

## RCGP Report on Tayside Revalidation Study

### 1. EXECUTIVE SUMMARY

#### 1.1 Introduction

60 Tayside GPs were recruited into a revalidation study which aimed to explore the value of a prescribed portfolio of feedback information about the doctor's individual practice and information from the environment in which the doctor worked (i.e. the GP practice).

The prescribed portfolio contained both personal and practice based feedback information. Personal feedback information was provided from Multi-Source Feedback (MSF), Patient Survey Questionnaire (PSQ), analysis of written complaints and a self assessed open book knowledge test (RCGP Scotland PEP).

Practice feedback information was provided from QOF plus data and data on 12 potentially dangerous co-prescriptions.

#### 1.2 Methods

In order to assess whether the prescribed feedback information covered the 4 GMC domains and 12 attributes we carried out a mapping exercise using the feedback formats mapped to the 4 domains and 12 attributes. This involved 2 phases:

1. At the start of the project we asked the participants to map the feedback formats based on how they thought they would map to the GMC framework. As most would have had no previous expertise of using these feedback formats, this was a measure of their *perceptions*.
2. At completion of the study we asked the participants to complete the mapping exercise a second time – on this occasion their responses would be based on their *experience* of the feedback formats (which involved receiving the feedback, reflecting on the feedback and using the feedback at their appraisal discussion).

Participants' experiences of using the open book knowledge test and other personal and practice based feedback tools was captured using semi-structured interviews with 6 appraisees and 6 appraisers.

### **1.3 Results**

- A high level of agreement by participants over how the feedback formats mapped to the GMC framework
- MSF as a feedback format was thought most likely to test most of the GMC framework
- Following experience of using the feedback formats – the only significant changes from their initial perceptions were that knowledge testing and patient surveys tested more of the GMC framework than they had though using their perceptions alone
- The open book knowledge test was valued by participants
- The open book knowledge test seems to act as a catalyst for further reading and learning
- MSF and PSQ feedback was particularly valued if it included comments about the doctor
- Provision of the 12 potentially dangerous co-prescriptions was valued by most participants and this data was used as a source of further exploration into the practice prescribing.

### **1.4 Conclusions**

The feedback tools used demonstrate that MSF, PSQ and open book knowledge testing are perceived by participants to map best to the GMC revalidation framework. The open book knowledge test is valued and can be a catalyst to promote further learning.

## **2. CONTEXT**

### **2.1 Revalidation**

Revalidation will be the system by which doctors will prove they are fit to practise medicine and will occur every five years.

### **2.2 RCGP Plans for Revalidation**

The domains and attributes of a doctor are described in the General Medical Council (GMC) document *Good Medical Practice* (GMP) and will inform the standards expected in revalidation. RCGP were charged with recommending standards for revalidation to be approved by the GMC before introduced. The Responsible Officer (RO) would make a recommendation to the GMC about a doctor's fitness for revalidation based on appraisal and local clinical governance information, but the GMC would decide on revalidation. Appraisal would have an important role in continuous performance development,

development of personal learning plans and supporting and informing revalidation. The appraiser would not be deciding whether evidence submitted met the evidence set.<sup>1</sup> Tools used would include criterion audit, Significant Event Analysis (SEA) and Multi-Source Feedback (MSF).<sup>2</sup> The RCGP National Advisory Panel would be available to RO in making recommendations for final high stakes judgement on revalidation by the GMC.

### **2.3 Tayside In-Practice Portfolio (TIPP)**

TIPP is a research study led by the University of Dundee and principally funded by the Chief Scientist Office, Scottish Government. The RCGP Tayside Revalidation Study described in this report, though separate to the TIPP study in its remit, was part nested within TIPP. The TIPP study attracted, in addition to its main funding by CSO, some additional funding and support from NHS Education Scotland (NES) and the Royal College of General Practitioners (RCGP) /NHS Revalidation Support Team. NES provided researcher involvement, support for initial administration costs and information meetings to aid recruitment for the TIPP study. RCGP/ Revalidation Support Team funded the development of a bespoke version of an open book knowledge test, RCGP Scotland's Personal Educational Planning tool (PEP) and, along with some support from CSO, funded a mapping exercise to test participants' perceptions of the testing of TIPP feedback tools against General Medical Council (GMC) attributes of Good Medical Practice (GMP). The PEP tool was used as one source of person specific feedback data for TIPP participants along with patient questionnaires, any complaints and colleague questionnaires. Lastly, prescribing data developed by University of Dundee and funded for the TIPP study by CSO was provided as practice specific feedback data.

