A new method of self-assessment during vocational training

N. J. CLEMENS, MRCGP, DRCOG
Vocational Trainee, Mid-Sussex Vocational Training Scheme

SUMMARY. The ability to assess oneself in general practice has to be learned. The ideal time to develop this ability is during vocational training. The lessons learned may be some of the most important before entering general practice itself.

As a new approach to this problem, a self-assessment book has been devised. The book has potential as a research tool and helps trainees to think more closely about their particular problems during patient contact.

Introduction

If standards in general practice are to continue to rise, the most effective audit must inevitably come from within the profession itself. In Britain, medical audit has now come to mean the assessment of general practitioner performance rather than an exercise in cost-effective study.

In such a diverse profession, assessment of standards is not easy. Several external methods are available, including the MRCGP examination and visits from the regional general practice sub-committee. Random case analysis has become the mainstay of external monitoring, encouraging constructive peer group criticism.

However, all these methods of assessment are incomplete unless combined with the development of the ability to assess oneself. The Committee of Enquiry into Competence to Practise (1976) commended the principle of self-assessment and peer group assessment.

With the advent of three-year vocational training schemes, there is now a useful period during which trainee general practitioners, with their ready-made peer group, can take time to develop their potential for self-assessment.

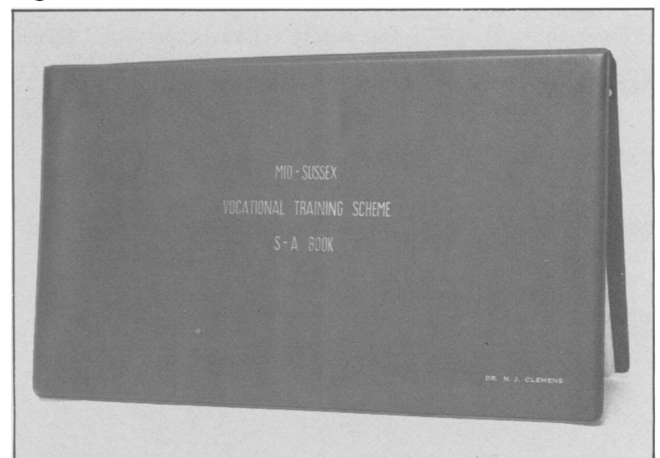
To some, constructive self-criticism comes naturally, and is reflected in their approach to general practice. For others, however, so much time is taken up with learning and practice of other facets of family medicine, that there is little time left for detailed self-assessment. Many opportunities can be missed because time is not put aside to take stock of progress. Postponed case discussion without detailed records can result in a serious time lag before deficiencies in trainees' knowledge and attitudes become apparent. The learning process is therefore less efficient. It seemed that any method used to encourage and improve self-assessment should consist of current detailed recordings involving both trainee and trainer.

It may also be hard to find time for research during a busy vocational training course. Retrospective surveys may be especially difficult to accomplish because of the diverse methods of data collection used by individuals in several different practices. When data collection is standardized from the beginning, this problem may be overcome and individuals, practices, and areas more easily compared.

Aims

To add to the relevance and enjoyment of the Mid-Sussex Vocational Training Scheme, I decided to design a simple and concise method of self-appraisal, which might also be used as a research tool. This takes the

Figure 1. *Cover of the self-assessment book.*



© *Journal of the Royal College of General Practitioners,* 1980, **30**, 734-737.

Each surgery should be represented on one side of the report sheet.
Every surgery must be tabulated if data are to be statistically significant.
There are three main aims:

i) To enable each trainee to assess himself and his progress.
ii) To give well-tabulated grounds for discussions between trainer and trainee.
iii) To collect data for research.

