

# Appraisal of family doctors: an evaluation study

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## SUMMARY

**Background:** Appraisal has evolved to become a key component of workforce management. However, it is not clear from existing proposals for appraisal of doctors whether employers, health authorities or primary care organisations should take responsibility for appraisal processes.

**Aims:** To evaluate the introduction of a pilot peer appraisal system in general practice and to gain insight into the reactions of appraisers and doctors.

**Design of study:** Semi-structured telephone interviews combined with participant surveys and documentary analysis.

**Setting:** Five health authorities in Wales.

**Participants:** General practitioners (GPs) appointed as appraisers and volunteer practitioners (doctors).

**Method:** Twenty-six appraisers were appointed and given training in the appraisal process, each appraising an average of eight individuals. Appraisers and appraised doctors participated in semi-structured telephone interviews and completed separate participant questionnaires.

**Results:** GPs willingly undertook peer appraisal in a volunteer-based pilot study where participation was recompensed. The majority of participating clinicians were positive, with appraisers reporting the most gain. Appraisers were enthusiastic, provided the process remained non-judgemental and did not threaten or burden their colleagues. Appraised doctors were less enthusiastic but the most significant perceived benefit was the opportunity to reflect on individual performance with a supportive colleague. There were, however, repeated concerns about time, confusion with revalidation and personal development plans, worries about including health and probity queries, and an opinion that the process would be entirely different if conducted with non-volunteers or by representatives of 'management'.

**Conclusion:** This study illustrated three fundamental problems for appraisal systems in general practice. First, there is as yet no organisational hierarchy in general practice. Perhaps the aggregation of practices into primary care organisations will generate a hierarchy. Second, the question of who conducts appraisals then becomes pertinent; this study illustrates a professionally-led peer appraisal model. Third, the spectre of summative assessment causes problems in appraisal schemes. Typically, only mutually agreed summaries are kept for future use in appraisal systems (for example, for promotion or discipline). So the proposal to use GP annual appraisal documentation as the basis of a summative 'revalidation' exercise is at odds with orthodox personnel practice, which regards appraisal as a formative process.

**Keywords:** appraisal; primary care; peer-led; performance; quality standards.

## Introduction

EDWARD Deming, the guru of 'total quality', condemned appraisal as one of the seven deadly sins of management practice.<sup>1</sup> He argued that variation in individual performance was attributable to random observations, sampling error, and the influence of contextual and system factors that lie beyond personal control. Recent interest in complexity theory, coupled with system-wide interventions in quality improvement,<sup>2</sup> recognises that one should not put too much faith in the 'appraisal' of individuals as a means of reducing variation. Has the proposal, therefore, that all doctors in the United Kingdom (UK) should undergo regular appraisal<sup>3</sup> come at a time when the trends in workforce management have changed direction?<sup>4</sup> It should be noted, however, that an appraisal system for clinicians was proposed at the same time as a five-yearly revalidation system.<sup>5</sup> These two processes were an effort to introduce a systematic way of addressing concerns about how best to ensure confidence that professional standards were being met and sustained. Both proposals were a response to a longstanding concern at the General Medical Council (GMC) about how to assess professional performance, anxieties that finally attracted a wider audience after the Bristol inquiry,<sup>6,7</sup> and other high-profile examples of unacceptable conduct. These developments mark a sea change in accountability arrangements and, although they might test the personnel capacity of the National Health Service (NHS), they are seen as methods that will reassure the public that the medical profession can safely continue to self-regulate. Nevertheless, in primary care, where general practitioners (GPs) are independent contractors and not direct employees, the intentions to introduce appraisal left many unanswered questions about implementation.<sup>8</sup>

Despite Deming's scepticism, appraisal has evolved to become a key component of workforce management. In the 1970s, appraisals focused on assessing an individual's performance but there has been a shift over the past two decades towards performance development, with an emphasis on a positive communication about the alignment of an individual's objectives<sup>9</sup> with those of the employing organisation. As the Chief Medical Officer for England states, the primary aim of appraisal in the clinical context is not to 'scrutinise doctors to see if they are performing poorly but to help them to consolidate and improve on good performance, aiming towards excellence'.<sup>3</sup> In summary, appraisals are documented, employer-led, but importantly, two-way, formative transactions.<sup>10</sup> This can be contrasted with revalidation, which is led by a regulatory body (GMC) and is a summative assessment of whether the individual is fit to practise. Nevertheless, there are many who will want appraisal and revalidation to become linked processes, emphasising the overlaps.

