

Pilot study of 360° assessment of personal skills to inform record of in training assessments for senior house officers

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The assessment of a trainee doctor's human skills, including teamworking, communication and maintaining trust, is difficult but necessary to confirm competence and to alert trainees and trainers of potential problems before they become intractable. This study used 360° team observation reports for this purpose. The process was easy to administer and valued by trainees.

Since 1996, specialist registrars (SpRs) in the UK have undergone an annual review of their progress during training, recorded on a record of in training assessments (RITA) form (Department of Health, 1998). Through these annual reviews, SpRs may 'pass' and progress to the next year of the programme. In the final year of the programme, a certificate recording the successful completion of specialist training is awarded.

It is anticipated that senior house officers (SHOs) will soon be required to undergo similar annual reviews of training assessments. The Conference of Postgraduate Medical Deans (COPMeD) has drawn up guidance and has produced a draft form to record reviews of SHOs' progress (unpublished communication, COPMeD, 2000). The recommended categories for assessment were drawn from the General Medical Council's (1998) booklet *Good Medical Practice*.

The categories on which SHOs are to be assessed are as follows:

- Good clinical care
- Communication skills
- Team working
- Maintaining good practice
- Maintaining trust.

Only the first is strictly clinical. The others describe generic, mainly inter-

personal, skills. These can be assessed by observation of behaviour in daily performance by a number of suitable observers (other doctors, nurses, trainees and other professionals) and over as long a period as practicable. This is known as 360° assessment.

360° feedback is increasingly used in industry to assess performance, to encourage improvements in worker performance and to inform decisions on promotion, assignment allocation and succession planning. The requirement is that raters are knowledgeable about the individual and are people whose opinions are valued by the individual and the organization (Tornow, 1993). Subordinates, peers, senior staff and customers all fit this description and are suitable raters of a worker's performance (Bracken et al, 2001).

This method of assessment has been validated. Church (2000) showed, in a global health services organization in the United States, that multi-rater peer reports on senior managers reliably correlated with manager performance as judged by independent appraisal-based measures.

Paget et al (1996) developed a system of multidisciplinary peer review for assessing physician performance, which is used by the Royal Australasian College of Physicians. In the USA, Ramsey et al (1996) and Wenrich et al (1993) involved nurses and other health workers in a similar method to assess the performance of practising physicians. These studies recommended approximately 10 to 15 responses per physician to ensure reliability. This system of assessment by gathering work-

ing colleagues' views has been shown to be acceptable and reliable.

The authors evaluated the practicality and acceptability of a 360° system of information collection to provide information for completion of a RITA form at George Eliot Hospital, a district general hospital in England. The study included 36 SHOs in nine different specialities during December 2000 and January 2001.

METHOD

Of the 36 SHOs at the trust 35 were informed of the pilot study (one psychiatry SHO could not be contacted) and told that their involvement was voluntary. Two declined to undergo the process and one agreed but then took unexpectedly long leave so was not included.

Speciality SHO programme directors distributed a pack of ten 360° 'personal section: team observation' forms (*Figure 1*) to each SHO in their division. The SHOs were instructed to choose ten fellow workers to complete a form about them and to send it to the postgraduate centre. Each SHO's forms were kept in a separate folder.

The raters chosen by the SHOs had to include at least five nurses and two other doctors. Other health-care team members, e.g. therapists, laboratory staff and secretaries, could also be chosen. All were required to identify themselves on the completed form. If a rater felt that he/she had insufficient knowledge of the SHO to give an opinion in a particular area, he/she was asked to indicate this on the form. Consultant trainers and other senior doctors completed the 360° 'clinical section' forms (*Figure 2*).

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West Midlands PMDE SHO RITA
Personal section : Team observation form

Name of SHO..... Date.....

PERSONAL PERFORMANCE (medical, nursing and other staff to score) Mark

- Motivation: punctual, responds to urgent calls promptly, enthusiastic
- Communicator: communicates well with relatives and patients, treats them with respect, conveys distressing information sensitively. Justifiably inspires trust
- Caring team worker: supports medical, nursing and other colleagues willingly; communicates well with them (verbal and written); respects their competencies. Willingly covers colleagues
- Polite, tidy, pleasant
- Response to and ability to deal with pressure and high workload
- Leadership: appropriately ambitious, inspires other health-care workers

Any other comments

Marks: A Good
 B Satisfactory
 C Needs some attention because

 D Unsatisfactory. Needs urgent attention because

(Use overleaf for more detailed comment as required)

Signature of reporter.....

Position held at Trust.....

Figure 1. 'Personal' assessment form completed by team members.

The completed forms provided the principal information required to issue formal RITA forms in subsequent meetings with each SHO. An overall A or B grade was awarded to those SHOs with scores of A or B in all or nearly all of their 360° forms. A score of C ('needs some attention, because...') in one category by up to 2 raters was accepted as satisfactory when 8 other raters gave A ('good') or B ('satisfactory') for that category. Such scores were always discussed with the SHO at the subsequent meeting.

