

Research paper

Accessibility, feasibility and educational impact of a peer review process for general practitioner consultation skills

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ABSTRACT

Background External peer review of consultations has been available to general medical practitioners (GPs) in the west of Scotland for several years. This study aims to assess the feasibility, accessibility and educational impact of consultation peer review for GPs.

Method An interview guide was developed and an independent researcher used this to interview a sample of 10 GPs who had submitted consultations for peer review in the previous six months.

Results All GPs interviewed felt that there had been educational impact as a result of consultation peer review, the majority had presented this material as part of their annual appraisal and thought that their

appraisal had been enhanced as a result. The process was both acceptable and feasible for the majority of GPs interviewed.

Conclusion Consultation peer review appears to be an acceptable and feasible educational activity, resulting in behaviour change. It may be useful as an alternative to multisource feedback and patient questionnaires in provision of evidence of effective communication skills for annual appraisal.

Keywords: appraisal, consultation skills, doctor–patient communication, patient satisfaction, peer review, revalidation

How this fits in with quality in primary care

What do we know?

Review of videos is an important teaching tool in general practice speciality training (GPST). Peer review has been identified as an effective educational method, providing meaningful feedback resulting in quality improvement for medical practitioners. Once communication skills have been developed they need to be practised or they may wither.

What does this paper add?

Consultation peer review appears to be a feasible and acceptable educational activity for general practitioners (GPs). Consultation peer review can result in behaviour change within the consultation. Consultation peer review can enhance the GP appraisal process. Further work to assess the feasibility, acceptability and educational impact for non-principals and sessional GPs and to define the effect on the appraisal process is needed.

Introduction

It has been clearly established that the delivery of effective doctor–patient communication not only enhances patient satisfaction, but can also lead to improved clinical outcomes.¹ Communication skills

have been recognised as an essential element in delivering high-quality patient care by both the General Medical Council (GMC)² and the Royal College of General Practitioners (RCGP).³ In the GMC's

Revalidation Framework,⁴ doctors are required to provide evidence of effective communication.

In the west of Scotland, established general practitioners (GPs) have been able to submit video recordings of their consultations with patients for external peer review and feedback since July 1999 (Box 1) (Appendix 1). Doctors submitting videos receive written feedback about their consultations using an instrument based on the patient-centred model.⁵ Feedback focuses on communication skills, partnership with patients, health enablement and development of a management plan. These areas correspond to the attributes described by the GMC in *Good Medical Practice*.² The video medium enables feedback to comment about both verbal communication and the often overlooked and important non-verbal aspects of doctor–patient interaction.⁶ Peer review has been identified as an effective educational method, providing meaningful feedback resulting in quality improvement for medical practitioners.^{7,8} It has also been established that once communication skills have been developed, they need to be practised or they may wither.⁹

Previous work relating to this activity has highlighted significant educational benefits, but also identified perceived barriers.¹⁰ Barriers to participation included lack of incentive, concerns about the practicalities of using the video medium, together with a significant level of apprehension that the process was too challenging and that participants may receive critical feedback.

This paper intends to assess the feasibility, accessibility and educational impact of consultation peer review for participating GPs.

Method

An interview guide (Appendix 2) was developed, and refined by four members of an already-established consultation peer review steering group. They employed a Delphi-type exercise to identify questions pertaining

to the accessibility, feasibility and educational impact of consultation peer review for individual practitioners.

A non-clinical independent researcher was appointed to conduct and audio-tape semi-structured interviews using this guide with a sample of 10 GPs, who had submitted consultations for peer review in the previous six months.

A purposive sample of 15 GPs was selected. This sample included similar numbers of male and female doctors, covering a broad age range taking care to select GPs who had consultation skills teaching in medical school or as a GP registrar (GPR) together with those who had not received teaching in this area. Equal numbers of GP specialist trainee (GPST) trainers and non-trainers were selected. For practical reasons, the sample GPs were based no more than 30 miles from the central office in Glasgow. Ten GPs were invited to take part in the study, and were offered a small honorarium for their contribution. If a GP declined to take part, the opportunity was offered to another from the original purposive sample.

The interviews were undertaken at a convenient time in the GP's main workplace.

The interviews were transcribed and analysed using Glaser's constant comparative method¹¹ by the independent researcher.

Results

The first 10 GPs invited to be interviewed accepted, and so those on the reserve list were not required.

The demography of GPs interviewed was as follows:

- 50% male: 50% female
- all were GP principals:
 - three had < 10 years' experience in general practice
 - six had > 10 but < 20 years' experience in general practice

Box 1 Consultation peer review process

- GP prepares videotape of six consultations with patients
- GP reviews consultations
- GP self-reflects upon consultations using patient-centred model
- GP compiles written log
- GP submits videotape and written log
- Videotape reviewed by reviewer with reference to written log
- Written feedback is prepared by reviewer, incorporating areas for development and suggestions for change
- Feedback sent to GP with original videotape
- GP further reviews and reflects upon consultations in conjunction with written feedback

- one had > 20 years' experience in general practice.