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**HOW THIS FITS IN***What do we know?*

There have been no previous evaluations of structured appraisal programmes for GPs on this scale. We know that there is a policy imperative to undertake personal appraisal for professional development purposes, already a contractual obligation for most of the UK.

*What does this paper add?*

It is feasible to carry out GP appraisal and it is acceptable (at least to volunteers). Appraisal is a positive experience for the majority and can be carried out by 'grass-roots' GPs. Appraisers gain much out of the process. This volunteer group of GPs understood the potential use of folders and summaries for purposes of revalidation and did not raise any serious concerns about this concept, although further clarity about the process was sought.



The implementation of appraisal in general practice holds particular challenges. Appraisal is an organisation-based process and the small partnership structure of primary care poses new challenges. The contracted general practice workforce has traditionally turned to its Royal College or to postgraduate education departments for professional development. Practitioners are innately wary of managerial assessment systems. It is not clear from the existing proposals whether the employer, health authorities or primary care organisations should take responsibility for appraisal processes. Or are there different models that could work? In the absence of any available mechanisms,<sup>11</sup> the Welsh Assembly Government accepted a proposal to explore this area. The aim was to assess training needs and test the feasibility of a peer-led appraisal system (Box 1). This paper reports a project evaluation.

**Method**

The project was evaluated by the following methods:

- process analysis;
- semi-structured telephone interviews;
- participant surveys;
- analysis of folder summaries; and
- peer and patient survey responses.

*Project process analysis*

Details of applications, appointments to appraiser posts, and the appraisal processes were followed and documented.

*Semi-structured telephone interviews*

The telephone evaluation aimed to explore in more depth those aspects of the project that were important to the appraisers and doctors. The interviews assessed strengths, areas of concern, and issues that required further attention. All appraisers who participated in the pilot appraisal process were contacted by a health services researcher (FW). In addition, one doctor from each appraiser group was selected for interview using a stratification method to ensure a

**Stakeholder engagement**

The following organisations were consulted: the Royal College of General Practitioners (Wales), General Practitioners' Committee (Wales), and the Welsh Assembly Government.

**Appraiser selection and training**

In May 2001, details of about 20 appraiser posts were circulated to 1800 principals and 160 non-principals in Wales, aiming to recruit appraisers who represented a cross-section of ethnic backgrounds, age, geographical location, size of practice, and contractual status (non-principals). Selection procedures excluded clinicians who had prior educational experience. The appraisers were offered payment of £300 per completed appraisal, and set a target of completing ten each. Two days of training by an external training organisation was planned. Appraisers were given flexibility regarding the appraisal process, with the proviso that completed folders would be available by April 2002.

**Doctor recruitment**

GPs in Wales were circulated with information about the appraisal study. The flyer emphasised the formative aim of the exercise and mentioned a possible link to revalidation. A reimbursement of £250 and a postgraduate education allowance (PGEA) allocation of up to 30 hours were offered for participation. Contact details were provided so that individuals could make direct approaches to appraisers of their choice.

**Documentation**

The appraisal 'folder' mirrored the headings of the GMC's *Good Medical Practice*,<sup>12</sup> thereby linking the process to a potential revalidation process,<sup>5</sup> the documentation prepared for special-ists in the NHS,<sup>13</sup> and other work.<sup>10</sup> The folder had the following sections: personal details, GMC and defence society numbers, description of current clinical activities, evidence of engagement in educational, audit, professional or practice development activities, evidence of engaging in teamwork, management, measuring the clinician-patient interface (consultation skill surveys, management of complaints), teaching or training, and monitoring of individual health and probity.

Box 1. Setting up a GP appraisal scheme.

wide cross-section of age, sex, and ethnic background. It was not the intention to provide an exact count of the number of responses to specific issues raised by the researcher, but rather to allow the responders to describe, in their own terms, what they believed were the strengths and weaknesses of the process. The telephone interviews were not audiotaped but the researcher kept detailed notes during the course of the interview. Quotes included to illustrate viewpoints are not verbatim. Broad themes within the data were then identified.

