genuine difficulties in identifying appropriate nominees and the drop-out rate and partial completion rates were relatively high.

The challenge of piloting the scheme online cannot be underestimated. Difficulties outlined above included inability to access e-mail, nominating and managing nominees’ e-mails and many cases of undelivered and undeliverable mail. Efforts made along the way included changing the Medical Council website to address the frequently asked questions. It also became apparent that it was necessary to increase the profile of Pivotal Research in order that volunteers and nominees would identify incoming e-mails.

There was a significant variation in the stems of the e-mails that were submitted to Pivotal Research. In a similar survey of hospital-based doctors, it is more likely that they would share an e-mail stem with their nominees (e.g. mbloggs@hospital.ie) and there would potentially be a narrower margin of error in this respect.

The paper questionnaire seemed to have caused the least amount of difficulty, however as the international trend is towards electronic based learning, in general it is preferable that this continues.

The study was also quite labour intensive with one member of staff full time on the phone and responding to general and technical enquiries.

The fact that the pilot was voluntary meant that doctors may not have prioritised their participation and some volunteers took many months to complete the process. Those that completed the process seemed to follow-up and make returns within a matter of two to three weeks. The time commitment for volunteers to complete the questionnaire was less than 15 minutes, however as reported some volunteers spent significant amounts of time trying to get their nominees to complete questionnaires, sometimes without success.

Liaising with Canada on a daily basis was not without its difficulties. Phone calls could only be made late in the afternoon and staff at Pivotal Research found it difficult to contact volunteers by telephone at times when questions arose.

Issues raised as part of this discussion are further explained in Part II – Summary Data and Feedback, wherein the data collated was reviewed and formed the basis of the report to Council.
Professional Practice Review
Report and Recommendations to Medical Council

Part II – Summary Data and Feedback

May 2008
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Aim / Background

Following the issuing of comprehensive and confidential reports to 126 participants in the PPR, it was agreed that summary data received from Pivotal Research would be reviewed and form the basis of the report to Council. A feedback questionnaire was also sent to all 167 participants, regardless of whether they completed the process or not.

This report is a follow-up to the report that was presented to Council in December 2007. Professional Practice Review, Report and Recommendations to the Medical Council, Part I – Recruitment and Process.

It is assumed for the purposes of this report that the Medical Council is familiar with the details of the project and the specific recommendations from that report.

Methods

Data / Attributes

The closing date for the receipt of all questionnaires, including patients’ questionnaires and both medical, non medical and self assessment questionnaires was set for 30th October 2007.

Pivotal Research then underwent a detailed process of establishing statistical norms and analysing the results of the Irish data.

It was agreed that the following attributes would be assessed based on a number of specific questions asked of the participants.

Medical Colleagues

- Clinical Competency
- Patient Interaction
- Professional Self Management
- Psychosocial Management of Patients

Non Medical Colleagues

- Patient Interaction
- Co-worker Communication
- Collegiality

Patients

- Patient Interaction
- Office Staff
- Communication Skills
- Surgery
- Information for Patients
- Access to the Doctor

A definition and explanation of each of these attributes is provided within the Results section.
Reports
A template for the final report was agreed. Individualised reports were sent by registered post to participants in the second week of March 2008. A summary report of the data based on attributes was made available to the office. The summarised data was anonymised and at no point was the identity of the participants made known to the office.

Feedback Questionnaire
A feedback questionnaire was agreed and sent out to participants following receipt of the reports. Participants were given the option of returning the questionnaire by mail, fax or email.

Results
1. Data on Attributes
A total of 126 reports were sent out. Of those, 61 were complete reports and 65 were incomplete. Of the incomplete reports 32 were missing one section and 33 were missing more than one section.

The reports were divided into four sections; patient feedback, medical colleague feedback, non medical colleague feedback and self assessment

The scores allocated to each question were graded 1-5 with 1 being the lowest score and 5 the highest.

The following results were provided to the office by Pivotal Research and constitute the summary data for the entire cohort (where available). Not all questions were answered by all participants so the total numbers vary for each graph. The graphs illustrate the distribution, range, mode and average score for each attribute by section.
Section 1 - Patient Questionnaires

Attribute - Patient Interaction

“The doctor spends enough time to listen, answer questions, demonstrates interest, empathy and respect. The doctor asks personal questions when appropriate, helps deal with worries, and discusses treatment plans. Patients indicate whether they would return or refer this doctor to family member or friend.”

