Professionalism & Use of Multisource Feedback

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Professionalism has been termed, a philosophy, a set of skills and habits resulting from basic relationships in human interaction [Emanuel, 2004]. Epstein and Hundert suggested that it is the "habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of an individual and the community" [Epstein, R.M & Hundert, and E.M 2002].

Medicine bridges the gap between science and society. Medical Professionalism has been under discussion for many years pertaining to the day to day interaction of the general public with the profession, and their expectations. In the recent era, this has been moved from an old, elite centred profession to the one which is more patient and public centred. Indeed it now signifies a set of values, behaviours and relationships that underpins the trust; the public has in the profession, and forms the basis for a moral contract between the medical profession and society [RCP London2005]. These changing expectations have played a vital role in altering the traditional roles and responsibilities of the medical professionals. In the recent past, the medical profession along with education and law has been under the hammer, challenged by the politicians, the public and other stake holders. The Government has urged that being more responsive, accountable and responsible to the patients should be at the heart of medical professionalism and to the modern healthcare system .But medical professionals perceive this increased public expectation of an access to the services , and evidence base care model based on outcomes as some of the challenges to professionalism [RCP London 2005].

Medical Profession upholds a core set of values [ABIM 2001]:

- Respect
- Trust
- Compassion
- Altruism
- Integrity
- Justice
- Accountability
- Confidentiality
- Leadership

- Collegiality
- Values & Skills expected by Society and Profession
- Commitment to teaching, mentoring, participating & promoting research, collaboration with colleagues & others, and advocating for social justice and the public health.
- Commitment to highest ethical and professional standard, by involving in annual appraisal, revalidation, continuous professional development and taking responsibility for owns health, supporting colleagues and ensuring patient safety.

Conventional model of self-regulation by professionals has failed and felt to be inadequate for the future. Self-Assessment Tool does not necessarily describe actual behaviour and serious concerns have been raised about its ability to generate consistent judgment of clinician's performance, a fundamental aspect of medical professionalism [Eva KW & Regehr G 2005]. David & his colleague in their systemic review noted that in the majority of comparative studies physicians were not able to accurately assess themselves, with little or no association between self-assessment and external assessment. Limitation has been found in self-assessment of professionals, and there had been a need for an external assessment process [Davies DA et al 2006].

There is no single preferred multisource feedback tool to assess professionalism but in general all should fulfil the Principles and Criteria drawn by Academy of Medical Royal Colleges and the GMC. Multisource Feedback tool adapted by Royal College of General Practitioners is used for discussion in this assignment.

MSF is known to measure clinical knowledge, skills, performance, and safety, quality of care, communication with the patient, team, and stake holders and to maintain high level of trust in the profession expected by regulatory, professional bodies, colleagues and members of public. Multisource feedback intent has been to provide professional and developmental guidance for behavioural changes and performance improvement and to assess professionalism and its core value [Bracken 2001, Berk RA 2009]. In medicine, it has been proven to be particularly useful in assessing humanistic, interpersonal and communication skills and collegial components of competence and professionalism [Bo Qu et al 2012, Frank, JR. 2005]. Its reliability and validity has been established, across different clinical settings, across different specialities, and in different parts of the world. [Lockyer JM, Violato C, Fidler H 2006, Violato C, Lockyer JM, Fidler H 2006, Archer et al 2005, Karlijn et al 2005].

Feedback is gathered from peers with similar knowledge and practice and other colleagues that include nurses and allied health professionals. Its aim has been to inform about observable behaviours and performance from different perspectives .Individual physicians are required to rate their own performance, and this will be examined against feedbacks from others to provide an in-put into desired professional and personal developmental plans, to influence changes in clinician's behaviour, thus subsequently enhance performance in all areas [Atwater LE, Brett JF 2005, Handfield-Jones et al 2002, Violato et al 2008a].

Medicine is a now a team sport and using MSF as an assessment tool, most of the team members would provide feedback on individual clinician's clinical practice, and other core values of medical professionalism. Professional competency, organizational skills, listening to the patient, ability to empathize, sympathize and prioritise are core values of professionalism in medicine, and as such this assessment tool provides an opportunity to members of the team to comment on these values in a clinician. However its ability to assess clinician knowledge, skills and performance could be subject to bias, easily influenced by assessors own knowledge, role in a team, assessors own professional background and social desirability factor. Medical science in general and behavioural medicine in particular has been associated with social and cultural factors thus continue to be influenced by values, attitudes, beliefs and ideology [Bouras N, Ikkos G 2013]. The tool also does not have any provision or requirement for the assessor's to endorse their feedback/observations with some example from day to day clinical settings or their interaction with the clinician being assessed but without compromising the integrity and validity of the whole process. These are some of the challenges associated with assessment of professionalism in the clinical setting.

Members of the team provide feedback on the Likert Scale which is widely used to measure attitudes, belief and opinion. The respondent is presented with a statement to indicate a degree of agreement and disagreement in a multiple choice format. It is named after Dr Rensis Likert, a sociologist at the University of Michigan, and first published in Archives of Psychology in 1932 entitled "A technique for the Measurement of Attitudes". Likert scale is easy to construct, understand, read and has been the most universal method for survey collection. The feedbacks are easily quantifiable using the simplest mathematical analysis. But with all its strength, the Likert Scale is uni-dimensional, has central tendency bias, acquiescence bias, social desirability bias, lack of reproducibility and in some cases it may be difficult to validate it. While most of the standardized MSF assessment tool doesn't take long, an average of 6 minutes if assessor has good knowledge of clinician (Wilkinson et al 2008), but time limitation has been an important barrier for low respondent rate in some areas.

