

Content of a trainer's report for summative assessment in general practice: views of trainers

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SUMMARY

Background. Summative assessment of doctors completing general practice vocational training will become compulsory for those completing training after 1 September 1996. One component of the assessment will be a trainer's report.

Aim. A study set out to consider the content of the trainer's report. It aimed to determine which elements of general practice general practitioner trainers believe are the most important for independent general practice; to seek the views of trainers as to the most appropriate methods for assessing these elements in summative assessment of general practitioner registrars; and to determine how frequently trainers have been sufficiently concerned about the performance of registrars to consider not signing the form denoting satisfactory completion of the training year.

Method. A questionnaire was sent to 1296 general practitioner trainers in the United Kingdom. The main outcome measures used were: the percentage of respondents indicating that an element was very important/crucial for independent general practice; the percentage of respondents indicating a favoured method of assessment that did not include a trainer's report at all; and the proportion of trainers who had ever considered not signing the form denoting satisfactory completion of the training year.

Results. The response rate was 78%. Of 75 elements examined, 31 were considered important for independent general practice by 70% or more of respondents. For 29 of these 31 elements, fewer than 30% of respondents would choose a method of assessment that did not include a trainer's report at all. Twenty-six per cent of respondents had considered not signing the form denoting satisfactory completion of the training year, which represents a trainer considering not signing this form once every 29 years.

Conclusion. These results provide a basis for the content of a structured trainer's report for summative assessment in general practice; such a report is likely to contain about 30 items. Data from the Joint Committee on Postgraduate Training for General Practice and the present study suggest that, for every form not signed, trainers considered not signing the forms of another 13 general practitioner registrars. This highlights the need for a report that will help trainers to make the difficult decision as to whether or not a registrar is ready for independent practice.

Keywords: summative assessment; vocational training assessment; educational standards.

Introduction

The need for assessment at the end of general practice vocational training has been recognized for some time.¹⁻⁴ An assessment package with four components has been suggested,⁵ with introduction planned for 1 September 1996. The package is designed to assess whether or not general practitioner registrars completing their vocational training have reached a standard which will allow them to undertake independent general practice.

The four components will be: a written examination, an observation of practice, a submission of written work and a report by the trainer. The inclusion of a trainer's report recognizes not only the unique relationship that is built up during the training period between trainer and registrar, but also the opportunity for part of summative assessment to be based on performance observed throughout the training year. Although doubts exist about the weight that should be attached to an assessment undertaken by one trainer,⁶ many authorities recognize the pivotal role that a trainer could have in assessment.⁷⁻¹¹ Currently, the only requirement for the trainer is to sign the form that denotes satisfactory completion of the training year.

A project was undertaken, the overall aim of which was to determine which aspects of the general practitioner registrar's skills, attitudes, knowledge and practice could be assessed validly and reliably by means of a structured trainer's report. This paper reports the first component of that project, namely the determination of which elements of general practice trainers believe should be contained in the trainer's report.

The first aim of this study was to determine the views of general practitioner trainers as to the relative importance for independent general practice of elements previously described as important in consensus statements. The second aim was to seek their views as to which of the four proposed assessment methods was the most appropriate for each of these elements. A third, subsidiary, aim was to determine how frequently trainers are sufficiently concerned about the performance of their general practitioner registrars to consider not signing the form denoting satisfactory completion of the training year.

Method

Questionnaire design and content

The design of the questionnaire was based on the guidelines suggested by Stone.¹² For each element of general practice, two questions were asked. The first asked the trainers to rate the importance of that element for independent general practice. Based on the results of a pilot exercise with 26 experienced trainers, answers were marked on scales from one (fairly important) to five (crucial). This format was chosen because it was felt that it would spread out the responses by reducing the likely clustering around 'very important'; it was considered unlikely that trainers would rate many elements of general practice as 'not important at all'.

The second question asked trainers to indicate which of five possible methods of assessment might be used to assess each element of general practice. The options given were based on the

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four proposed assessment methods, namely written examination, external observation, registrar project and trainer's report; a category entitled 'other' was also included. Trainers were asked to tick all the boxes that they felt might apply; if they ticked the box denoting other, they were also asked to describe what technique they would use.