*Participant surveys*

Separate questionnaires were designed for the appraiser and doctor groups. The aim of the appraiser survey was to assess their views about recruitment, training provision, the documentation provided, the appraisal process, and suggested future support requirements, by asking them to write short notes. For the doctor survey, a five-point adjectival 'agreement' scale was used that asked for their views on levels of perceived threat and benefit, aid to professional development, the impact of the process on future practice, and whether the appraisers had a supportive approach.

### *Analysis of folder summaries*

Summaries were analysed by one of the researchers (GE) for the presence or absence of a personal needs assessment and an individualised personal development plan. Each appraiser was given a score from one to five for the quality of the documented summary.

### *Peer and patient questionnaires*

After consultation with the GMC, modifications were made to instruments developed in the United States for 'recertification',<sup>14</sup> where 20 peers and 40 patients are asked to complete questionnaires about the clinician. Doctors were given the option to collect information using peer and patient survey questionnaires.<sup>15,16</sup>

## **Results**

### *Project process analysis*

The project was launched in early 2001. Eighty-seven doctors applied for the appraiser posts: 26 were appointed (eight of whom were female) in September 2001. Appraisers were selected from the five health authorities: their ages ranged from 31 to 57 years (mean = 45 years); two were from training practices; six had primary medical degrees outside the UK and seven were from an Asian ethnic background. The majority (19) were full-time principals (which included two single-handed practitioners), five were part-time principals, and two were non-principals. The planned training provision was reduced from two days to one day so that an interim feedback meeting provided a forum for troubleshooting and shared learning between appraisers. In total, 207 doctors were recruited. An average of eight individuals were appraised (only two appraisers completed fewer than five appraisals); the mean distance between pairs was 13 miles (range = 100). All the appraisers completed the pilot; nine of the recruited doctors declined to complete the appraisal process. Appraisers took between three and 15 hours to complete the process of preparation, introduction, appraisal interview, and follow-up (mean = 7.5 hours).

Although there was wide variation, the doctors reported spending 15 hours on the appraisal process (interviews, meetings, and data collection) and 24 hours on writing the material to include in the folders. The mean age of the doctors was 44; 149 were male, 58 (27%) female; five participants were non-principals; 30 had qualified outside the UK; and 32 doctors had Asian ethnic backgrounds. Given the overall cost of £151 300 for the initiative, the calculated cost per completed appraisal was £731.

### *Semi-structured telephone interviews*

All 26 appraisers and 24 of the chosen sample of 26 doctors were interviewed for approximately 15 minutes: responder anonymity was assured.

*Appraisers' views.* All but two of the 26 appraisers found the process a very positive, rewarding, and educational experience. These two remaining appraisers were positive in principle but their experience had been jaundiced — in one case by problems of ill health and in the other by reported poor doctor motivation. Appraisers felt that the process was inter-

esting and educational. They valued hearing the experiences of practitioners with similar problems and gained ideas about how to improve their own organisation; for example, one had adopted a '999' emergency protocol for receptionists and another had introduced critical incident meetings. Over half of the appraisers reflected that the appraisal project also presented an opportunity to influence and improve standards, network with GPs outside their normal peer group, and feel part of a bigger enterprise:

*'It's good that at my age I am able to get involved with something very different from routine GP work. It's also given me the opportunity to talk to different people that I wouldn't normally talk to.'*

The decision to select appraisers who had no prior educational experience meant that many participants reported substantial knowledge gain about policy developments. They were content with the process because it was conceptualised as not threatening, not judgemental or hierarchical, and viewed appraisal not as an added burden but as an opportunity to reflect on practice:

*'It's an opportunity to meet your peers in a non-threatening manner and be able to discuss both good things and difficult things without any repercussions.'*

Half of the 26 appraisers reported their concerns that the time requirements had been significantly underestimated, especially given the tasks of delivering appraisal folders to geographically disparate practices. The additional time involved also raised financial issues, and appraisers were concerned about how the locum cover could be provided. There was concern about the lack of guidance regarding the material that should be included in the folders. Although some appraisers recognised the importance of flexibility, varying interpretation by doctors of the type of evidence that should be included was perceived as a problem. Certain sections of the folder caused particular confusion; for example, some were unsure about the probity heading and felt that the focus on practice documents could reflect organisational characteristics rather than those pertaining to individuals.

