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, repsect 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 chage, 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. [a]Between 904 and 974 respondents answered each question. [b]Including case finding, screening, health education and monitoring of preventive activities. [c]Including hypothesis formation and testing. [d]For example, disease registers and computerized registration data. [e]For example, in practice or team meetings, telephone contracts and contracts with families. [f]Including 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 precess 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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