SHO RITA meetings were conducted with two consultants, neither of whom were currently working with the SHO being assessed. After viewing each SHO's 360° forms, log book and study leave record, the two consultants agreed on the category scores in private. The SHO then joined them to receive a verbal résumé of the results but was not told which raters had given which scores. Commendations and advice were given as appropriate, but the process was not treated as an appraisal. (Issues such as career goals, documented setting of further learning objectives and study leave plans were not discussed, these being part of the agenda for the SHO's next meeting with his/her educational supervisor.)

On leaving the meeting, SHOs were asked to fill in an anonymous questionnaire giving their views about the practicalities and value of the process. This asked whether they found the process of distributing the 360° forms practical, whether they thought the system of assessing personal qualities is fair (accurate), and whether they found the process helped their own development. They were also asked to add any comments they had on this RITA process.

RESULTS

Thirty two out of 36 (89%) of the SHOs took part in the collection of assessments (Table 1). Two had declined the process and two others did not take part

Figure 2. 'Clinical' assessment form completed by supervising doctors.

West Midlands PMDE SHO RITA
Clinical section

Name of SHO..... Date.....

CLINICAL (senior doctors to comment) Mark

- History and examination skills
- Use and interpretation of investigations
- Medical knowledge
- Clinical intelligence — forms appropriate diagnosis and management plans
- Able to summarize and present cases clearly
- Clinical procedures — practical skills, surgical skill (if relevant)
- Appropriate prioritization and requests for assistance
- Response to and ability to deal with pressure and high workload
- Attitude to education: constructive attitude to clinical mistakes, attends educational meetings, reads around the subject, responds well to teaching, involved in clinical audit
- Promptly attends to routine tasks (KMR1 forms, outpatient letters, discharge summaries, death certificates, TTOs)
- High-quality letters, summaries, notes

Any other comments

Marks: A Good
 B Satisfactory
 C Needs some attention because

 D Unsatisfactory. Needs urgent attention because

(Use overleaf for more detailed comment as required)

Signature of reporter.....

as discussed above. Twenty nine of the 32 (91%) completed the process with a meeting, three being absent on leave at the end of their placements.

The response rate to the questionnaire evaluating the process was 23 out of 29 (79.3%) (Table 2).

The number of forms returned per SHO was 10 each in the specialities of general surgery, obstetrics and gynaecology, and plastic surgery (Table 1). This was the recommended number for the assessment to be reliable (Wenrich et al, 1993; Ramsey et al, 1996). Some SHOs in other specialties returned fewer completed forms, but most almost achieved the required number. The team workers chosen by SHOs to complete their 360° forms were from a wide range of health-care groups (Table 3). Only two cases of pairs of SHOs completing forms for each other occurred, suggesting that collusion was not a serious problem.

All SHOs were assessed as performing well. None received less than an overall B grade on their RITA form.

SHOs were happy with the process and the great majority found it practical,

a fair assessment of their personal qualities and helpful to their further educational development. The questionnaires completed by the SHOs after the RITA meetings were anonymous, but only one reported that the process had not been helpful for his/her future development (Table 2). Those finding it helpful must have included some who learned that in some categories one or two of their raters had suggested that they 'needed some attention, because...'. None received an overall C or D grade, so it was not possible to determine how this might have affected their perceptions of the process and its fairness.

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DISCUSSION

This pilot study has shown that a 360° system for gathering information on SHO performance in a number of humanistic areas for a RITA process is practical and acceptable to SHOs. Most also found the process fair and helpful for their future development.

The finding that no SHOs scored low enough to justify an overall C or D

score on their RITA form raises concern that the system could fail to identify poor performers at all and that team observers might be reluctant to give low scores. The number of SHOs included in the study, however, was probably too small to justify an assumption that some SHOs were likely to have had poor attitudes which were not picked up by this assessment.

Team observation (360°) reports have been used in the speciality of obstetrics and gynaecology for some years to inform the RITA process for SpRs. They give valuable guidance to trainers and trainees. Nurses and midwives have not proved reluctant to award low scores to trainees when necessary. In a review of 3386 team observation reports, there were numerous instances of low scores being awarded by nurses for poor attitudes among SpRs (L Wood, personal communication, 2001).