Attribute - Office Staff

“The staff are capable, helpful, pleasant, respectful and professional. The staff works well with the doctor and maintains confidentiality.”
Attribute - Communication Skills

“The doctor informs the patient about test results, makes appointments with specialists and provides reports as required. The doctor asks about medication regime, and explains preventative care measures. The doctor follows up with patients, provides printed health information and informs of continued care.”

Attribute - Surgery

“The surgery is accessible, clean, private and appropriately sized with adequate equipment.”
"The doctor provides thorough explanations of the illness or injury, treatment choices, future preventative measures and return follow up care. The doctor explains the medications and possible side effects."

"The doctor is easily accessible by phone during the day and during after hours for urgent matters. Appointments can be made quickly and the waiting time in reception is not too long."
Section 2 – Co-Worker Questionnaires

Attribute - Patient Interaction

“The doctor communicates effectively with patients and their families in a non judgmental manner that conveys courtesy, respect and compassion. The doctor is available to patients and to colleagues about mutual patients. The doctor maintains confidentiality and is responsible for professional actions including patient care.”

Attribute - Communication

“The doctor provides clear written communication, including prescriptions. The doctor’s verbal communication with others is effective and the doctor makes appropriate use of community resources for psychosocial aspects of illness.”
"The doctor interacts and collaborates with co-workers in an effective and courteous manner which recognises their professional skills and knowledge."
Section 3 – Medical Colleague Questionnaires

Attribute - Clinical Competency

“The doctor is effective in communicating, collaborating and coordinating patient care (including continuing care) with other health care professionals and maintains quality medical records. The doctor transfers and refers patients appropriately and communicates referral information to patients. The doctor manages complex patients, performs technical procedures skillfully and demonstrates appropriate judgement. The doctor appropriately selects diagnostic tests, assesses diagnostic information, makes correct diagnosis and selects treatment in a timely manner.”

Attribute - Patient Interaction

“The doctor communicates effectively with patients and their families in a manner that conveys respect and compassion. The doctor maintains confidentiality and is willing to accept a patient back from a consultant for continuing care.”
Attribute - Professional Self Management

“The doctor manages his / her own health care resources, professional development and stress. The doctor participates in a system of call to provide care outside of regular office hours, accepts responsibility for professional actions and is aware of shortcomings.”

Attribute - Psychosocial Management of Patients

“The doctor recognises psychosocial aspects of illness, makes appropriate referrals and use of community resources and manages patients with complex psychosocial problems.”
2. Data from Feedback Questionnaires (n=76)

Section 1: Volunteering Information

Question 1

How did you hear about PPR?

- Medical Press: 47%
- Irish College of General Practitioners: 28%
- CME Group: 10%
- Colleague: 8%
- Medical Council: 7%

Question 2

How did you volunteer?

- Email: 63%
- Phone: 24%
- Website: 6%
- Letter: 2%
- Other: 5%
Question 3
How would you rate the information available on the project?

- Very Good: 35%
- Adequate: 49%
- Poor: 16%

Question 4
Volunteering for the project was a straightforward exercise

- Agree: 65%
- Disagree: 16%
- No opinion: 19%
Section 2: Patient Information

Question 5

The information was informative & useful for the patients, the practice staff and GP

- Disagree: 7%
- Agree: 71%
- No opinion: 22%

Question 6

The patients had enough information prior to engaging in the process

- Disagree: 7%
- Agree: 71%
- No opinion: 22%
Question 7

The patients enjoyed the opportunity to give feedback on the practice and GP

- Disagree: 5%
- No opinion: 22%
- Agree: 67%

Question 8

Did your patients have any difficulty completing the questionnaire?

- No: 69%
- Yes: 31%
Section 3: Volunteer Experience

Question 9

The Professional Competence Office was, in general, supportive and helpful throughout the process.

- Agree 68%
- Disagree 6%
- No opinion 26%

Question 10

Pivotal Research inc. was, in general, supportive and helpful throughout the process.