TIPP is an assessment based on a WEB based portfolio of evidence. The purpose of the TIPP study is to research and inform national and international medical licensing systems in their future ongoing development by publication of new and innovative peer reviewed published evidence, particularly around high stakes decisions.

TIPP is a specified portfolio of external assessment aimed at personal reflection and improvement. The emphasis is on externally directed learning based on an explicit understanding of fairness of discrimination of performance (reliability of test). The use of self evaluated knowledge test (PEP) and practice and non person specific prescribing data in the TIPP study are not within RCGP plans for revalidation. TIPP researchers hope that future published evidence from TIPP will be helpful to national and international agencies, including RCGP, to find new and innovative future methods of testing. Findings are still being finalised and will be published and disseminated in due course.

### **2.4 RCGP Revalidation Proposals**

The following headings are from the original call by RCGP for research projects to support their revalidation proposals.

1. The recruitment process and outcome (recruitment rate in different groups) with reasons for non-recruitment when available

2. The extent to which evidence in existing appraisal folders (whether on paper or electronic) meets the evidence requirements in revalidation folders
3. The extent to which minimal, medium and demanding extra evidence collection is required to cover all the evidence requirements of revalidation folders
4. The extent to which the evidence in the putative revalidation folders meets the standards set by the RCGP
5. The views of participant GPs and key informants in the PCOs on the proposed evidence as for feasibility, reliability, accuracy and attribution (to the individual, not the team); and on the fitness of annual appraisals now for the purposes required in revalidation

The Scottish bid submitted by NHS Education for Scotland and the University of Dundee was not successful in this tender. However, RCGP/ NHS Revalidation Support Team subsequently negotiated with these organisations to support a smaller piece of research alongside the TIPP study. The purpose was to investigate participant agreement of coverage of Good Medical Practice (GMP) by the tools tested within TIPP, including the RCGP knowledge test developed for TIPP - mPEP. RCGP also expressed an interest in the testing and comparison of participant GP views of some of RCGP tools. Some of these were intended for use for revalidation by RCGP (colleague and patient feedback). RCGP also expressed an interest in the views of participants on knowledge testing (mPEP) and practice data, as innovative elements within TIPP but not planned by RCGP to be included in revalidation. The details of the Tayside RCGP/NHS Revalidation Support Team funded study are reported in section 2.

## Short Summary of the Findings of the Tayside Revalidation Study

### Key Findings

- There was a high level of agreement by participants on their perceptions of how well feedback tools tested *Good Medical Practice* attributes.
- MSF was the tool thought most likely the tool likely to test a broad range of GMC attributes.
- Experience of feedback demonstrated improved value by participants in perception of how well a Knowledge Test and Patient Questionnaires tested attributes of *Good Medical Practice*. Perceived coverage of other tools were unchanged from pre-study perceptions.
- modularPEP was successfully implemented with all 60 GP participants on two occasions. On this basis, mPEP appears to be a feasible and acceptable method, given the tested context of an open book knowledge test which is self assessed. Further analysis of data is outstanding.

### 3. Tayside RCGP/ NHS Revalidation Support Team FUNDED STUDY

The TIPP study offered a platform to assist the testing of two additional RCGP strands to 'add value' to the Revalidation Pilot undertaken by the University of Warwick.

The additional Tayside strands were:

- 1) A GP participant mapping exercise
- 2) Development of RCGP modular mPEP.

These two strands provided triangulation with participant views from University of Warwick's findings to RCGP on participant views of tested assessment tools (mapping) and an additional area of interest not otherwise tested and suggested by the Fifth Shipman Inquiry (open book knowledge testing).