The interviews revealed fundamental concerns about the purpose of appraisal, the government's motivation and its exact relationship to revalidation, and worries about the confidentiality of appraisal folders, particularly regarding health problems. Four appraisers were anxious about how they would deal with 'poor performance', especially if the doctors were more 'experienced' or acquaintances. The appraisers also considered the pilot *artificial* in that it utilised a sample of volunteer doctors. Consequently, they thought that the appraisal process would be more difficult when conducted on GPs who had to be actively recruited, as they felt that the bulk of their colleagues remained fearful of appraisal:

*'Because this is a pilot there is a sense of artificiality about it. When it's rolled out the scheme will include GPs who are not so good and less willing to be appraised. And then that will take more time and effort from the*

*appraisers as we'll have to jig them along more.'*

Many appraisers revealed their lack of understanding about the current changes in professional development and assessment. Personal and practice development plans, appraisal, and revalidation are different concepts, but the interviews revealed confusion about the distinctions. This confusion may in part be explained by the fact that appraisal training was considered to be inadequate by 11 of the 26 appraisers:

*'There was no guidance given on the manner or mechanism of appraisal. Is it supportive? Is it for purposes of inspection?'*

On the other hand, having 'peers' as appraisers, rather than academics or GPs linked with management, was considered important lest doctors became suspicious of motives. The peer and patient questionnaires were also considered inappropriate for the UK primary care context.

The appraisers suggested improvements in the following areas: increase the time allowance for each appraisal to 12 hours, provide more administrative support for the distribution of folders and analysis of peer and patient questionnaires, more guidance about documentation and access to a sample folder, and access to support (for example, mentors and local small support groups). The other significant suggestions were to formalise the procedures for handling sensitive issues, such as poor performance, ill health or possible fraud.

*Doctors' views.* Most of the doctors found the process constructive, stimulating, and non-threatening. Doctors were, however, less motivated and enthusiastic than the appraisers. Five doctors admitted initial apprehension but were glad to have participated and benefited from the process:

*'Initially I was resistant because I was too busy. I was volunteered, but now I'm glad I did it. It's made me focus on my learning, which is something I've neglected.'*

Of the 24 doctors interviewed, two had dropped out of the process (one because of time pressure and one as a result of a perceived mismatch with the appraiser as they considered themselves to be more senior and experienced than their appraiser). Another doctor reported that the process had been extremely stressful and unpleasant but had continued as a result of the appraiser's support. Three doctors appeared evasive about reporting their true opinions to the researcher, as they seemed reluctant to engage with the researcher in a full discussion of their views. This could possibly be owing to a misunderstanding that the telephone interview formed part of their own performance evaluation, or perhaps a reluctance to truly reflect on the appraisal process.

Most doctors felt that appraisal had offered them an opportunity to reflect on their own strengths and weaknesses, and career progression with another practitioner who understood their situation. Rather than feel threatened, many felt the benefit of feedback and confirmation that they

were performing satisfactorily, particularly if they practised in relative isolation:

*'It's a good idea to evaluate yourself and get a chance to improve on those areas which require improvement. It's also good to present yourself to others on those areas that you are strong on.'*

One doctor reported that they had instigated appraisal for other non-medical colleagues within the practice. Although a few doctors remained subdued in their support, the general feeling was positive.

Many doctors remained confused about the aim of appraisal in relation to other overlapping processes, such as revalidation and personal development plans. The requirement to produce folders that were 'inspected' contributed to this issue:

*'I'm still confused as to where appraisal fits in with revalidation and whether it will inform revalidation.'*

Three doctors felt that the process had not adequately assessed their educational needs and were uneasy with the principle of GPs being involved in what they called a 'self-policing' exercise. Two others stated that they had concerns about confidentiality and would resist reporting health problems, believing this to be the remit of an occupational health service. Although only one doctor reported a poor relationship with their appraiser, five others raised concerns about impartiality, and reinforced the view that appraisers should not be 'academics' or representatives of 'management'. Some perceived the process as an 'examination', betraying a misunderstanding of the key principles. Doctors also reported concerns about the length of time required to produce folders and wanted protected time and reimbursement for locum cover.