A covering letter explained the reason for undertaking this study, the basis of the questionnaire and exactly what each of the assessment methods might entail. At the time of the study, the exact method for assessment by external observation had not been chosen, but the covering letter explained that the likely options were either videotaped consultations or simulated surgeries; the decision to use of videotaped consultations only became widely known after the questionnaires had been gathered in.

The questionnaire content was based on three documents, each describing a consensus view of the attributes of general practitioners in the United Kingdom and Europe.¹³⁻¹⁵ In total, questions on 75 elements of general practice were included. For clarity, the elements were grouped into five categories:¹⁴ patient care (42 elements), communication (five), organization (14), professional values (eight), and personal and professional growth (six).

Questions seeking sociodemographic and practice data on each trainer were also included; in addition, each trainer was asked whether or not he or she had ever considered not signing the form denoting satisfactory completion of the training year. Respondents were also asked to list any additional questions that they wished to see included in the trainer's report.

Sample size and structure

The basic sample size calculation used was:¹⁶

$$n = \frac{1.96^2 Np(1-p)}{1.96^2 p(1-p) + \Delta^2 N}$$

where n is the sample size, N the total number from which the sample is taken and, p the estimate of the proportion of responses with the desired value. Because the outcome of principal interest was the identification of those elements judged important by a considerable majority of trainers, a value of 0.7 was chosen for p , while a value of 0.025 was chosen for the acceptable margin of error (Δ) to ensure narrow confidence intervals. Using information available from all regional advisers in the UK in August 1994, $N = 3447$ for which $n = 939$. Assuming a response rate of 75%, the sample needed to contain at least 1252 trainers.

All regional advisers in the UK were approached in June 1994 to ask if they would be willing to provide lists of the trainers in their regions. A total of 27 advisers were approached (24 civilian trainers and three from the armed forces) of whom 26 agreed to be involved. This resulted in the names of 3335 trainers being available for inclusion in the study out of the total of 3447 trainers in the UK at the time of the study. A random number table¹⁷ was used to select a total of 1296 trainers. Whenever the random selection resulted in the selection of one of the trainers approached in the pilot phase, the next name on the list was selected.

Questionnaires were sent initially in September 1994 with follow-up questionnaires to non-respondents after four weeks and again after a further five weeks.

Data analysis

Responses were entered onto the *EPI INFO* software package. For each of the 75 elements being examined, two calculations were made. First, the percentage of respondents indicating an importance score of four or five was calculated. Secondly, the percentage of respondents whose response to the question on methods of assessment indicated that they would favour a combi-

nation of methods that did not include a trainer's report was also calculated. The denominator for the calculation of percentages was the total number of responses for that question. Percentages alone are given because the exact number of respondents to each question varied (between 92.8 and 98.5% of the total number of respondents). Confidence intervals for the percentages were calculated using the *Confidence interval analysis* package.¹⁸ Comparisons between respondents and non-respondents were made using the chi-square test for proportions and the standard error of difference between means.

Results

Response rates and characteristics of respondents

Of the 1296 questionnaires sent to trainers, 41 were returned because the recipients felt that they were ineligible for the study: 28 were no longer trainers, nine had retired from general practice and four were on long-term absence from practice. Of the remaining 1255 eligible for inclusion, 985 were returned, of which 974 could be included in the study, an adjusted response rate of 77.6% (974/1255).

The mean age of respondents was 44.3 years; 867 (89.0%) were men. The mean total list size of their practices was 8806 patients, served by a mean of 4.8 partners. Respondents had been trainers for a mean of 7.8 years. Most of the respondents (72.6%) would usually have a general practitioner registrar based in their practice for 9-12 months at a time.

Respondents were compared with non-respondents for sex and year of qualification (obtained from *The medical register*¹⁹). Reliable information was available for 269 of the 281 non-respondents. There were no statistically significant differences between respondents and non-respondents with regard to sex (11.0% of 974 were women versus 8.6% of 269) or year of qualification [mean 1973 (SD = 6.9) versus 1973 (SD = 6.5)].