If these sheets are to be used in research, a certain uniformity of data collection is desired. Hence these explicit instructions:-

Column Heading	**Instructions**
No V (Number of Visit)	: Whether 1st, 2nd, 3rd etc. time patient has been seen in surgery during trainee's period in any one practice. If more than 3rd visit, write 'R' for recurrent in this column. It is hoped that 'R' entries may stimulate reappraisal of cases.
Name	: Surname plus initials e.g. BROWN J.D.
Age	: In years.
Sex	: M or F.
S (Service)	: Immunization etc.
Presenting Complaint	: Must be genuine FIRST complaint and NOT your provisional diagnosis or subsequent, more revealing complaints. E.g. **Headache** may be the **presenting complaint.** Husband's behaviour may be a more revealing complaint. **Marriage problem** may be **provisional diagnosis.**
Provisional Diagnosis	: Please attempt to write **something** for each patient even if this may be an extremely tentative diagnosis depending on either further interviews or investigations. Do not be afraid to write 'no idea'. **DO NOT LEAVE THIS COLUMN EMPTY!**
C (Confidence Column)	: Denotes trainee's confidence in provisional diagnosis. Graded as follows:- 1 Sure; 2 Some reservations; 3 Depends on further investigations; 4 Suspicious; 5 No idea
Treatment:	
Verbal	: Includes everything from patient reassurance and counselling to loss of temper.
Medicinal	: Name, dosage and length (in days or weeks etc.) of prescription.
RT (Repeat)	: Tick if repeat prescription.
Invest (Investigations)	: Includes all non-clinical evaluations. E.g. X-ray, blood and urine testing. Please list all investigations AND results whether relevant to the final diagnosis or not.
Ct. (Certificate)	: When issued, write duration of validity thus:- 1/52 = 1 week. 1/12 = 1 month. 1/7 = 1 day. If none issued, leave blank.
F.U. (Follow-up)	: Whether:- a) Given definite follow-up appointment:- 1/52, 1/12, 1/7 as above. b) Told to return if problems: PRN. c) Not given follow-up: Leave blank.
REF. (Referral)	: Whether patient referred to another department: GOP = Gynae. Out-Patients; SW = Social Worker; ANC = Ante-Natal Clinic; DN = District Nurse; MedOP = Medical Out-Patients; SurOP = Surgical Out-Patients; Psi = Psychiatrist. Pso = Psychologist; PSW = Psychiatric Social Worker; HV = Health Visitor; OOP = Orthopaedic Out-Patients; POP = Paediatric Out-Patients; IP = In-Patient Admission; SpOP = Out-Patient Department in specialities not listed above.
Remarks	: Used in conjunction with 'Remarks/ Further Reading' column at the bottom of the report sheet. If no room in 'Remarks' column, write 1-6 in that column then expand opposite relevant number below.
Blank Column	: Can be used for any particular piece of research or for overflow remarks.
Remarks/ Further Reading	: Used with 'Remarks' column as above and also by trainee and trainer to list suggested reading around particular cases.

Figure 2. *Instruction sheet.*

form of a self-assessment book (S-A book) which has the following aims:

1. *To enable the trainee to learn to assess himself/herself*
The trainee is encouraged to think about his/her attitudes and reactions to each consultation as and when they occur. If these attitudes and reactions are changing, trainee and trainer are immediately aware and no time is lost before they can be discussed in detail.

2. *To increase trainer/trainee contact*
The very existence of more detailed records encourages trainer and trainee to sit down and discuss cases after

each surgery. The trainer can, more easily, pick up important points either missed or deliberately avoided by the trainee.

3. *To standardize data collection*
Standardizing data collection helps any research project, especially retrospective surveys involving several different trainees or practices. It also allows for more effective comparison of trainees or practice profiles.

The self-assessment book

The self-assessment book (Figure 1) has a hard-wearing, loose-leaf cover, personalized to encourage an immediate sense of participation by the newly appointed trainee. It contains one instruction sheet (Figure 2), to make sure all data are recorded in a uniform manner, several data collection sheets and a single data summary sheet.

Data collection sheet

The data collection sheets (Figure 3) are completed as well as the usual practice notes, and were found to be less inconvenient to complete than was first envisaged. They also encouraged deeper thought about each consultation.

Particular points to note are as follows:

1. *The 'number of visit' column*
This aims to pick up recurrent attenders at the surgery to stimulate earlier case reappraisal. The number of first visits may be used to calculate the percentage of the trainer's list seen by the trainee during his attachment.

2. *The 'presenting complaint' and 'provisional diagnosis' columns*
These aim to demonstrate differences between the presenting complaint and the patient's real problem. This encourages the trainee to 'look beneath the surface' of each consultation.