### *Participant surveys*

*Appraiser survey.* A total of 23 of the 26 appraisers completed questionnaires. They were content with the recruitment process, although one appraiser doubted the generally agreed policy of excluding educationalists from applying. Although the appraisers appreciated the opportunity to meet each other, the training was perceived to be inadequate. The main concerns were about the lack of practical experience; one individual suggested that the selection process should assess aptitude by using simulated appraiser-doctor interviews. They also wanted more guidance about the proposed use of the appraisal documentation. One individual summarised the experience by saying that:

*'...appraisal still needs to be defined and explained before we appraisers can really know what we are doing.'*

The documentation provoked a mixed response. All felt that the folder was well designed, but wanted more guidance about the type of documents that should be included. Were practice protocols relevant? Should there be proof of the individual's contribution to the development or imple-

mentation of such a protocol? One person said that ‘as a non-academic’ they had found the documentation ‘incomprehensible’ and wanted to see a ‘completed folder’ to assess the standard required. The appraisers conducted the appraisal in different ways but a common pattern was an introductory telephone call, visit or small group meeting to explain the appraisal process, followed up by review visits or telephone calls; about two or three contacts in total. It was clear that the appraisers were exploring the best method. One approach resulted in positive reflections and consisted of an explanatory individual visit, followed by a group meeting to share concerns and questions. This was then followed up with individual visits. Venues were a mix of appraiser or doctor practice or postgraduate centre. The appraisers reflected that the process was more comfortable if the doctor was on home territory; a venue that also added important contextual information. One appraiser warned against appraising one’s own professional partners.

The appraisers were clear that more support was necessary: electronic communication and telephone access to an experienced appraiser were common suggestions and regular meetings to standardise processes were requested. In other words, the appraisers were clearly committed to the work but wanted more structural help. Twenty-one of the appraisers reported that they had enjoyed the experience and 16 were prepared to continue, and would recommend the work to colleagues.

*Doctor survey.* Of the 207 doctors, 174 (84%) fully completed questionnaires; a third of participants had prior experience of a personal development plan. Table 1 summarises the results, which show that, although 30% of the responders felt threatened by the prospect of the process, only 8% felt threatened when taking part in the exercise. It is also clear that the majority of responders feel positive about the benefits (62%) and that they recognised it as a way to develop their practice (70%). The majority (83%) of responders felt supported during the appraisal, received useful advice (74%), and felt positive about the prospect of taking part in an annual appraisal process (63%). Notable free text comments included one from a doctor who had compared notes with colleagues and was worried about a lack of uniformity between appraisers; another noted that the ‘appraiser had

as much to learn as me’.

*Analysis of appraiser summaries*

A total of 182 appraiser summaries were available to be examined (87% completion). All the documents were legible (or in typeface); 50% had evidence of a personal needs assessment and 54% contained individualised professional development recommendations. There was substantial variation in the quality of the summaries and, although a template was made available, there was no real consistency in the summary formats produced; the mean appraiser quality score was 3.15 (standard deviation = 1.3) and six appraisers had mean scores below 2. The main difficulty was their descriptive nature and the lack of personal development needs identified in the doctors appraised, and details about how those needs would be addressed.

*Peer and patient questionnaire responses*

The use of these survey tools was optional, yet 108 doctors used the peer questionnaires and 107 used the patient questionnaires (results will be published separately), a positive opt-in rate of about 60%. The results from this survey sample will be reported separately. It was noted, however, that there was a strong feeling that the validity of the questionnaires should be significantly improved for use in a UK primary care context and more guidance given about arriving at representative, comparable samples.

