THE EFFICACY OF MULTISOURCE FEEDBACK TOOLS TO ASSESS CLINICIAN'S PROFESSIONALISM

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ABSTRACT

Doctors have long been considered to be trustworthy amongst the public. This stems from the perception that they are professionals and follow a core set of values. Although many doctors will be professional in their conduct, there will be individuals who do not adhere to these values. Assessment systems need to put into place to ensure that all doctors within the defined occupational group are assessed for their professional behaviour. One attempt at the latter has been the Multi-Source Feedback Tool (MSF). The MSF is a structured assessment tool that is sent to a pre-defined number of fellow health professionals that is completed by them and serves to provide both a quantitative and qualitative assessment of one's clinical professionalism. There needs to be increased awareness of the benefits of MSF tools in Pakistani medical institutions. We also feel that more research is needed to augment its effectiveness in assessing professionalism.

KEY WORDS: Professionalism (MeSH); Feedback (MeSH); Ethics, Professional (MeSH); Multi-Source Feedback (Non-MeSH); Pakistan (MeSH).

THIS ARTICLE MAY BE CITED AS: Gul M, Hassan H. The efficacy of multisource feedback tools to assess clinician's professionalism. Khyber Med Univ J 2017; 9(3): 157-161.

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Date Submitted: August 26, 2016

Date Revised: August 29, 2017

Date Accepted: August 30, 2017

INTRODUCTION

Professionalism has been philosophically termed as a set of skills and habits resulting from basic relationships in human interaction.[1] 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".[2]

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. 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. This forms the basis for a moral contract between the medical profession and society.[3] 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 as well as law have been under the hammer, challenged by the politicians, the public and other stake holders. The Pakistan Medical and Dental Council dictates that clinicians need to uphold the principles of honesty and justice.

Clinicians must be working with colleagues in ways that best serve patient's interests and not to discriminate others based on "class, caste, colour, religion, sex, ethnicity, occupation, creed, religion and social status".[4]

The American Board of Internal Medicine states that medical professionals need to uphold a core set of values[5]:

- Respect
- Trust
- Compassion
- Altruism
- Integrity
- Justice
- Accountability
- Confidentiality
- Leadership
- Collegiality
- Values & Skills expected by Society and Profession
- Commitment to teaching, mentoring, participating and promoting research, collaboration with colleagues and 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 one own health, supporting colleagues and ensuring patient safety.

Attempts to assess health professionals against such criteria can be challenging in the clinical setting. 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.[6] David and his colleagues 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.[7]

The multisource feedback (MSF) assessment process has been widely adopted in the United Kingdom (UK). For example, it is used by United Kingdom foundation programme, Royal College of Psychiatrists and Royal College of General Practitioners. There is no single MSF tool used by all medical education institutions in the United Kingdom to assess professionalism but in general all should fulfil the principles and criteria drawn by Academy of Medical Royal Colleges and the General Medical Council (GMC), UK. Examples of MSF tools used by clinical institutions such as from select Royal Colleges in the United Kingdom can be found freely online by the public. These tools from the different institutions are very comparable in terms of the modality being assessed. There is an awareness of the MSF process within Pakistan but its use is not as widespread. In the MSF tool information is gathered from peers with similar knowledge and practice as well as 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 is examined against feedback from others. This is to provide an input into desired professional and personal developmental plans, to influence changes in clinicians' behaviour and thus subsequently enhance performance in all areas.[8-10]

Medicine is a now a team sport and requires involvement of a multi-disciplinary team comprising of health professionals from a wide range of specialities. Using the MSF as an assessment tool allows these assessors from different backgrounds to comment on issues of professional competency, organisational skills, listening to patients, ability to empathize and sympathize from the frame or perspective of that particular professional group. In the MSF tool members of the team provide feedback on the Likert Scale. The respondent is presented with a statement to indicate a degree of agreement and disagreement in a multiple-choice format. The tool 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".[11] The required frequency of conducting MSF assessments varies across different specialities and depend on the 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 and her colleagues have suggested that at least 15 completed colleagues' feedbacks are required.[12] However, guidelines from Royal College of General Practitioner (RCGPs) recommend five clinicians feedback in secondary care and at least 5 clinicians and 5 non-clinicians provide the feedback in the primary care setting.

Team working skills, interpersonal skills, communication with patient, colleagues both written and verbal are seen as some of the fundamental component of medical professionalism and are key modalities assessed for in the MSF. The model of the doctor-patient relationship in the UK is also in contrast to most overseas doctors' 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. This can prove to be a challenge for overseas Doctors. With almost 40% of NHS Doctors being foreign born, level?? raise the standard of English Language Competency Test to address issues around communication skills and that overseas trainees should be provided with an additional training not necessarily captured in International English Language Competency Service (IELTS) Test.[13] IELTS may not necessarily identify difficulties with subtleties of language and dialect and doctors understanding of non-verbal communication, social and communication norms.

BENEFITS OF MSF

MSF is known to measure elements of clinical knowledge, skills, performance, safety and quality of care. It will also measure communication with patients, team, and stake holders. The object of this is to assess and maintain a high level of trust in the profession expected by professional bodies, fellow colleagues and members of public. The MSF's intent has been to provide a professional and developmental guidance for behavioural changes and performance improvement.[14,15] In medicine, it has been proven to be particularly useful in assessing humanistic, interpersonal and communication skills and collegial components of competence and professionalism.[16,17] Its reliability and validity has been established across different clinical settings and across different specialities and is used in different parts of the world.[18-20] MSF has been known to contribute to positive changes in a physician's behaviours in all areas, with particular relevance to professionalism. A Pakistani prospective study that incorporated MSF into postgraduate doctors into their training, at a teaching hospital in Lahore, found a global improvement in their conduct in all core domains related to professionalism.[21]

MSF is an important component of the learning process and as such an effective tool in providing feedback around core values of professionalism to trainee doctors. In another 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.[22] In this scenario, the behaviours under question were directly observed by the assessor.