Responses to questions

The 31 elements considered important for independent general practice by 70% or more of respondents are shown in Table 1 together with the percentage of respondents whose response to the question on methods of assessment indicated that they would favour a combination of methods that did not include the trainer's report. Whilst Table 1 is dominated by clinical skills, Appendix 1 contains the majority of skills not directly related to patient care. There were 23 elements for patient care, one for communication, three for organization, three for professional values, and one for personal and professional growth. The 44 elements considered important for independent general practice by fewer than 70% of respondents are shown in Appendix 1. No additional items for inclusion in the trainer's report were suggested by more than 5% of respondents.

A total of 251 of 952 respondents indicated that they had considered not signing the form indicating satisfactory completion of the training year (26.4%, standard error 1.4). Based on a mean of 7.8 years of training, this represents 3.4% of trainers each year considering not signing a registrar's form; the corollary of this is that an individual trainer would, on average, consider not signing a form once every 29.5 training years, or for every 1800 general practitioner registrars completing their vocational training each year, 61 trainers would consider not signing a form.

Discussion

The process of summative assessment has been under development for some years.²⁰ The development of a trainer's report suitable for summative assessment has been described but was

Table 1. Elements considered important (score of 4 or 5) for independent general practice by 70% or more of respondents and percentage of respondents who did not choose a trainer's report as a method of assessment.

Element	% of respondents (95% CI) ^a	
	Scoring element 4 or 5	Not choosing trainer's report
<i>Patient care — the doctor:</i>		
Can recognize common physical, psychological and social problems	98.0 (97.0 to 98.8)	13.7 (11.6 to 15.9)
Diagnoses and manages acute emergency situations appropriately	96.1 (94.6 to 97.2)	8.3 (6.6 to 10.2)
Responds appropriately to requests for urgent attendance at patients	91.3 (89.3 to 93.0)	5.4 (4.0 to 7.0)
Is able to give an intravenous injection	90.3 (88.2 to 92.1)	21.0 (18.4 to 23.6)
Demonstrates a broad knowledge of all aspects of appropriate drug use ^b	89.4 (87.5 to 91.4)	24.4 (21.7 to 27.1)
Is able to examine each system (eg respiratory) and organ (eg eye) proficiently	89.2 (87.3 to 91.2)	17.6 (15.2 to 20.0)
Is able to undertake basic cardiopulmonary resuscitation	88.4 (86.4 to 90.4)	43.2 (40.1 to 46.4)
Undertakes appropriate examination with appropriate consideration of patients' needs and feelings	88.0 (86.0 to 90.1)	15.6 (13.3 to 17.8)
Is able to use sphygmomanometer proficiently	87.1 (85.0 to 89.2)	25.7 (23.0 to 28.5)
Is able to give an intramuscular injection	86.7 (84.6 to 88.9)	20.5 (18.0 to 23.1)
Is able to use vaginal speculum proficiently	86.2 (84.0 to 88.4)	20.2 (17.7 to 22.8)
Is able to undertake a vaginal examination proficiently	85.6 (83.4 to 87.8)	20.0 (17.5 to 22.5)
Is able to undertake a cervical smear proficiently	85.2 (82.9 to 87.4)	20.1 (17.6 to 22.7)
Is able to use stethoscope proficiently	84.8 (82.5 to 87.1)	24.7 (22.0 to 27.4)
Is able to undertake a rectal examination proficiently	82.1 (79.7 to 84.5)	21.1 (18.5 to 23.7)
Is able to use peak-flow meter proficiently	81.2 (78.7 to 83.7)	23.7 (21.0 to 26.4)
Is able to use auriscope proficiently	80.8 (78.3 to 83.3)	25.0 (22.3 to 27.8)
Has knowledge and skills to deal with life events and crises	79.8 (77.2 to 82.3)	8.8 (7.1 to 10.8)
Is able to assess mental state proficiently	78.7 (76.1 to 81.3)	18.2 (15.8 to 20.6)
Chooses appropriate management for each problem with the patient ^c	76.8 (74.1 to 79.4)	14.8 (12.6 to 17.1)
Provides appropriate care and support for patients and families	76.3 (73.6 to 79.0)	5.9 (4.5 to 7.6)
Includes patients' beliefs, ideas, concerns, effects of the problem and expectations in assessment	74.9 (72.2 to 77.6)	16.0 (13.7 to 18.3)
Is able to use ophthalmoscope proficiently	72.0 (69.2 to 74.9)	25.8 (23.0 to 28.5)
<i>Communication — the doctor:</i>		
Demonstrates effective communication skills when dealing with patients	94.9 (93.3 to 96.2)	14.4 (12.2 to 16.6)
<i>Organization — the doctor:</i>		
Is aware of his/her own limitations, skills of others and has ability to delegate appropriately	82.0 (79.5 to 84.3)	4.9 (3.7 to 6.6)
Is able to manage his/her own time	81.0 (78.5 to 83.5)	4.4 (3.2 to 5.9)
Understands his/her obligations according to NHS contract and regulations	70.1 (67.2 to 72.9)	30.2 (27.3 to 33.1)
<i>Professional values — the doctor:</i>		
Possesses and applies ethical principles	80.5 (78.0 to 83.0)	8.6 (7.0 to 10.6)
Is able to maintain his/her own physical and mental health	78.3 (75.7 to 80.9)	7.7 (6.0 to 9.6)
Is willing to accept appropriate responsibility for patients, partners, colleagues and others	71.4 (68.5 to 74.2)	4.5 (3.3 to 6.1)
<i>Personal and professional growth — the doctor:</i>		
Is able to identify strengths and weaknesses in his/her performance	76.5 (73.8 to 79.1)	7.5 (6.0 to 9.4)