3. *The 'confidence' column*
This helps the trainee to think more deeply about his reaction to each consultation. It provides a useful lead into further discussion and is an integral part of the self-assessment programme.

4. *The 'remarks/further reading' column*
This provides a permanent record of reading topics suggested by the trainer, who can then ensure that relevant cases are followed through completely.

Data summary sheet

The data summary sheet (Figure 4) aims to summarize all the data which have been collected and may be used to compare individual performance or practice profiles. Both axes include several blank spaces for individually designed prospective surveys. The permanent entries on each axis aid data collection for future retrospective surveys.

Figure 3. *Sample data collection sheet.*

No.V	NAME	AGE	SEX	S	PRESENTING COMPLAINT	PROVISIONAL DIAGNOSIS	C	TREATMENT VERBAL	TREATMENT MEDICINAL	TREATMENT RT.	INVEST.	Ct.	F.U.	REF.	REMARKS
1		7	M.		Abdominal pain	Separation anxiety	2	Seed sown							Rather asthmatic.
2		36	M		? sperm count result	Free floating anxiety	2	Reassurance							Wife anorexic
R		62	F		Wants tuinal	Bereavement	1	Support	Tuinal Mogadon	✓					? Try mogadon substit.
1		30	M	✓	Wants certificate	IQ 72	1					6/12			
R		62	M.		For BP check	Essen. Hypertension	1		Slow-trasicor Navidrex	✓ ✓	150/90		3/12		Anxiety re son & wife
1		12	F		Sore throat cough	URTI	1		Actifed syrup						
R		29	F		Vaginal discharge	Physiological norm	1	Reassurance							Has transmitted her anxieties to me → over investigation
2		5	M.		Cough	URTI	1		Actifed syrup						
R		75	F		For BP check	? Hypertension	2	Stop inderal	moduretic	✓	160/85		1/12		
3		5	F		Earache	Otitis media URTI	1		Amoxil Otosporin						? consider T & A's later.
1		3	M.		Cough	URTI	1		Actifed						
R		62	F		BP check	? Hypertension	2	Stop inderal	Navidrex	✓	160/80		2/52		
1		9	F		Sore throat	viral URTI.	2		Aspirin						
2		29	F		Chest pain	Cancerophobia	1	Reassurance					prn		
R		70	F		Feels better	Alcoholism	1	Discussed			LFT normal MCV 104				B12 folate to come ① .
2		28	F		Niggling cough	Anxiety about "pill"	1	Discussed	Ovranette	✓					
R		65	F		Come for test results	Polymyalgia Rhem	1		Prednisolone	✓	ESR 21		6/52		

REMARKS/FURTHER READING ETC:–	
1.	Causes macrocytosis .
2.	
3.	
4.	
5.	
6.	

SURGERY	
TIME:	0830.
PLACE:	Main Surgery
DATE:	
TYPE:	General

MALES	3
FEMALES	8
CHILDREN	6
TOTAL	17

28 DAY PERIOD	17/4/78 – 15/5/78				16/5/78 – 14/6/78				15/6/78 – 13/7/78			
	No.	M	F	Ch.	No.	M	F	Ch.	No.	M	F	Ch.
No. PATIENTS	117	46	52	19	255	78	131	46	307	109	143	55
S	10	1	9	0	16	4	12	0	25	14	11	0
C 1	76	29	34	13	183	60	91	32	230	77	104	49
C 2	22	9	9	4	38	10	20	8	46	19	22	5
C 3	5	2	2	1	8	3	5	0	16	5	10	1
C 4	5	2	2	1	13	4	8	1	6	4	2	0
C 5	9	4	5	0	13	1	7	5	9	4	5	0
RT.	6	1	5	0	24	5	18	1	31	13	18	0
INVEST.	18	10	8	0	48	17	26	5	54	20	31	3
Ct.	6	1	5	0	11	3	8	0	6	5	1	0
F.U.	32	15	15	2	52	18	26	8	50	22	25	3
REF.	3	1	1	1	7	2	5	0	15	7	6	2
% of total.		39	44	17		31	51	18		36	47	17
No. prescriptions	69											
% given prescription	59%				51%				43%			
No. Rpt prescript.	5				24				23			
% Rpt prescript.												
No. first visits	107				182				167			
% first visits	91.5%				71.4%				54.4%			
% "C1."	65	63	65	68	72	77	70	70	75	71	73	89
% referred	2.5	2.2	1.9	5.3	2.7	2.6	3.8	0	4.9	6.4	4.2	3.6
% "investigated"	15	22	15	0	19	22	20	11	18	18	22	6

