Membership by Assessment of Performance: developing a method for assessing established general practitioners

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SUMMARY

Over 200 general practitioners (GPs) and others have contributed to the development of Membership by Assessment of Performance (MAP): a new scheme for assessing established GPs. By means of a Delphi consultation with a broad cross-section of the profession, a working conference, piloting with potential candidates, and repeated checking with reference panels, the assessment was developed within two years. We report the development of MAP, including the results of the Delphi consultation, which asked 'Which aspects of a general practitioners performance are important to assess?'.

Keywords: *assessment of performance; general practitioners; Delphi consultation; MAP.*

Introduction

IN the mid-1960s, potential members of the Royal College of General Practitioners (RCGP) were, on occasions, visited in their practices to assess their eligibility for membership.[1] In 1991 the College Council agreed to consider introducing a system of membership by assessment for established practitioners.[2] Doubts expressed by faculties led to a delay in pursuing this idea, but a survey showing a demand for such a scheme[3] led to the College Council creating a working group to explore the possibilities for Membership by Assessment of Performance (MAP) further.

This has now become a new route to membership of the RCGP, and the first candidates are expected to be assessed later this year. We report the process by which this scheme was developed as an essential element in the assurance of its quality.

The basis for this method of development

It was vital that MAP must be of equivalent standard to the MRCGP examination, assess important aspects of the daily work of GPs, and be open to consistent interpretation by candidates and assessors.

The membership examination (MRCGP) started in 1965 and is currently undertaken by some 2000 candidates each year, most of whom are near the end of vocational training. It is a test of competence. We had to develop a method to assess GPs working in a wide variety of circumstances, both demographic and personal (e.g. both principals and non-principals, full- and part-time). If candidates achieved a prescribed standard of performance, they could be admitted to membership of the RCGP.

Doctors, patients, managers, and the government all have views on the importance of the different parts of a GP's work. As a route to membership of a professional organisation, we considered it appropriate to restrict our collection of views to practising GPs, yet from a wide variety of settings.

It is desirable that a method of assessment should be open and consistent in order to be seen to be just. We needed to produce a scheme that would be published in full so that potential candidates would know in advance exactly what is expected of them, and the scheme needed to be assessed consistently on differing occasions. These were demanding and potentially labour-intensive criteria, and we therefore had to consider whether we could adapt an existing scheme for our purpose. Our immediate choice was Fellowship of the RCGP by Assessment.[4] This began in 1989 for those seeking to demonstrate the 'highest possible' standards of practice. If we had reduced the requirement to examine a number of new cases of cancer from 15 to, say, eight, this might have been feasible for some criteria. However, others, such as the requirement to have adequate emergency drugs and equipment, are not amenable to a lower standard, so we abandoned this option.

The expert group guiding the development of MAP knew of no other existing set of standards of performance by GPs that could be used or adapted to our purpose. We therefore decided to carry out our own consultation exercise with a wide section of the profession in order to determine the criteria upon which to base MAP.

Consulting the profession

We identified a wide variety of GPs from organisations representing those GPs (Box 1). Each organisation was asked to supply the names of 60 of their members chosen at random, all of whom were sent an explanation of the study and an invitation to participate. Volunteers were required to be in active general practice and expect to remain so for the next year. From the names supplied we selected, at random, 20 people from each group to take part.

To consult such a large number of individuals, we chose a Delphi technique.[5] These are useful for developing standards when there is insufficient research-based evidence in the area. A group of people are asked the same questions and amalgamated answers are fed back through a series of two or more stages. The technique has the advantages of overcoming geographical separation and interpersonal conflicts between participants or excessive deference to 'experts', and has been used in previous consultation exercises with GPs.[6,7]

Each participant was sent instructions explaining the study and asking them to 'suggest aspects of a GP's performance that are important to assess'. They were told that it did not matter if they did not know *how* an aspect of performance might be assessed; if they thought it important they were to include it. We gave 12 separate areas of practice as *aide memoires* collated from previous work on the quality of general practice[8-11] and not in any order of importance. Responders were asked to write brief phrases or sentences and to reply within three weeks, with reminders being sent to non-responders.

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- Associate members of the RCGP (excluding GP registrars)
- Association of University Teachers in General Practice members
- Fellows of the RCGP by assessment
- MRCGP candidates who passed the membership examination in 1996
- MRCGP examiners
- Overseas Doctors Association members
- RCGP Council members
- RCGP members who passed the membership examination before 1992
- Small Practices Association members

Box 1. Groups that took part in the study.

We recruited 175 GPs to take part in the study from the target of 180, and 91 (52%) sent in replies to the first round. All replies (65 000 words) were transcribed onto a spreadsheet, and each was independently checked and categorised into one of the 12 areas of practice, retaining all responses. A group of four GPs from Mersey Faculty then read through all the responses in each area and produced 113 new statements to encompass the views expressed in the first round (Table 1). They were asked to produce about 10 statements in each area because we wanted the second Delphi round to be of reasonable length yet comprehensive and specific. There was a small change in the content of the original areas to improve clarity and consistency. Continuing professional development was merged with review of performance and we created a new area: consultation. These statements were then sent back to the Delphi group asking them to number each statement as aspects of performance, either 2 = essential; 1 = desirable; 0 = unnecessary. Additional opinions were invited as free-text comments. A total of 128 (73%) replied to the second round.