**Discussion**

*Main findings*

This study showed that GPs were willing to undertake peer appraisal in a volunteer-based pilot study where participation was recompensed. Although it must be recognised that it is not possible to generalise from this self-selected group, the overwhelming majority of clinicians who participated were positive about the process, with the appraisers reporting the most gain. Appraisers were enthusiastic, provided the process remained non-judgemental and did not threaten or burden their colleagues. Those being appraised were not as enthusiastic, but the most significant perceived benefits were the opportunities to reflect on individual and practice performance with a supportive colleague. There were, however,

Table 1. Doctors’ opinions about the appraisal process (n = 207).<sup>a</sup>

Item	Strongly agree (%)	Agree (%)	No opinion (%)	Disagree (%)	Strongly disagree (%)
I felt threatened by the prospect of the appraisal process	2	28	5	39	13
I felt threatened during the appraisal process	0	8	5	55	21
I feel the appraisal process has benefited my practice	13	49	15	9	1
I experienced the appraisal process as a way of helping me to develop myself/my practice	20	50	12	6	0
I experienced the appraisal process as a test of my performance	1	32	16	34	4
The appraiser conducted the appraisal process in a supportive way	37	46	2	1	1
The appraiser was able to provide useful advice	17	57	8	5	1
I valued the appraisal process	16	54	12	5	0
I feel positive about taking part in an annual appraisal process	13	50	10	12	1
I think the appraisal process will be the most significant influence on my future professional development	2	19	24	34	7

<sup>a</sup>12% to 13% uncompleted responses to questionnaire items.

repeated concerns about time, confusion with revalidation and personal development plans, worries about health and probity queries, and an opinion that the process would be entirely different if conducted with non-volunteers or by representatives of 'management'. The introduction of patient and peer surveys was regarded as a method that could be done comparatively easily, but many felt that the process was not worth the effort involved. This component of the process is likely to be of more value in informing revalidation than appraisal, although there may be opportunities to identify learning needs in areas such as communication skills. Based on this pilot study, the Wales Assembly Government plans to provide an appraisal scheme to all principal and non-principal GPs in Wales, which will be managed by the Department of Postgraduate Education of General Practice to provide a link between appraisal and the provision of educational activity to match the identified needs.

### *Strengths and weaknesses of the study*

The evaluation used multiple methods and revealed aspects that may have otherwise remained hidden. The telephone interviews offered an opportunity to elicit views that would not have been easily expressed by other means. Although a number of research methods were used, the evaluation could have been strengthened by the inclusion of qualitative data generated from observations of appraisal sessions. The inclusion of this method of data collection could have allowed some insight into how participants communicate with each other and construct a joint understanding of the process. We should also note that we were only able to evaluate here the first episode of what is seen in human resource terms as an ongoing process of reflection and review. It remains to be seen whether the positive comments of the participants in this study translate into actions that are perceived to add value to their clinical practice.

### *Context of other studies*

Some evidence of small-scale voluntary peer appraisal exists — practice-based or as part of educational personal development plan schemes<sup>17-19</sup> — but this is the first evaluation of a systematic service GP appraisal process that we have been able to identify.<sup>20</sup> A survey of UK health authorities in 2001 and primary care organisations revealed that none had implemented any schemes.<sup>10</sup>

### *Implications*

This study illustrated three fundamental problems for appraisal systems in general practice. First, there is as yet no organisational hierarchy in general practice. Should appraisal (by definition) be part of a system where individual needs are met by organisational responses? Perhaps the aggregation of practices into primary care organisations will generate a hierarchy. Second, the question of who conducts appraisals then becomes pertinent; this study illustrates a professionally-led peer appraisal model. GPs usually work in small, flat, autonomous organisations, hence the view that appraisers should come from the grass roots (although it is debatable how long this status could be retained). Third, the spectre of assessment causes problems in appraisal schemes. Typically, only mutually agreed summaries are

kept for future use in appraisal systems (for example, for promotion or discipline). So the proposal to use GP annual appraisal documentation as the basis of a summative 'revalidation' exercise is at odds with orthodox personnel practice, which regards appraisal as a formative process.

The training and support requirements of any appraisal system are key ingredients, especially if appraisers who are not well versed in recent professional development approaches are selected. Those selected were clearly learning 'on the job' and the main lesson was the realisation that an administrative support system would have to be designed to ensure that appraisers were undertaking similar approaches.