28 DAY PERIOD	14/7/78 – 11/8/78				12/8/78 – 9/9/78				10/9/79 – 30/9/79				6 MONTHS TOTAL			
	No.	M	F	Ch.	No.	M	F	Ch.	No.	M	F	Ch.	No.	M	F	Ch.
No. PATIENTS	190	72	87	31	302	101	146	55	190	61	82	47	1361	467	641	253
S	11	5	4	2	29	13	14	2	18	7	11	0	109	44	61	4
C 1	142	57	58	27	252	85	113	54	160	48	67	45	1043	356	477	220
C 2	26	10	13	3	31	10	20	1	18	9	7	2	181	67	91	23
C 3	11	2	9	0	8	2	6	0	6	2	4	0	54	16	36	2
C 4	9	2	6	1	6	3	3	0	3	1	2	0	42	16	23	3
C 5	2	1	1	0	5	1	4	0	3	1	2	0	41	12	24	5
RT.	14	5	7	2	24	8	16	0	13	4	8	1	112	36	72	4
INVEST.	20	5	13	2	34	9	25	0	11	3	8	0	178	62	106	10
Ct.	2	2	0	0	7	1	6	0	3	3	0	0	35	15	20	0
F.U.	27	15	9	3	37	12	25	0	12	8	4	0	210	90	104	16
REF.	6	2	3	1	10	3	7	0	5	1	4	0	46	16	26	4
% of total.		38	46	16		33	48	19		32	43	25		34	47	18
No. prescriptions																
% given prescription	51.5%				42%				48%				48%			
No. Rpt prescript.	15				23				28				108			
% Rpt prescript.													8%			
No. first visits	121				138				47				762 ≡ 33.9% total list.			
% first visits	63.7%				45.7%				24.7%				57%			
% "C1."	75	79	67	87	83	84	77	98	86	83	80	100	77	76	74	87
% referred	3.1	2.8	3.5	3.1	3.3	3.0	4.8	0	0	0	0	0	3.4	3.4	4	16
% "investigated"	11	11	15	7	11	9	17	0	6	5	10	0	13	13	17	4

Figure 4. *Sample data summary sheet.*

The sample sheet of six months' consultations shows the following:

1. That the trainee met 33·9 per cent of the trainer's total list in six months.
2. Forty-eight per cent of consultations ended in a prescription being written; eight per cent of these were repeat prescriptions.
3. Only 57 per cent were first-time consultations.
4. Consistently greater consultation by females (children not included).
5. Slow increase in confidence (not a normal finding amongst trainees).
6. Reduction of investigations done as time went on.

All these findings are of personal interest and are more useful when trainees or practices are compared.

Future filing

When each trainee has completed his course, all data collection and data summary sheets can be surrendered to the scheme's secretary and filed for future reference.

Confidentiality can be maintained by blacking out the 'name' column before surrender. In the future, this column could be moved to the extreme left of the sheet, then cut off and destroyed before the remainder is filed.

Discussion

The self-assessment book has now been in use in the Mid-Sussex Vocational Training Scheme for two years. In my experience, and that of my colleagues, it did indeed bring trainers and trainees closer together and greatly encouraged continuous self-assessment by everyone concerned. The trainers found it easier to identify gaps in their trainees' knowledge and the latter were beginning to think harder about their particular problems with the doctor/patient relationship. A data collection sheet from a morning's surgery provided a good lead into discussion amongst members of the 'practice workshop'. The potential for research has yet to be fully realized. Nevertheless, the book has already proved to be a very worthwhile project of continuing practical value. Refinements such as provision of a less cumbersome 'visiting' version may further improve the general idea.

Reference

Alment, E. A. J. (Chairman) (1976). *Competence to Practise.* London: Committee of Enquiry into Competence to Practise.

Addendum

Dr Clemens is now a principal in general practice in Crawley Down, West Sussex.