Five main areas of interest emerged from the data:

- motivation
- practicalities of making a videotape
- preparation of written submission
- written feedback
- educational impact.

Motivation

Appraisal and future revalidation were motivational factors for all 10 GPs, several of whom simply wanted to assess their own skills, hence reviewing their personal learning needs:

... consultation comes up every five years in the appraisal process. (GP4)

Well these things are quite painful to do ... you are exposing a bit of yourself to the world, so I may not have done it had I not had a hoop to jump through. (GP5)

Potential new GPST trainers in Scotland all submit consultations for peer review; this was the main motivation factor for three of the GPs interviewed:

I was doing the GP trainers' course.... (GP6)

Several GPST trainers were due to be reaccredited as a training practice. In the west of Scotland it is suggested that trainers submit a video of themselves consulting prior to training practice reaccreditation visits:

... we were approaching training practice reaccreditation. (GP4)

Practicalities of making a videotape of GP consultations

Those GPs working in training practices had few practical problems: the practices owned a camera and tripod and had the ability to set a camera up in the surgery; receptionists were proficient in, and happy to explain, consent procedures to patients; and help was on hand from either the GPST or trainer if any problems arose.

... it is something that we have used, particularly for training purposes, over the last 10 years (GP4)

One GPST trainer described how advanced planning helped, but videotaping did add to the complexity of his day:

... you would look to provide slightly more time ... to allow for the consent procedure, setting up ... which slightly reduces my availability for patients. (GP7)

GPs in non-training practices had several hurdles to jump before completion of a videotape. Time was a

particular challenge. A couple of GPs did an extra surgery on their day off, so they could have a little more time.

I came in on a holiday ... (GP2)

I had to borrow a camera ... I'm a bit of a technophobe. (GP8)

Some patients were consented (by receptionist) and some were not, so I had to double check. (GP7)

Some GPs videotaped a normal surgery, without editing:

I tried to keep it as real as possible. (GP5)

I didn't in any way tart up the process. (GP3)

Others selected an acute surgery, which tended to include patients with first presentation of illness rather than those revisiting with chronic problems.

I did 'on the day' type people. (GP2)

Patients seemed happy to help.

... mostly people just seem to forget it is there. (GP2)

Once it was explained to them (patients) that it was to help the doctor to improve, I think most were happy to oblige (GP6)

Preparation of written submission

Most GPs felt that preparation of the written submission took a considerable amount of time:

... you have to look through each consultation once, possibly twice, to analyse, jot down ideas and step back to make it useful. (GP7)

... you not only have to transcribe the tape, but look at it and reflect upon what you would do differently, and what the learning points are. (GP10)

One GP was aware that he could learn more by submitting a consultation he perceived to be difficult.

I felt comfortable enough to pick a really difficult consultation ... I know it's just other GPs looking at this ... (GP6)

Several GPs, mainly the GPST trainers, realised that they learned a lot by viewing and reflecting on their consultations:

I saw myself not giving the patient long enough to talk without interruption. (GP2)

... it was more (the) doctor-patient issues that were quite revealing (GP9)

... what I had actually done was remember to use the methodology that I was supposed to be putting into practice ... so that actually made me change. (GP4)

Most felt that the learning log was helpful in organising their self-reflection.

... it broke it up into manageable categories that you could get a grasp of ... (GP6)

... it focused what you were writing about, otherwise where would you start? (GP8)

Some found the learning log a challenge:

... at this point in my professional career, I'd have much rather written prose. (GP1)

People tend to do themselves down a bit and think they are worse than they actually are. (GP5)

Written feedback

For many, the written feedback was reassuring, often confirming what the GP had noted on self-reflection.

... somehow, someone else saying that is reassuring ... (GP10)

I had anticipated most of the issues. (GP9)

... essentially, we practise behind closed doors, there aren't many opportunities for an experienced peer to actually look at your work ... in terms of actual communication skills this is pretty unique. (GP7)

Some were pleased that the reviewers had noted extra areas for development, and found feedback useful because it was specific.