CI = confidence interval. ^aBetween 928 and 974 respondents answered each question. ^bIncluding actions, interactions, side effects, costs and legal aspects. ^cIncluding the care of chronic problems.

considered by trainers in only one region.²¹ The present study considered the views of a large sample of trainers from throughout the UK.

Although postal questionnaire surveys have limitations, this method allowed the views of a large group of trainers to be established with 28% of all trainers in the UK responding to the questionnaire. Although no information was available on the specific reasons for non-response, there was no evidence of bias in favour of a certain age group or sex among respondents. Long questionnaires are at risk of inducing response bias,²² but no evidence of this was seen.

The finding that one quarter of trainers had considered not signing the form indicating satisfactory completion of the training year is of considerable concern. Because trainers were not asked if they had considered not signing this form for more than one general practitioner registrar the estimate provided by this

study is likely to be an underestimate of the true figure. However, it is similar to results obtained in the one region currently undertaking summative assessment (T S Murray, personal communication). Compared with the number of forms currently not being signed,^{5,23,24} the results from the present study suggest that for every form not signed trainers consider not signing the forms of another 13 general practitioner registrars. This highlights the need for a system that will help trainers to make the difficult decision as to whether or not a registrar is ready for independent general practice.

In deciding exactly which elements should be included in the trainer's report, weight needs to be given to those elements considered by 70% or more of trainers to be important for independent practice. It was found that the elements mainly comprised those associated with patient care. This suggests that trainers believed strongly that the knowledge, skills and attitudes needed

for clinical care remain paramount for independent general practice. However, the results also suggest that trainers recognized that independent general practice requires more than clinical skills alone — in particular, it is important to be able to communicate effectively with patients and to apply ethical principles. Trainers also recognized the importance of general practitioners looking after themselves if they are to survive independently, as exemplified by their rating of the importance of a doctor's need to manage his or her own time and to maintain his or her health.

If the elements considered by fewer than 70% of trainers to be important for independent practice were excluded from the trainer's report, what areas of general practice would not be covered? The use of some diagnostic equipment, the provision of preventive care, teamwork, practice management and research would be lost. However, it could be argued that, in general, these elements are probably more desirable than crucial for independent general practice (for example, although it is highly desirable to work in conjunction with colleagues it may well be possible to provide adequate care without this attribute).

Inevitably, any cut-off point is arbitrary. However, the choice of 70% as a cut-off point ensured that at least one element from the five main groups of elements was included without the total number of elements becoming too unwieldy for trainers to consider. If these arguments are accepted, then it is reasonable that the trainer's report should contain only the 31 elements considered by 70% or more of respondents to be important.