#### 3.1 *Mapping Exercise*

##### 3.1.1 *Background*

A mapping exercise had been conducted by RCGP to highlight methods by which General Medical Council (GMC) attributes of Good Medical Practice are to be tested.<sup>2</sup> The Tayside Study provided an opportunity to investigate general practitioner opinion on which tools used in Tayside In-Practice Portfolio (TIPP) (colleague opinion, patient opinion and complaints, clinical governance practice based prescribing data, and self

evaluated open book knowledge test (modular PEP)) were thought to test these same GMC attributes. A particular area of interest was the perceptions of colleague opinion as tested by Multi-Source Feedback (MSF), given the high expectations by RCGP of the method as testing 10 of the 12 desired attributes of a doctor. The purpose of this exercise was to assess portfolios and blueprint or map their contents to the GMC framework by researching the views of participants on the perceived outcome of those assessments at the start and end of the study. This included participants' value of all assessments used, including the innovative assessment tools, namely: patient and colleague questionnaires; knowledge evaluation by modular PEP; practice clinical governance data; and patient complaints. In addition, to assessing the perceived coverage of testing by the sources of data used in the TIPP study, the mapping exercise afforded opportunity to test the reliability (inter-rater agreement) of general practitioner views on the testing of attributes by tools<sup>3</sup>. This analysis assessed the reliability of participant views as expected by RCGP key outcome 5 and was made possible by the addition of the Tayside study to the RCGP national pilot.

### **3.1.2 Methods**

#### **3.1.2.1 Recruitment**

General practitioners (n=61) and their appraisers (n=12) were recruited for the study. Appraisers were recruited from Scottish appraisal (n=8) and for the purposes of the study appraisers (n=4), doctors with an educational background in assessment including RCGP iMAP assessment. Study appraisers were recruited as 23 Participant GPs' allocated Scottish Appraisers declined invitation to take part in the study. Reasons given included workload, payment issues and a belief in; 'If it ain't broke don't fix it'. 60 general practitioners completed all aspects of the study with one doctor dropping out after completion of the initial mapping exercise due to other unforeseen commitments.

#### **3.1.2.2 Participants**

Sixty one general practitioners completed the mapping exercise pre-study. Sixty general practitioners completed the repeat mapping exercise on completion of the study

#### **3.1.2.3 Materials**

Participant general practitioners were asked to complete a 7 point Likert rating scale to record their perceptions of how well TIPP feedback sources tested the 12 attributes from the four domains of Good Medical Practice. A matrix was presented via the TIPP website: rows represented attributes and columns represented TIPP tested feedback sources. The exercise was completed at the outset of the TIPP study and again on completion. The purpose of this manipulation was to see if experience of the feedback methods had altered their value as perceived by participants.

#### **3.1.2.4 Statistical Analysis**

Descriptive statistics, ANOVA with associated Post –Hoc tests (Tukey HSD; Tukey B), and Generalisability (G) Theory were used to assess the perceived value of feedback methods and the level of inter-rater agreement of participant general practitioners on these opinions. This assessment was made before, and after experience of usage of the methods of feedback, at the beginning, and end of the study respectively. Paired t-tests

were conducted to assess significance of any differences in perceived value of tools at beginning and end of study

### **3.1.3 Results**

Generalisability (G) theory was used to assess agreement between participant GP raters (inter-rater reliability). G co-efficient was extremely high at 0.99 both before and after study assessments when generalised across all raters.

Mean scores for each feedback source for each GMP attribute are given in Table 1 (pre study) and Table 2 (post study). There were significant differences across tools for each GMC attribute in participant perceptions ( $P=0.001$ ). Post hoc tests were used to investigate any paired differences between tools. This allowed identification of homogeneous subsets of tools with no significant differences, but with significant differences with these sub-sets and remaining tools ( $p=0.05$ ). Feedback sources (as homogeneous sub-sets) in the sub-set most highly valued for each attribute are highlighted in green; and the least highly valued sub-set is highlighted in red. MSF was the most highly valued tool and was expected by participants to be the best test for the majority of attributes 11/12. Patient satisfaction questionnaires were thought to test three attributes best (7, 9, 10). Practice data was expected to test attribute 4, well. Conversely, knowledge testing was not expected to best test any attribute pre-study but was thought to test attributes 1 and 2 well post study.

Table 3 shows comparison of means between pre and post study. Paired t tests revealed significant differences between only patient satisfaction ( $p, 0.02$ ) and knowledge tests ( $p, 0.001$ ) between pre and post study in participant value of the formats.

### **3.1.4 Conclusions on Mapping Exercise**

It should be remembered that the Tayside revalidation study was limited to testing sources of feedback from TIPP tested tools (colleague feedback, patient feedback and complaints, knowledge testing, and practice sourced data not specific to individual). A similar mapping exercise had previously been researched by authors of this report, based on opinion of: GP educators, GP trainers and their doctors in training (GP registrars) on the coverage (based on an earlier version of GMP) by other tools of interest to RCGP namely, criterion audit and significant event analysis (SEA) <sup>4</sup>. Both tools were perceived as limited in their coverage and added value in testing with only one of the six domains tested from the version of GMP current at time of study, namely *Maintaining Good Medical Practice*. In addition, this domain was considered tested by all tools in the study except patient satisfaction questionnaires ( $n=7$ ).