I suppose it is the things that I hadn't recognised that are the most useful ... I have subsequently tried to alter and fine tune some things... (GP7)

... someone had taken the time, and had come up with things that would help me specifically. (GP6)

GPAQ (General Practice Assessment Questionnaire) feedback didn't mean very much, this was more specific. (GP6)

One GP found the feedback unhelpful:

... there is no real understanding that you have seen this patient every week for the last 10 years ... (GP8)

... the tendency with the feedback is to skim over the bits you are doing well and pick out the few wee bits where there was room for improvement. (GP8)

Although there were some valid points, overall I don't really want to change my consultation style. (GP8)

GPs were not happy when feedback ventured into clinical territory:

... the things that were contentious were when the feedback was directed towards clinical management. (GP7)

Several GPs suggested that they might have learned more from group or face-to-face feedback:

... you learn not only about yourself, but from watching other people. (GP10)

... it might be more constructive to do it live rather than on a cold bit of paper. (GP1)

Others felt, from previous experiences, group feedback could be more threatening, and less helpful.

There were one or two glaring errors (on another GP's tape) but I didn't feel able to say in a group setting, so he did not learn anything. (GP5)

Educational impact

All 10 GPs considered that they had learned something that had resulted in altering their behaviour during their consultations, either from their self-reflection or from the written feedback. Several commented on being aware of the importance of focusing on patients' ideas, concerns and expectations early on in the consultation, almost half recognised that they should allow the patient to speak and try not to interrupt. A number felt that the importance of structure in the consultation had been reinforced and two others indicated their future intention to give patients more choice in management issues.

Six of the 10 GPs interviewed said they would resubmit consultations for review in the future:

... one of the merits of doing it twice is that you change in that period ... the mistakes you make are different ... (GP5)

... this is something if you had the time you would want to do several times. (GP3)

Of the four who would not resubmit, one was an experienced GP who felt that she had other more pressing future learning needs.

I would be on relatively non-challenging ground ... I need to do other things ... (GP9)

The GP who had found the feedback unhelpful felt that it was a lot of work for little benefit:

Overall, I think the gain didn't necessarily outweigh the stress and the time and the hassle. (GP8)

Five of the 10 GPs had already used their feedback to discuss communication skills core category with their appraiser, a further three (8/10) intended to discuss their feedback at their next appraisal.

Four of the five GPs who had already discussed their feedback at their appraisal interview felt that the appraisal process had been greatly enhanced, with more development opportunities as a result of discussion of their consultation feedback.

One GP felt that the discussion at her appraisal interview had not been worthwhile:

... essentially, we are both talking about a letter, it says nothing really. (GP8)

Discussion

Main findings

The process of consultation peer review was both acceptable and feasible for the majority of GPs interviewed. All GPs considered that there had been an educational impact, and the majority of those who had discussed this evidence at their appraisal thought that the appraisal process had been enhanced as a result.

Strengths and limitations

Direct observation of performance in daily practice is of high validity,¹² as it closely replicates the real professional world.¹³ Peer review of video is both more feasible and less costly than either direct observation of standardised patients¹³ or employing reviewers to directly observe doctors in their surgeries. Although it is possible that there is an 'audience effect' for both GPs and patients when consultations are recorded, it is likely that this is less so than if a reviewer was physically present in the consulting room.

The GPs interviewed had all voluntarily submitted a video for peer review, which demonstrates that they considered this to be a feasible educational activity. Recruitment from this purposive sample of GPs who had already submitted a video may well have produced different results from those we would have obtained from a random sample of GPs. In addition, it should be noted that this group of GP principals took part in an educational exercise which is not common practice for established doctors, and that this activity was undertaken voluntarily. The voluntary nature of the activity is likely to influence how participants viewed the process and the feedback provided. In recent years, the demographic of the GP workforce has changed significantly with many doctors having a portfolio career and there has been a significant increase in the number of non-principals. As a result, there may be difficulties in extrapolating these results to the GP population as a whole. Although the comments were mainly positive, particularly with regard to educational impact, one participant did not feel that this was a worthwhile exercise, it may have been useful to explore this perception more fully beyond the criteria of the interview guide. Although a minority, the opinions expressed should not be discounted as these reservations may be representative of the wider GP population.

All GPs did manage to make a videotape, although a number found that this was not possible within their usual working day. Those GPs working in a training environment found the process of videoing their

consultations less problematic. Experience indicates that this activity becomes easier with practice, but it would be helpful if some of the practical difficulties could be removed from the process for participants. Previous Dutch work describes the installation of equipment in surgeries of participating GPs by trained operators thus reducing the hassle factor.¹⁴ It became clear that those GPs who had experience in reviewing consultations, either in their role as a GPST trainer, or because they had recently been a GPST themselves found self-reflection easier, and appreciated that it could be a powerful learning tool. With only one exception (GP8), the GPs found their feedback helpful, reassuring and specific. All were happy with the comments about communication skills, but less so when feedback discussed clinical management. All 10 GPs appreciated that they had altered their behaviour whilst consulting as a result of this activity. The majority of the GPs had either used or intended to use their feedback as evidence during their appraisal and on reflection considered that the appraisal process had been enhanced as a result of this form of feedback. Previous research has indicated that appraisers also considered the appraisal process to have been enhanced by the provision of externally peer-reviewed evidence.¹⁵