- Agree 47%
- Disagree 13%
- No opinion 40%
Question 11
The completion and return of the patient questionnaires was a straightforward process

- Agree: 63%
- Disagree: 27%
- No opinion: 10%

Question 12
The online assessment questionnaire was easy to complete

- Agree: 80%
- Disagree: 15%
- No opinion: 5%
Question 13

Did you experience any technical problems completing the online assessment questionnaire?

- No: 22%
- Yes: 78%
  - Login Difficulties: 46%
  - Instructions hard to follow: 10%
  - Internet facilities inadequate: 6%
  - Spam filters and firewalls obstructing access: 16%
Section 4: Medical / Non-Medical Colleague Experience

Question 14

Online nomination of colleagues was user friendly and easy to complete

No 25%
Yes 75%

Question 15.1

Did your medical colleagues experience any technical difficulties in accessing and completing the online questionnaire?

No 50%
Yes 50%
Question 15.2

Did your non-medical colleagues experience any technical difficulties in accessing and completing the online questionnaire?

- Yes 56%
- No 44%

Question 16

Did you experience any difficulties in nominating the requested amount of medical and non-medical colleagues?

- Yes 70%
- No 30%
Question 17

Did you experience any difficulties getting your nominees to complete the questionnaire in the given time?

- No: 27%
- Yes: 73%
Section 5 – Free Text for Comments

Question 18 – Feedback Comments (representative comments)

Comments on Patient Information

“Despite my best efforts some patients took home the questionnaires.”

“Some misunderstood the reasons for questions.”

“A lot asked for help in completing the form.”

“Elderly find it difficult to complete questionnaires.”

“Some patients illiterate, some poor English.”

“I will run my own patient satisfaction survey.”

“Not possible to alter physical aspects of my surgery namely parking and upstairs access.”

Comments on volunteers’ experience

“I had difficulty to recruit as rural Ireland is not fully computerized. It was ironic that HSE computer staff was fire-walled.”

“Could not get quota of non medical colleagues.”

“I found not being able to contact the research company by phone somewhat frustrating.”

“Difficult to get enough non medical colleagues interested.”

“Many people just did not bother. I also got requests to fill feedback on other colleagues and found it very time consuming. Was not sure I was qualified to answer many of the questions.”

“No way to contact Pivotal Research Inc except by email, 6 hours behind.”

“The most difficult part was to ask colleagues to complete the questionnaires and follow up with them.”

“As they were based in Canada, there was a significant time delay in dealing with my queries.”

Comments on Medical / Non-Medical Colleagues’ experience with questionnaires

“Would have been much easier had colleagues completed a paper questionnaire too.”

“I was very interested and motivated to complete the study. I still failed to get enough of my non medical colleagues to complete it. This might be easier as they get used to it. I was amazed how many found electronic communication a problem.”

“This section was straightforward for me as I use a computer extensively in my everyday practice. It could be very daunting for any colleagues who are not computer literate.”
“Don’t know any difficulties experienced by colleagues in completing questionnaires.”

“Some colleagues found it hard to log on.”

“It would have been easier to communicate by post.”

“Found getting colleagues to complete survey difficult.”

“Difficult to get required numbers of medical colleagues. Some non medical colleagues failed to complete questionnaire despite reminders from me.”

Comments on Report

“Excellent feedback. It is good to know what patients and others value in your work and what areas you need to improve. The breakdown of each attribute is most useful. Excellent overall.”

“No scores recorded due to insufficient responses from medical and non medical colleagues.”

“I work in this practice 1 day a week and I felt many of the questions were not relevant to my circumstances e.g. surgery access and access to me outside of these hours is beyond my control. Working only 1 day a week meant that in effect having a month to complete the pilot project. I think future refinements of the exercise have scope to make instrument more user friendly for those in part time practice.”

“There should be a postal and or telephone option for completing the surveys.”

“Enormous time commitment.”

“I found it very interesting to see how my colleagues perceived me.”

“I was happy to see what patients thought.”

“The emails throughout the process were unhelpful as they were generic and not specific to my situation. Need to be able to see who has replied to avoid situation where inadequate response is the outcome.”

“I have to sit down and read it properly, some surprising results. Food for thought.”

“I will review what I do with practice staff and decide of any changes needed and if so what they might be.”