The documentation of appraisal interviews is a problem that hinges on the aim of the process. If the 'folders' are to be used as 'evidence' for revalidation, they will become tomes: the typical weight of each folder was 1.2 kg. If, however, the aim is to document reflection on personal development needs, the structure can be more fluid, encouraging individual variation in terms of interests, baseline knowledge, and contextual requirements. The provision of exemplars, clearer guidance, adequate time, and administrative time to support the practicalities and paperwork involved were the key messages of the evaluation, but the more fundamental issue was about the degree of confidentiality required if health and probity issues are also included. This intertwining of employment accountability, clinical governance, and formative education leads to confusion.

GPs do not have an occupational health service and do not arrange any supervision for the interpersonal therapeutic roles that they shoulder. Despite recent proposals, professional development is typically conceptualised as attendance at meetings. This study shows that if GP appraisal can be a formative process conducted by trustworthy peers, it could well be what doctors need most. It was, as one said, 'exactly the lift I needed'. Although the imminent arrival of revalidation has clearly been a significant driving force for appraisal systems, the linkage must be carefully managed to avoid compounding potential difficulties. If the process is closely linked to 'performance management' (with feedback to primary care organisations and clinical governance systems), it would contradict the spirit of 'appraisal'. It is a conundrum that has not been adequately addressed at the policy level.

### **References**

1. Deming WE. *Out of the crisis*. Cambridge, MA: MIT Institute for Advanced Engineering Study, 1986.
2. Plsek PE, Wilson T. Complexity science: complexity, leadership, and management in healthcare organisations. *BMJ* 2001; **323**: 746-749.
3. Department of Health. *Supporting doctors, protecting patients*. London: The Stationery Office, 1999.
4. Fletcher C. Performance appraisal in context: organisational changes and their impact on practice. In: Anderson N, Herriot P (eds). *Assessment and selection in organizations*. Chichester: John Wiley and Sons, 1994.
5. General Medical Council. *Revalidating doctors*. London: GMC, 2000.
6. Smith R. All changed, changed utterly. *BMJ* 1998; **316**: 1917-1918.
7. Department of Health. *Learning from Bristol. The Department of Health's response to the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995*. London: The Stationery Office, 2002.
8. Elwyn G, Edwards A, Riley C. Managing revalidation in general practice. *Clinician in Management* 1999; **8**: 193-197.

9. Armstrong M. *A handbook of personnel management*. London: Kogan Page, 1984.
10. School of Health and Related Research. *Appraisal for GPs*. Sheffield: SHaRR, 2001.
11. National Assembly for Wales. *Maximising clinical performance*. Cardiff: National Assembly for Wales, 2000.
12. General Medical Council. *Good medical practice*. 1997, London: GMC, 1997.
13. Central Consultants and Specialists Committee. *Appraisal for senior hospital doctors: statement from the Central Consultants and Specialists Committee*. London: British Medical Association, 1998.
14. American Board of Internal Medicine. *Recertification: program for continuous professional development*. <http://www.abim.org/cpd/cpdhome/index.htm> (accessed April 2003).
15. Ramsey PG, Wenrich MD, Carline JD, et al. Use of peer ratings to evaluate physician performance. *JAMA* 1993; **269**: 655-660.
16. Fidler H, Lockyer JM, Toews J, Violato C. Changing physicians' practices: the effect of individual feedback. *Acad Med* 1999; **74**: 702-714. <http://www.academicmedicine.org/cgi/content/abstract/74/6/702> (Accessed April 2003.)
17. Jelley D, van Zwanenberg T. Peer appraisal in general practice: a descriptive study in the Northern Deanery. *Educ Gen Pract* 2000; **11**: 281-287.
18. Elwyn G. Professional and practice development plans for primary care. [Editorial.] *BMJ* 1998; **316**: 1619-1620.
19. Elwyn G, Carlisle S, Hocking P, Smail S. Practice and professional development plans (PPDPs): results of a feasibility study. *BMC Fam Pract* 2001; **2**: 1. <http://www.biomedcentral.com/1471-2296/2/1> (Accessed April 2003.)
20. Dodd M, Rutt G, Illing J. A system of appraisal for general practice trainers: a pilot study. *Educ Prim Care* 2002; **13**: 48-54.

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