In most settings, the clinicians can select their preferred colleagues for feedback. Concerns have been raised about self-selection of colleagues and their ability to provide constructive feedback. Self-selection of colleagues for multisource feedback continues to be a debate, as disappointing feedback was received by clinician's who intentionally selected responders who didn't know them well (Sergeant et al 2005). But Ramsey and colleague didn't find any difference in feedback between self-nominated raters and those selected by a senior colleague thus couldn't establish this positive link between familiarity and scores from the multisource feedback [Hall 1999, Lockyer 2003, Ramsey et al 1993].Therefore it is important to carefully design the whole process so as to minimise selective recruitment of participants. The required frequency of Multisource Feedback [MSF] varies across different speciality, role of a clinician, and duration of placement. It has been recommended to have one per placement for full time trainee, once per year for part time trainee and once every five years for clinician in substantive post as per GMC revalidation requirement. Wright & her colleagues have suggested that at least 15 completed colleague's feedback is required [Wright et al 2012]. But guidelines from RCGPs recommend five clinicians feedback in secondary care and at least 5 clinicians and 5 non-clinicians feedback in the primary care setting.

Large variation in multisource feedback has been reported based on responder's professional background. It has been reported that peer, admin or managers were less likely to raise concerns than consultants or nursing staff [Bullock et all 2009]. Less favourable responses from colleagues were found to be independently predicated by medical professionals having their medical degree obtained from countries outside the United Kingdom, doctors working on a non-substantive post, doctors working as a general practitioner and psychiatrists.

Team working skills, interpersonal skills, communication with patient, colleagues both written and verbal are seen as some of the fundamental component of medical professionalism. With almost 40% of NHS doctors are foreign born ,recommendation has been made to raise the standard of English Language Competency Test to address issues around communication skills and that overseas trainees should be provided with additional training not necessarily captured in International English Language Competency Service (IELTS)Test [Paul et al 2014 & Hashmi A 2009. IELTS may not necessarily identify difficulties with subtleties of language and dialect and doctors understanding of non-verbal communication, social and communication norms. The model of the doctor-patient relationship in the UK is also in contrast to most overseas doctor's country of qualification. In most of these countries, the services are lead and managed independently by the medical professionals, with little or no concept of team work, which is at the heart of medical professionalism to ensure quality of care and patient safety.

Multisource Feedback has been known to contribute into changes in physician behaviours in all areas, with particular relevance to professionalism. It is an important component of learning process and as such an effective tool in providing feedback around core values of professionalism to the trainee doctors. In a study of performance changes over time, the importance of "observability" has been highlighted, and it was noted that the physician being rated was more likely to consider behavioural changes and accept the validity of feedback, if behaviour under question is directly observed by the assessor [Brinkman et al 2007]. Clinical supervisors, Local Clinical Tutors and members of the MDT contribute into MSF, with the whole process overseen by local Deaneries to support trainee doctors and identify doctors in difficulties. Multisource feedback influence behaviour changes among physician, with particular reference to their communication skills, but less likely to be in their clinical competence or any improvement in this area [Sargeant et al 2007]. This is further supported by Tham in his study, as it was suggested that multisource feedback assessments were useful in bringing attention to physicians interpersonal and communication skill, less likely to be identified in self-assessment [Tham 2007].However it is important for the clinician to accept the credibility of the process to assess professionalism, as it has been noted that the perception held by the physicians about accuracy and effectiveness of multisource feedback and credibility of the reviewers influences subsequent practice improvement and professional development [Bing-You & Paterson 1997,Brett & Atwater 2001 ,Sergeant 2005].

One of the limitations of multisource feedback process is that the assessors often don't have any formal training, and as such have no understanding of expectation by different professional and regulatory bodies. The process will become more reliable if training workshops are offered by the organization, to enhance the inter-rater reliability among the participants by presenting case scenario or case vignette. Royal College of General Practitioners have developed training videos for assessors but the focus was noted to more on the process rather than skills required for a

constructive feedback on core values of professionalism. Some of Deaneries however have started offering training around work based assessments and feedback to clinicians involved in supervising trainee doctors and some colleges like RCPCH & RCPsych have produced written guidance on completing MSF.

In general the tool has received commendation from general practitioners, and as such it is useful in assessing the core values of professionalism including confidentiality , respect for the patient , colleagues, communication skills , probity , leadership role in circumstance it is required , the trust ,values, skills expected by the society and the profession. But this tool on its own lack its effectiveness in assessing clinicians/learners commitment to teaching , mentoring ,promoting research , collaboration with colleagues in advocating social justice and public health and their commitment to continuous professional development , some of the core values of medical professionalism laid down by ABIM in 2010. The tool required assessors to comment on clinician's health status, but this is seen as a limitation as most of the team members will not have any knowledge of individual clinician health or health related disabilities or limitations.

Concerns have also been raised about its methodology to identify doctors with poor performance [Hill et al 2012]. Thus Wright and her colleagues remained cautious of using MSF in isolation to make an informed decision about a doctor professionalism and fitness to practice [Wright et al 2012]. Therefore caution should be taken when interpreting feedback regarding doctor's professionalism [Campbell et al 2011]. Campbell & colleagues further emphasized that based on sampling bias some doctors could be at risk of obtaining higher or lower scores thus doesn't necessarily reflect the actual variation between doctors in relation to the core values of professionalism. It has been difficult to evaluate as to what extent these systemic variation in performance of doctors is based on non-clinical factors such as ethnic back ground, and not a usual doctor, is a matter for further investigation and research. Alice and Julian in their systematic review have agreed that multisource feedback leads to performance improvement, but it was noted that individual factors and the context of feedback have a notable effect on the response [Alice & Julian 2010]. More research needs to undertake to evaluate its effectiveness in assessing other core values of professionalism, minimising self-selection bias, and how it influences professional development and further acceptance by the clinicians.

References:

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