Peer review by the medical team and by multidisciplinary workers was

TABLE 1.
Senior house officers (SHOs) taking part in the SHO record of in-training assessment process, by speciality

Speciality	Total SHOs in speciality	Total SHOs taking part	SHOs having face-to-face interviews	Mean no of 360° forms per SHO
Accident and emergency	5	4	3	5.3
Anaesthetics	4	4	4	8.0
Medicine	6	6	5	8.2
General surgery	3	2	2	10
Obstetrics and gynaecology	5	5	5	10
Paediatrics	6	6	6	7.3
Plastic surgery	2	2	1	10
Psychiatry	1	0	0	0
Trauma and orthopaedics	4	3	3	9.7

TABLE 2.
Results of the questionnaire to SHOs on the RITA process (based on the 23 responses out of 29 SHOs interviewed)

Category	Yes	No	Chi-square	Probability
Process of 360° forms is practical	18	5	12.5217	0.0005
Fair assessment of your personal qualities*	18	4	15.3636	0.0001
Helpful to your further development	22	1	34.7826	0.0000

RITA = record of in training assessment; SHO = senior house officer. *question unanswered by one respondent

TABLE 3.
Numbers of 360° forms completed by each category of health-care worker

Clinical forms	
Consultants	31
Clinical assistants	1
Personal forms	
Consultants	9
Staff grade doctors	12
Clinical assistants	3
Specialist registrars	10
Trust doctors	2
Other senior house officers	28
House officers	8
Ward clerks	9
Hospital managers	11
Medical secretaries	15
Postgraduate centre manager	1
Staff nurses	40
Nursing sisters	31
Specialist nurses	1
Nurses (unspecified)	54
Midwives	15
Health-care support workers	10

authoritatively recommended by Jolly and Grant (1997) as a reliable approach to the difficult task of assessing personal skills in training grade doctors, but it has not been widely adopted in the UK.

Not all aspects of performance can reliably be assessed by supervising consultants alone. Other health-care team members are in more frequent contact with SHOs and often see them working under stress and in routine interaction with patients, relatives and other team members. They are better placed to recognize and rate the quality of communication, teamworking and respect for patients that an SHO demonstrates in daily work (Ramsey et al, 1996).

It is an educational axiom that assessment drives learning and achievement, so trainees focus on objectives they will have to prove they have met in a later assessment. It seems likely, therefore, that knowing in advance that they will be assessed as a teamworker, as a communicator, as trustworthy and as responsible for their own education will encourage SHOs to improve in these attitudinal areas.

A further advantage of 360° team observation reports for the assessment of personal skills is its practicality and ease of administration. Other methods for the competence assessment of patient and relative communication skills are valid and reliable, e.g. objective structured clinical examinations (OSCE) using standardized patients (experienced patients or actors primed to provide standardized clinical histories or to simulate situations requiring skilled handling by clinical staff) and video recordings of consultations (Aspergen, 1999; Fuller and Smith, 2001). These, however, require an infrastructure beyond the means and time available to most clinical teaching units in the UK.

The authors are not aware of valid methods other than 360° reports for the assessment of the skills of communication within the clinical team, of teamworking in general and of maintaining trust. The highest level of evidence of attainment of a skill is the demonstration of the behaviour in routine daily practice, i.e. performance in vivo. Performance assessment has, therefore, much to commend it. Indeed, it can be

argued that it would not be valid to sign off an SHO as competent in these areas without asking the health workers with whom he/she works for their views.

For the assessment of clinical skills and knowledge, methods available include observed practice, casenotes review, OSCE, multiple choice questions and critical incident audit (Newble, 1983). Knowledge, skills and attitudes must be assessed (Bloom, 1956) and both competence and performance evaluated. It should be remembered that no one method can assess all the domains of learning.

This pilot study indicated that there were no serious shortcomings among the SHOs assessed by this method, with rater reports usually concurring. In the event of more than two adverse reports on an SHO in any performance category, it is intended that more detail will be sought in private from raters giving low scores. Further reports will then be obtained from a group of co-workers selected by the clinical tutor and training programme director in the speciality to provide more detail on the SHO's performance. The initial round of information gathering should be seen as a screening process, to be followed by a more detailed collection of information if concerns are revealed.

If an SHO failing the assessment appeals against the result, he/she should be allowed to see the reports personally, the issues having been previously discussed with the raters themselves. All the 360° forms are signed by the rater, and low scores will require justification by raters if they lead to a fail.

The authors regard this system of assessing personal skills as 'work in

progress'. It is their intention to learn from the pilot study to make the process as user-friendly as possible.

CONCLUSION

It will soon be mandatory for all SHOs to undergo assessments of personal skills for a RITA process. 360° assessment is an acknowledged way to do this. This pilot study indicates that such a system can be both practical and acceptable to trainees in a district general hospital setting. **HM**

Conflict of interest: none.

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KEY POINTS

- It is expected that from 2002 senior house officers (SHOs) will undergo annual reviews of assessments of them in several specified areas of personal skills. A satisfactory record of in training assessment (RITA) will be required for the revalidation of training grade doctors.
- Those signing an SHO's RITA form will need real evidence that they have demonstrated competence in the specified areas.
- Valid assessment of personal qualities, including teamworking, communication skills and trustworthiness, can be made by team observation reports (360° assessment) of SHO performance.
- Despite predictions of administrative difficulties, the pilot study reveals that such a system is both easy to administer and acceptable to the trainees.