#### *Participant agreement on testing of TIPP study sources of data*

The extremely high level of agreement was not surprising given the number of raters canvassed. It should be remembered that this agreement of perceptions is no proof of the construct validity of the tested tools. MSF, in particular, hopes to test a broad range of

attributes of a doctor and this claim of validity is an area of interest and current research by an author of this report.

*Participant opinion on coverage of testing of GMP by TIPP studied sources of data*

This mapping exercise was reassuring in that it demonstrated broad agreement in expectation of the value of tested methods of feedback to provide valid test of desired GMC Good Medical Practice attributes. On a cautionary note, it is noted that half (6/12) desired attributes rely on most highly valued methods by only one format of assessment (MSF). In addition, MSF is expected to best test 11/12 attributes. It will be important to further investigate the validity of MSF to reassure that outcomes match expectations. It is interesting that the value of patient opinion and knowledge testing improved with experience.

### **3.2 PEP Knowledge Test**

#### **3.2.1 Background**

The Personal Education Planning tool (PEP) was launched by RCGP Scotland in 1992. It has evolved through paper-based and CDROM formats into a web-based facility that was rolled out across the UK in 2007.

From its inception, PEP has been a formative self-assessment tool suited to all GPs. There is no pass nor fail outcome to the test, but comparison with peer performance is possible. It is perceived that, because of its non-summative and educational approach, it is generally trusted by the GP community.

PEP's primary objective is to identify the learning needs of individual GPs by the use of AKT (Applied knowledge test) – style items or questions. The items are a mix of SBAs (Single best answers) and EMIs (Extended matching items). The assessment covers all clinical aspects of the GP Curriculum, as well as management and ethical issues. PEP's secondary objective is to provide relevant evidence-based feedback and electronically-linked reference material, immediately on completion of each item.

Two versions of PEP have been developed – nPEP and mPEP. The former consists of 150 items covering the whole GP curriculum and providing a rapid broad-brush self-assessment aimed at doctors commencing GP training. mPEP is in modular form and offers a more in-depth assessment within each curricular domain. Each module covers 4 curriculum areas. A total of 5 modules will be developed by April 2011. The modular version of PEP could lend itself to possible future implementation of different modules being administered over time to encourage feasibility of the process of feedback.

The PEP used in TIPP was a bespoke 60 item version, focusing on chronic disease management, referral issues and prescribing.

### ***3.2.2 Views of Participants***

A specific review of the acceptability and usefulness of modular PEP (mPEP) in identifying educational needs and contributing to a revalidation portfolio was undertaken. In addition to the review of the value of mPEP as reported by participants in TIPP, a further report was added by Dr Alan Melville who led on the development and preparation of mPEP. The self assessed knowledge test was used to stimulate participants' opinion on future learning objectives, based on feedback provided for each question. We believe that there have been no significant problems highlighted with use of mPEP as a feedback tool. There remains the possibility that there would be concern were it to be used for summative purposes and /or administered in exam conditions. The qualitative data on mPEP will be made available to RCGP once findings for the TIPP study have been concluded.

### ***3.2.3 Future Additional Report***

An additional report will be made available at the conclusion of the TIPP study. This will include evidence on participant experience of provided feedback tools including PEP, as assessed using both quantitative and qualitative methods.