“My report was useless – ‘insufficient data’ in all 3 categories, so all they sent me was an analysis of my self assessment. The process was quite difficult but to get no results from it was infuriating. I had been an advocate of this but not now.”

“Good feedback is very difficult to get and so it is very valuable. I cannot help wondering about the selection of the reports by the doctor being reported on. I did do a day or so of sequential patients but chose on a day I was feeling energetic and emphatic. Does this matter?”
“Report confusing and too long.”

“I like the vast information that was presented in the report.”

“Would be slow to volunteer again and would not recommend this process to a colleague.”

“It will take a while to digest the information, but I think/ know there is room for change / improvement.”

“Overall it was a very worthwhile experience. The most difficult part was asking colleagues (both medical and non medical) to complete questionnaires and follow up on them.”

“The quality initiative of PPR Program was somewhat poor – Patient Assessment results would have been what we expected before PPR – Self assessment is definitely ‘biased’. Co worker section – Biased – we all work together. However we found it exciting and enjoyed taking part and we continue to strive to improve.”

“Heap of rubbish, no objective valid assessment of clinical skills, diagnosis.”

“I felt the exercise was a useless exercise (albeit without any report) and of little benefit to me in improving my practice. Sight of the report might change my mind, in particular patient and colleague comments. Having to wait 6 months for the report is dreadful and I would feel the PPR project fails on that alone.”

“I really found this experience very worthwhile. I would and will recommend it to my colleagues.”

**Question 19**

The report was easy to read and useful to my practice

- **Agree** 71%
- **Disagree** 11%
- **No opinion** 18%
Question 20
Overall I found the PPR process to be very useful and informative about my practice

No opinion 26%
Agree 51%
Disagree 23%

Question 21
I will make changes to my practice as a result of my review

No 25%
Yes 75%
No opinion
Discussion

A review of international literature will demonstrate that the principles and values of good medical practice are well defined and can be broadly categorised into the following clinical and non-clinical domains:

**Non-clinical Domains**

1. Relating to Patients
2. Communication and Interpersonal Skills
3. Collaboration and Teamwork
4. Management (including self management)
5. Scholarship
6. Professionalism

**Clinical Domains**

7. Clinical Skills

Within the framework of a professional competence program, doctors need to demonstrate that they are competent in all domains of practice. In the assessment of the non-clinical domains the assessment of choice is the use of a peer review tool such as multi-source feedback.

The analysis of both the summary data and the feedback questionnaire provides useful information on maintaining professional competence. This will shape the future of the use of this assessment tool amongst the profession in Ireland.

Several questions within each of the questionnaires were used to assess relevant attributes. Patients, medical and non-medical colleagues each assessed different attributes. In establishing the Irish norms it became clear that these are at least equivalent to those of Canada. Favourable comparisons to our Canadian colleagues are testament to the standard of medicine in general practice in this country.

Analysis of the summary data indicates that patients scored their doctors particularly high in the areas of ‘Patient Interaction’, ‘Communication’ and ‘Patient Information’. This mirrors the findings of the Insight 07 report into consumer satisfaction in the HSE which found that 84% of patients of General Practitioners rated their care as excellent or very good. Patients’ assessment of the front office service in the doctors’ practice also shows that non-clinical staff were held in high regard. Scores were slightly lower on aspects of practice that doctors have little or no control over i.e. the practice premises or ‘Surgery’. ‘Access to the Doctor’ was also scored slightly lower with a broader range and lower average score. Factors influencing both access and premises are more complex and would need further investigation and evaluation.

In general, volunteers felt that the feedback from their patients was very useful and one doctor was inspired to continue to run his own patient satisfaction survey based on his experience.

Non-medical colleagues scored their medical colleagues highly in both ‘Patient Interaction’ and ‘Collegiality’. Although the average scores were still high for ‘Communication’ there was a much broader range of scores suggesting a more mixed experience.

Equally medical colleagues scored their General Practitioner colleagues highly in the areas of ‘Patient Interaction’ and ‘Psychosocial Management of Patients’. Scores for ‘Clinical Competency’ are quite varied but remain within acceptable limits. The judgement of clinical competency is based on the use of many assessments and tools and should be viewed in this context and in the absence of specific concerns. The scores for Professional Self Management where doctors were judged on managing their own resources, personal stress etc. were slightly lower with a broad range and merit further study.