Clinical supervisors, local clinical tutors and members of the multi-disciplinary team contribute into MSF, with the whole process overseen by local Deaneries to support trainee doctors and identify doctors in difficulties. This is a comprehensive process that is unique and not found in other types of assessment tools or processes. Conducting competency tests can be challenging in busy healthcare institutions. The MSF tool is very quick to complete by the assessor and is typically delivered by electronic systems such as email within the electronic portfolio network. The latter also serves to reduce the risk of fraudulent activity and improve the credence of the information gathered. In addition, the MSF tool being a Likert scale is easy to construct, understand and read. It is one of the most universal methods for survey collection. The feedbacks generated are easily quantifiable using the simplest mathematical analysis. The analysis of which is typically automatically generated using computerised software.

LIMITATIONS OF MSF

With all its strength, the Likert Scale is unidimensional, has central tendency bias and social desirability bias.[23] There may be a lack of reproducibility. Moreover, large variation in multisource feedback has been reported based on the responder's professional background. It has been reported that peer, admin or managers were less likely to raise concerns than consultants or nursing staff.[24] In addition, less favourable responses from colleagues were found to be independently predicated by medical professionals having their medical degree obtained f

rom countries outside the UK, doctors working on a non-substantive post and doctors working as a general practitioners and psychiatrists. The tool's ability to assess clinician knowledge, skills and performance could be subject to bias, easily influenced by the assessor's own knowledge, role in a team, assessors own professional background and social desirability factor. Medical science in general and behavioural medicine has been associated with social and cultural factors thus continue to be influenced by values, attitudes, beliefs and ideology.[25]

Another limitation of MSF 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 or by presenting a case scenario or case vignette. The Royal College of General Practitioners have developed training videos for assessors but the focus was noted more on the process rather than skills required for a constructive feedback on core values of professionalism. Some Deaneries however, have started offering training around work based assessments and feedback to clinicians involved in supervising trainee doctors and colleges like the Royal College of Psychiatrists have produced written guidance on completing MSF.

DISCUSSION

There is a demand from regulatory authorities that health professionals maintain professional standards. Whilst clinicians must complete standardised examinations to demonstrate clinical competencies, there needs to be an assessment process to determine the level of non-theoretical competencies doctors need to practice safely and effectively. The MSF tool is an attempt to ascertain this and this article has looked at the pros and cons of this assessment process. We feel that the MSF is a positive step to addressing the latter needs: that its use needs to broaden within Pakistani medical institutions but there is still room for improvement. Firstly, with regards to the actual process of assessment, in most settings where MSF have been used, 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 clinicians who intentionally selected responders who didn't know them well.[26] On the other hand, Ramsey and colleagues 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.[27-29] Therefore, it is important to carefully design the whole process to minimise selective recruitment of participants.

Secondly with reference to the content of the MSF tool, it does not require the assessor to endorse their feedback with some examples from day to day clinical settings, the opportunity is there on an optional basis. Additional comments in this section may serve to highlight exceptional acts of positive conduct within the clinical setting. One may argue that the current approach might restrict useful information from being noted so we would recommend that more emphasis is put into this domain and specifically request from the assessor to note any behaviours where one has gone beyond his expectations or conversely has been detrimental to the delivery of care. Also, the MSF tool addresses core values of professionalism including confidentiality, respect for the patients, colleagues, communication skills and probity. However, this tool on its own lacks its effectiveness in assessing a clinician's commitment to teaching, mentoring, promoting research and collaboration with colleagues in advocating social justice. These are some of the core values of medical professionalism laid down by the American Board of Internal Medicine (ABIM).[5] In addition, the tool requires assessors to comment on the clinician's health status, but this is seen as a limitation as most of the team members will not have any knowledge of individual's health or know about health-related disabilities or limitations.

In terms of improving healthcare services, MSF can influence behaviour changes among physicians, with particular reference to their communication skills but it was less likely to be used in their clinical competence.[30] The former 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 skills.[31] In comparison, this was less likely to be identified in self-assessment. To ensure improvements in professionalism, it is important for the clinician to accept the credibility of the assessment process, as this influences subsequent practice improvement and professional development.[26,32,33]

The MSF should not be used alone when assessing a clinician's conduct. Wright and her colleagues remained cautious of using MSF in isolation to make an informed decision about a doctor professionalism and fitness to practice.[12] Campbell and 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.[34] Moreover, it has been difficult to evaluate as to what extent systemic variation in performance of doctors is based on non-clinical factors such as ethnic back ground or substantive nature of clinical placement and this is a matter for further investigation and research. More research needs to be undertaken to evaluate its effectiveness in assessing other core values of professionalism, minimising self-selection bias and encourage assessors to highlight specific examples of exemplary work or conversely highlight areas of poor practice. Overall, MSF is a useful tool to assessing a clinician's professionalism, we would encourage its uptake into medical training programmes globally especially in Pakistan and support the need for further research to improving its efficacy in determining its stated objectives.

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AUTHOR'S CONTRIBUTION

Following authors have made substantial contributions to the manuscript as under:

MG: Concept, Literature search, drafting the manuscript, final approval of the version to be published

HH: Drafting the manuscript, final approval of the version to be published

Authors agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

CONFLICT OF INTEREST
Authors declared no conflict of interest
GRANT SUPPORT AND FINANCIAL DISCLOSURE
NIL