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**04.07.10**

## Mean Participant Ratings Tools V Attributes Good Medical Practice.

**Table 1** Participant Perceptions Pre-Study

Tool	Good Medical Practice Attributes												Mean	95% CI
	1	2	3	4	5	6	7	8	9	10	11	12		
1	<b>5.38</b>	<b>5.46</b>	<b>5.52</b>	<b>4.84</b>	<b>4.62</b>	<b>4.51</b>	<b>5.48</b>	<b>5.97</b>	4.93	5.02	<b>5.72</b>	<b>5.59</b>	5.25	5.16-5.35
2	3.92	3.66	<i>1.69</i>	<i>2.98</i>	<i>2.48</i>	<i>2.1</i>	<b>5.89</b>	2.48	<b>5.8</b>	<b>6.05</b>	<b>5.36</b>	4.59	3.92	3.77-4.06
3	3.75	3.69	3.49	<b>4.2</b>	<i>2.84</i>	<i>1.62</i>	<i>1.97</i>	2.79	<i>2.08</i>	<i>1.75</i>	<i>1.72</i>	2.31	2.68	2.57-2.8
4	3.94	3.98	<i>1.56</i>	<i>2.54</i>	<i>2.52</i>	<i>1.56</i>	<i>1.61</i>	<i>1.61</i>	<i>1.62</i>	<i>1.54</i>	<i>1.57</i>	<i>1.57</i>	2.14	2.05-2.24
5	3.3	<i>2.8</i>	3.31	3.49	3.31	2.39	4.03	2.61	3.82	4.3	3.77	3.69	3.4	3.28-3.52
Mean	4.06	3.92	3.11	3.61	3.15	2.44	3.79	3.09	3.65	3.73	3.63	3.55	3.48	
95% CI	3.88-4.24	3.74-4.1	2.89-3.34	3.43-3.79	2.97-3.34	2.25-2.62	3.56-4.03	2.87-3.31	3.42-3.88	3.49-3.97	3.39-3.87	3.32-3.78		

### Key to tables

**BOLD** valued methods (homogeneous post-hoc sub-set)

*Italics* valued methods (homogeneous post-hoc sub-set)

### Tools:

1 Colleague Feedback                      2 Patient Questionnaire                      3 Practice Data  
4 Knowledge                                      5 Patient Complaints

### GMC Attributes

- 1 The GP maintains professional performance
- 2 The GP applies knowledge and experience to practice
- 3 The GP keeps clear, accurate and legible records
- 4 The GP puts into effect systems to protect patients and improve care
- 5 The GP responds to risks to safety
- 6 The GP protects patients and colleagues from any risk posed by his/her health
- 7 The GP communicates effectively
- 8 The GP works constructively with colleagues and delegates effectively
- 9 The GP establishes and maintains partnerships with patients
- 10 The GP shows respect for patients
- 11 The GP treats patients and colleagues fairly and without discrimination
- 12 The GP acts with honesty and integrity

**Table 2** Participant Perceptions Post-Study

Tool	Good Medical Practice Attributes											
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	1	2	3	4	5	6	7	8	9	10	11	12	Mean	95% CI
1	<b>5.27</b>	<b>5.07</b>	<b>4.77</b>	<b>4.8</b>	<b>4.53</b>	<b>4.65</b>	<b>5.72</b>	<b>6.05</b>	4.95	<b>5.37</b>	<b>5.87</b>	<b>5.68</b>	5.23	(5.14-5.31)
2	4.42	3.9	<i>1.95</i>	<i>3.12</i>	2.87	2.38	<b>5.85</b>	2.68	<b>5.93</b>	<b>5.95</b>	<b>5.13</b>	<b>4.8</b>	4.08	(3.94-4.22)
3	<i>3.75</i>	3.98	2.87	<b>4.1</b>	3.27	1.83	<i>2.25</i>	2.85	<i>2.23</i>	<i>1.85</i>	<i>1.83</i>	<i>2.18</i>	2.75	(2.63-2.87)
4	<b>4.58</b>	<b>4.67</b>	<i>1.58</i>	<i>2.7</i>	2.8	1.72	<i>1.95</i>	<i>1.92</i>	<i>1.68</i>	<i>1.77</i>	<i>1.75</i>	<i>1.87</i>	2.41	(2.3-2.53)
5	<i>3.33</i>	<i>2.62</i>	3.2	<i>3.43</i>	3.13	2.25	4.12	2.87	3.92	4.3	3.77	3.73	3.39	(3.26-3.52)
Mean	4.27	4.05	2.87	3.6	3.32	2.57	3.98	3.27	3.74	3.85	3.67	3.65	3.57	
95% CI	(4.1-4.44)	(3.87-4.22)	(2.66-3.08)	(3.44-3.82)	(3.13-3.51)	(2.37-2.77)	(3.74-4.21)	(3.05-3.5)	(3.52-3.97)	(3.61-4.09)	(3.43-3.91)	(3.43-3.88)		

### Key to tables

**BOLD**

Highest valued methods (homogeneous post-hoc sub-set)

*Italics*

Lowest valued methods (homogeneous post-hoc sub-set)