In deciding which elements should be included in the trainer's report, weight also needs to be given to the methods of assessment chosen by the trainers. Because the principal aim of the present study was to design a trainer's report, it was decided to focus on the proportion of trainers who believed that a trainer's report was not an appropriate method for assessing an element. Of the 31 elements, one was found to be distinctly different, namely the assessment of cardiopulmonary resuscitation (43% of respondents felt that the trainer's report should not be part of the assessment). For a further four of the 31 elements, 25% or more of respondents felt that the trainer's report should not be part of the assessment. Three of these represented clinical skills; for these elements, the modal response was assessment by external observation in conjunction with the trainer's report. Unfortunately, after the questionnaires had been distributed, the decision was made that the external observation of practice would be based on videotaped consultations. This method will not be suitable for assessing many of the practical skills. Because the trainer's report was the alternative method chosen by respondents for assessing these clinical skills, it would seem reasonable to include them in the trainer's report. For the element that focused on the need for a doctor to understand his or her obligations according to NHS contracts and regulations, the modal response was assessment by written examination in conjunction with the trainer's report. For these reasons, it is suggested that the only item of the 31 chosen on the basis of importance that should definitely be excluded from the trainer's report is the assessment of cardiopulmonary resuscitation, although consideration should be given to excluding the element on NHS obligations and regulations if it is to be covered in the written examination.

The contents of summative assessment will inevitably tend to drive the contents of the general practitioner registrars' and trainers' curricula for the training year. There is a risk that, if the standards set for assessment are truly minimal, the curriculum itself will be minimalist. However, by using formative assessment, trainers and registrars should be able to recognize early in the training year those areas on which effort needs to be concentrated in order to ensure that the registrar will pass summative

assessment; once they are confident that this assessment can be passed then it should be possible for the majority of the training year to focus on higher levels of performance.

This paper describes a consensus view of what is important for independent general practice today, and which aspects are considered suitable by trainers for assessment by means of a trainer's report. The results provide a sound basis for the development of a structured trainer's report for use in summative assessment in general practice.

Appendix 1. Elements considered important (score of 4 or 5) for independent general practice by fewer than 70% of respondents.

Element	% of respondents scoring 4 or 5 (95% CI) ^a
<i>Patient care — the doctor:</i>	
Copes with anxieties felt as a result of unstructured presentations, difficulty in reaching conclusions, and lack of continuous patient monitoring	67.4 (64.4 to 70.4)
Makes effective use of medical records	65.8 (62.8 to 68.8)
Considers and follows up psychological and social factors	65.4 (62.4 to 68.4)
Understands importance of involving and educating patients	64.9 (61.9 to 67.9)
Is able to use time as a diagnostic and therapeutic tool	64.4 (61.4 to 67.4)
Knows available agencies and resources and has skills to refer appropriately	62.3 (59.3 to 65.4)
Uses management plans which include effective use of other team members	61.8 (58.7 to 64.9)
Demonstrates an understanding of effect of social and environmental circumstances on patients	57.5 (54.4 to 60.6)
Understands principles involved in prevention in general practice ^b	56.3 (53.2 to 59.4)
Understands principles of problem definition ^c	55.5 (52.3 to 58.6)
Is able to provide effective preventive services to individual patients	53.4 (50.3 to 56.6)
Is able to use patellar hammer proficiently	49.1 (45.9 to 52.2)
Has a knowledge of systems used to identify individuals and sections of practice population ^d	41.7 (38.6 to 44.9)
Is aware of costs of his/her activities and recognized limits to those costs	37.3 (34.3 to 40.4)
Is able to use electrocardiograph proficiently	37.0 (34.0 to 40.1)
Is able to provide effective preventive services to the population	34.4 (31.4 to 37.4)
Is able to use tuning fork proficiently	34.1 (31.1 to 37.1)
Is able to use proctoscope proficiently	33.1 (30.1 to 36.0)
Is able to use laryngoscope proficiently	7.4 (5.8 to 9.3)
<i>Communication — the doctor:</i>	
Demonstrates understanding and respect for colleagues	68.7 (65.8 to 71.6)
Uses his/her knowledge of practice and of patients appropriately in various contacts ^e	53.8 (50.7 to 57.0)
Has an understanding of importance of meetings and discussion with colleagues	52.0 (48.9 to 55.2)
Demonstrates skills to discover strengths and weaknesses of colleagues and their need for support	38.3 (35.2 to 41.4)
<i>Organization — the doctor:</i>	
Understands importance of need to manage a practice effectively	64.1 (61.0 to 67.1)
Has a knowledge of the most important sections of NHS contract and regulations regarding sources of income and superannuation	47.2 (44.1 to 50.4)
Is able to take appropriate action when organizational problems are identified	47.0 (43.9 to 50.2)
Has a knowledge of most important organizational aspects of practice and partnership ^f	44.5 (41.4 to 47.7)
Is able to monitor aspects of practice activity	44.4 (41.2 to 47.5)
Understands principles of successful introduction of change and innovation	42.2 (39.1 to 45.3)
Understands medicosocial legislation and impact of this on patients	37.7 (34.6 to 40.7)