As previously stated in Part 1, recruitment and buy-in to the project was a challenge. However 167 volunteers were recruited, and although not all of these completed the process, the data was sufficient to establish norms for the Irish context. The analysis shows that volunteers were recruited through a variety of strategies,
although most (63%) signed up through the website. 84% felt that the information available to them was either adequate or good and the majority felt the process of signing up was straightforward.

Most volunteers had a good experience with the patient questionnaires agreeing that the patients were well informed prior to participation. They also reported that patients had no particular difficulties in completing the questionnaires and also enjoyed the opportunity to give feedback to the practice. Those who encountered difficulties felt that the elderly, the illiterate, and non-native English speakers had more difficulties than others, these patients’ needs should be considered in future studies.

Our previous concerns about the logistical and technical difficulties that volunteers encountered were borne out in the feedback questionnaire. Three quarters of the volunteers reported technical difficulties which spanned the range of technical problems previously discussed e.g. logging on, spam filters and firewalls amongst others. Over two thirds were satisfied with the local support with these difficulties whereas less than half felt that Pivotal Research were supportive and helpful throughout the process. Several feedback comments were made about the difficulties in contacting Pivotal Research because of the time difference in Canada. This was an issue that the project office had noted in previous discussions.

One of the main areas of difficulty for volunteers was the nomination process for medical and non-medical colleagues. Half of those surveyed said that their colleagues had difficulties in accessing and completing the questionnaires and 70% of volunteers said that they had difficulties in nominating the required number of colleagues and getting them to complete the questionnaires in time. This was also discussed at length in the free text of the feedback questionnaire. Many felt that their colleagues were simply not interested or did not bother filling out the questions. Others were surprised at how many colleagues found electronic communication a problem. Having a postal or telephone option for colleagues was suggested by several participants.

The majority of volunteers found the report easy to read, useful and informative about their practice. Almost two thirds (63%) of respondents said that they would make changes to their practice based on their reports.
Conclusions and Recommendations

- This project was a ground-breaking exercise in the attempt to assess non-clinical domains of a volunteers’ practice. Many useful lessons were learnt and the contribution and feedback from the participants who helped pioneer this process is acknowledged.

- Certain issues have been raised by the assessment process and may merit further evaluation. These issues include communication with non medical colleagues, patients’ experiences with the surgery premises and access to the service.

- Overall, participants felt that it was a worthwhile exercise and they valued the feedback from their colleagues and patients.

- The assessment was effective, almost two thirds of respondents said that they would make changes to their practice based on their feedback.

- The project has demonstrated that the multi-source feedback may be an effective tool for the assessment of non-clinical competencies. As a practice improvement tool, it is an important piece of a quality improvement system which meets the needs of patients, doctors and other healthcare stakeholders.

- Logistical and technical difficulties were clearly the biggest barrier for participants to enrol and complete the process. With an increasing emphasis being placed on Information Technology it is imperative that the Postgraduate Training Bodies actively participate in providing assistance / training to ensure their members have an acceptable level of computer literacy. The PPR results have shown that a short-fall in “electronic maturity” does exist in the current population and this needs to be considered for future projects.

- Despite the fact that some participants felt that the exercise should be paper based, there is a commitment to continuing with an electronic system. Providing a back-up or supplementary postal, fax or telephone service is worth considering. Discussions with more experienced providers have confirmed that technical difficulties are common in the early stages of piloting but resolve with experience.

- Using a closer provider that is more familiar with the delivery of the system electronically may also help to address many of the problems that arose. A second pilot in a different population, using another provider would help to address these concerns. Proposals for a second pilot are being discussed in the context of the development of Professional Competence Schemes with the Postgraduate Training Body Forum.

- In conclusion, this assessment tool is a useful addition to the many assessment tools that are part of the quality improvement system throughout the continuum of medical education in Ireland in line with best international practice.

- It is anticipated that further assessment tools will be evaluated for purpose as the experience with the assessment of professional competence matures.
References

1. UCD, HSE. Insight 07 Health and Social Services in Ireland – a survey of consumer satisfaction. 2007

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