Cost and resource issues were unfortunately not assessed as part of this study. Costs for video review would include initial purchase of a video camera, administrative costs relating to the safe transportation of videos and reimbursement for the reviewer preparing written feedback. The process should also be acceptable to patients. Although this issue was not considered as part of this study it has been established previously that, provided appropriate informed consent is obtained, videotaping consultations appears to have no detrimental effect on patient satisfaction.¹⁶ Obtaining informed consent from patients did not appear to be a barrier, although this was not studied formally.

The future

Consultation peer review appears to be an acceptable and feasible educational activity for the majority of GPs sampled, and has resulted in behaviour change. This is a credible activity which is useful both educationally and as a marker of quality improvement and good medical practice. The process would be less onerous for GPs if protected time was available and technical help was to hand. In the latest Good Medical Practice framework for appraisal and revalidation⁴ there is significant emphasis on utilising multisource feedback (MSF) and patient questionnaires to provide evidence of effective communication skills. This may prove to be very difficult for doctors who work in small practices or who work in a number of different settings.

Peer review of consultations offers an alternative method of providing this evidence. Further work with non-principals and sessional GPs would be required to ensure these findings can be replicated.

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ETHICAL APPROVAL

This study was approved by Scotland A Research Ethics Committee, Edinburgh.

PEER REVIEW

Not commissioned; externally peer reviewed.

CONFLICTS OF INTEREST

The author manages Consultation Peer Review Group.

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Appendix 1

LOGBOOK

CONSULTATION NUMBER

Please use this sheet when reviewing each consultation prior to submission. Consider each of the areas Communication, Partnership, Health Enablement, and Management Plan – rate your consultations 1–5 (poor-excellent) by circling the appropriate number and carefully explain your reasons for this choice in the space provided. The reviewer will use this information when formulating feedback.

Communication

Explain	1	2	3	4	5
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Partnership

Explain	1	2	3	4	5
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Health Enablement

Explain	1	2	3	4	5
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Management Plan

Explain	1	2	3	4	5
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Summary of learning points in this consultation

Knowledge – learning needs identified

Interview questions

Proposed topic/questions	Comments
ACCEPTIBILITY	
1. Not many GPs have videotaped themselves in the surgery can you tell me what prompted you to submit a videotape of consultations for peer review?	Own idea, Asked to by higher authority Trainer, potential new trainer For appraisal
2. Can you tell me a bit about your experience in taking part in this educational activity?	
3. Have you used any other method to assess your consulting skills? (most principals will have used GPAQ) How does this activity compare?	Try to find out what they have changed as a result of each intervention
FEASIBILITY	
4. What was your experience re the practicalities of making a videotape of consultations?	Probe re any difficulties e.g. access to camera, layout of room, successful recording of consultation
5. Did you find there were any ethical issues you had to consider before embarking on this activity?	Confidentiality of doctor Confidentiality of patient Informed consent, explaining to staff Informed consent, explaining to patient Examinations off screen
6. Were there any time issues for you as a result of preparing this tape for submission?	Preparation time Consulting time Technical time transferring onto VHS tape Writing submission log
7. Would DVD have been easier?	
8. How did you find the process of completing the self reflective log? Did anything in particular make this easy/ difficult?	Probe for problems with paperwork, and attitudes
9. How did you deliver the tape to 2CQ?	Hand delivery, recorded postal delivery
EDUCATIONAL IMPACT	
10. Tell me, did you learn anything about your consulting when viewing your consultations and completing the self reflective log? If so, has there been any change in your consulting as a result	Find out if GP felt he/she had skills to self reflect.
11. Was the written feedback useful?	Did it address the concerns you identified in your log? Were there any suggestions for change? Were these suggestions appropriate? Did you feel the suggestions were helpful?
12. What was the value of this feedback? What was good, what was not so helpful?	
13. Has your consulting style altered as a result of this activity? If so, how?	Find out any specific changes, ask for at least one change.
14. Have you used any other method to assess your consulting skills? (most principals will have used GPAQ) How does this activity compare?	Try to find out what they have changed as a result of each intervention

Proposed topic/questions

Comments

GENERAL

15. Did you discuss this educational activity at your appraisal?

16. Did this discussion make a difference to the quality of your appraisal

Probe to find out if discussing video feedback enhanced / detracted from appraisal process

17. Do you intend to submit a tape in the future, if so when?

Probe to find out why/ why not

18. Would you recommend this activity to a colleague

Probe to find out why/ why not