Understands application of new technology to general practice	31.8 (28.9 to 34.8)
Knows how and where to intervene in the community on behalf of others	25.4 (22.7 to 28.2)
Is able to determine and respond to health needs of the community	24.5 (21.8 to 27.3)
Has an understanding of basic methods of research as applied to general practice	15.6 (13.3 to 17.9)

Professional values — the doctor:

Shows tolerance, respect and flexibility when responding to ideas of others	67.0 (64.0 to 69.9)
Is aware of factors that influence relationship between personal and professional life	65.8 (62.8 to 68.8)
Is aware of his/her own values, beliefs and attitudes, how they are influenced and how they affect others	64.7 (61.7 to 67.7)
Is willing to undergo peer review and is able to give and receive criticism	56.4 (53.3 to 59.5)
Recognizes social, cultural and organizational factors that define and affect his/her work	43.3 (40.2 to 46.5)

Personal and professional growth — the doctor:

Is aware of factors that limit his/her effectiveness	61.1 (58.1 to 64.2)
Is able to manage and overcome factors that limit his/her effectiveness	57.8 (54.6 to 60.9)
Can define his/her own educational needs and appropriate methods of meeting those needs	56.1 (53.0 to 59.3)
Can recognize, define and respond to change, including changing needs in patients, colleagues and the community	49.1 (46.0 to 52.3)
Is able to produce change in self and others	41.3 (38.2 to 44.4)

CI = confidence interval. ^aBetween 904 and 974 respondents answered each question. ^bIncluding case finding, screening, health education and monitoring of preventive activities. ^cIncluding hypothesis formation and testing. ^dFor example, disease registers and computerized registration data. ^eFor example, in practice or team meetings, telephone contracts and contracts with families. ^fIncluding agreements, accounts, buildings and tax.

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Patient consent to observation

This paper describes the response of patients attending an academic family practice unit to being asked for written consent for a supervising physician to observe a resident performing physical examination or to videotape to consultation. Previously, patients had been informed about the process of supervision in a brochure and signs in the waiting room. They were asked for consent orally. It is particularly relevant to practice in the UK because it will become increasingly necessary to observe general practitioners in training in order to gather evidence of competence as summative assessment is implemented.

The outright refusal rate was low (2.7% for observation only, and 14.8% for observation and video). More patients refused consent for observation and video than for observation only, but of those who gave consent, nearly a quarter expressed some negative feelings in a semi-structured interview afterwards. Of the 28% of patients who had a negative reaction to being asked for written consent, the majority were concerned about invasion of privacy. Those who had been observed thought that they had acted differently because of being observed, or had felt pressurized into giving consent. Some felt uncomfortable or embarrassed during the visit, or were concerned about confidentiality, especially access to medical records or the videotapes.

The need to devise clear, sensitive policies and procedures for obtaining consent is emphasized as well as the ethical importance of ensuring that the care of patients is not adversely affected by their refusal to consent to observation.

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General Practitioner, Newbury, and Convenor Simulated Surgery Working Party, Panel of Examiners

Source: Shafir MS, et al. Patient consent to observation. *Can Fam Phy* 1995; **41**: 1367-1372.

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