### Tools:

1 Colleague Feedback                      2 Patient Questionnaire                      3 Practice Data  
4 Knowledge                                      5 Patient Complaints

### GMC Attributes

- 1 The GP maintains professional performance
- 2 The GP applies knowledge and experience to practice
- 3 The GP keeps clear, accurate and legible records
- 4 The GP puts into effect systems to protect patients and improve care
- 5 The GP responds to risks to safety
- 6 The GP protects patients and colleagues from any risk posed by his/her health
- 7 The GP communicates effectively
- 8 The GP works constructively with colleagues and delegates effectively
- 9 The GP establishes and maintains partnerships with patients
- 10 The GP shows respect for patients
- 11 The GP treats patients and colleagues fairly and without discrimination
- 12 The GP acts with honesty and integrity

Table 3

**Comparison TIPP Participant Mean Scores Before and After Study**

Tool	Good Medical Practice Attributes											
	1	2	3	4	5	6	7	8	9	10	11	12
1A	<b>5.38</b>	<b>5.46</b>	<b>5.52</b>	<b>4.84</b>	<b>4.62</b>	<b>4.51</b>	<b>5.48</b>	<b>5.97</b>	4.93	5.02	<b>5.72</b>	<b>5.59</b>
1B	<b>5.27</b>	<b>5.07</b>	<b>4.77</b>	<b>4.8</b>	<b>4.53</b>	<b>4.65</b>	<b>5.72</b>	<b>6.05</b>	4.95	<b>5.37</b>	<b>5.87</b>	<b>5.68</b>
2A	3.92	3.66	<i>1.69</i>	<i>2.98</i>	<i>2.48</i>	<i>2.1</i>	<b>5.89</b>	2.48	<b>5.8</b>	<b>6.05</b>	<b>5.36</b>	4.59
2B	4.42	3.9	<i>1.95</i>	<i>3.12</i>	2.87	2.38	<b>5.85</b>	2.68	<b>5.93</b>	<b>5.95</b>	5.13	4.8
3A	3.75	3.69	3.49	<b>4.2</b>	<i>2.84</i>	<i>1.62</i>	<i>1.97</i>	2.79	<i>2.08</i>	<i>1.75</i>	<i>1.72</i>	2.31
3B	<i>3.75</i>	3.98	2.87	<b>4.1</b>	3.27	1.83	<i>2.25</i>	2.85	<i>2.23</i>	<i>1.85</i>	<i>1.83</i>	<i>2.18</i>
4A	3.95	3.98	<i>1.56</i>	<i>2.54</i>	<i>2.52</i>	<i>1.56</i>	<i>1.61</i>	<i>1.61</i>	<i>1.62</i>	<i>1.54</i>	<i>1.57</i>	<i>1.57</i>
4B	<b>4.58</b>	<b>4.67</b>	<i>1.58</i>	<i>2.7</i>	2.8	1.72	<i>1.95</i>	<i>1.92</i>	<i>1.68</i>	<i>1.77</i>	<i>1.75</i>	<i>1.87</i>
5A	3.3	<i>2.8</i>	3.31	3.49	3.31	2.39	4.03	2.61	3.82	4.3	3.77	3.69
5B	<i>3.33</i>	<i>2.62</i>	3.2	<i>3.43</i>	3.13	2.25	4.12	2.87	3.92	4.3	3.77	3.73

A – Denotes pre study

B – Denotes post study

**Key to tables**

**BOLD**

Highest valued methods (homogeneous post-hoc sub-set)

*Italics*

Lowest valued methods (homogeneous post-hoc sub-set)

**Tools:**

- 1 Colleague Feedback
- 2 Patient Questionnaire
- 3 Practice Data
- 4 Knowledge
- 5 Patient Complaints

**GMC Attributes**

- 1 The GP maintains professional performance
- 2 The GP applies knowledge and experience to practice
- 3 The GP keeps clear, accurate and legible records
- 4 The GP puts into effect systems to protect patients and improve care
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- 6 The GP protects patients and colleagues from any risk posed by his/her health
- 7 The GP communicates effectively
- 8 The GP works constructively with colleagues and delegates effectively
- 9 The GP establishes and maintains partnerships with patients
- 10 The GP shows respect for patients
- 11 The GP treats patients and colleagues fairly and without discrimination
- 12 The GP acts with honesty and integrity

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