Producing and piloting a draft document

We invited all those who had taken part in the Delphi study, representatives of the General Medical Council and British Medical Association, and the profession in general by means of an advertisement in this *Journal*, to a conference in January 1998. The main task of the event was to translate the results of the Delphi rounds into assessable criteria for MAP. Sixty delegates considered four areas of practice in facilitated small groups, with each area being covered by two different groups. The delegates were given a set of all results from the Delphi rounds (i.e. Table 1) and were asked to stay close to the collective views from that consultation.

The different criteria produced by the conference were made into a draft document that was reviewed with two potential MAP candidates. Their task was not to complete a full MAP assessment, but to produce the sort of evidence they would use to support an application and to identify statements that were difficult to follow, for example, because they were ambiguous. We then tested the full draft scheme with four more pilot candidates in May 1998. They submitted evidence in advance and were visited by two assessors who interviewed them and their staff, examined records, and conducted an assessment that was as near as possible to the full scheme; again constrained by the short time available that the candidates had to prepare.

The experience of these visits enabled us to submit a scheme MAP to the RCGP Council in June 1998. The Council recommended that this be submitted to the Annual General Meeting (AGM) as a proposal for a change in College Ordinances allowing this new route to membership. Three further pilot assessments were undertaken in the autumn of 1998.

Ten revisions of the draft MAP document were considered by the faculty and national MAP working groups in 1998, each allowing minor refinements to make the scheme as clear as possible. The AGM adopted MAP as a new route to membership of the College in November 1998 and, after Privy Council approval, MAP became available in April 1999. The first version of MAP includes 36 compulsory criteria (including a video or simulated surgery to MRCGP standard) and a requirement to gain 10 points from the 16 optional criteria.[12]

Discussion

Many of the responders belonged to more than one professional group; often three or four. For that reason we did not analyse the results by different professional categories. Although we tried to consult as wide a section of the profession as we could, we depended upon professional associations being able to give us lists of names of members, and the proportion of their members this represented varied with their size. They represent a cross-section of the profession, but not one weighted for all variables because Delphi panels typically include a disproportionate number of enthusiasts.[5]

The process of converting the initial replies into a schedule that could be marked might have resulted in some proposals being ambiguous or a statement that might be agreed with only in part. For example, they might agree that a candidate should keep up-to-date with chronic disease management, but that a 'learning portfolio' might not be an appropriate way to demonstrate this, or they might consider this as unintelligible jargon. We had to condense a considerable amount of initial data into the series for the second round, and we have retained all the original replies for future reference. The responders apparently had little difficulty in suggesting aspects of GPs' performance that should be assessed in a scheme such as this. This probably reflects a growing awareness of professional assessment as a whole and possible individual components of it.

Delphi techniques can be used to substantially increase a group's capacity to generate ideas.[5] Various modifications are possible depending upon the purpose of the study, and, in this case, we needed to know the range of performance measures that the profession thought important and to have some indication of the level of support for each. There was no commitment to include any individual criterion in the MAP scheme, although all involved in its development have tried to be faithful to the Delphi group's ideas and opinions. We did not attempt to reach any pre-determined level of consensus.

The highest scoring criteria reflect traditional ideas of the role of the GP, such as availability and clinical skills as well as good practice management. In contrast, the least favoured criteria include some current ideas such as formularies, complementary therapies, and apparent over-easy access by patients. Health promotion in general scored badly, and visiting the over-75s does not feature at all.

As far as possible we were concerned to develop a system of assessment that concentrates upon the performance of the individual GP, irrespective of the practice or primary care groups where they are working. We believe that this system will complement performance indicators for primary care groups, which will be developed separately.[13]

There are now a number of quality assurance schemes for general practice.[14] MAP is unique in being developed from a consultation process with a wide section of the profession. It remains to be seen whether this will ensure its credibility and popularity.

References

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Table 1. Statements expressed as a result of the Delphi rounds.

Statement	Scores[a]
Demonstrate the system for urgent problems necessitating same-day appointments.	250
Demonstrate arrangements for care of emergency situations in and out of office hours.	247
Sufficient drugs and equipment should be available for the doctor to manage the variety of acute problems seen by GPs.	243
Records are comprehensive, legible, and appropriately accessible.	242
The candidate's prescribing should be clinically appropriate.	242
Adequate time for consultations, telephone contact, visits, and office work.	239
The doctor demonstrates appropriate management.	239
The doctor demonstrates appropriate history-taking and examination.	237
Referral letters must be legible, timely, and contain relevant information.	236
The doctor explains the diagnosis to the patient.	236
An effective system for dealing with mail, telephone calls, and results must be demonstrated.	235
Consistently picks up cues suggesting the possibility of serious illness.	235
The doctor reaches an appropriate working diagnosis.	235
The doctor arranges appropriate follow-up.	234
GP records contain an up-to-date list of medication.	229
Demonstrate competence to perform emergency resuscitation (CPR).	228
The practice must demonstrate ethical handling of confidential medical records.	224
Demonstrate a balanced portfolio of learning in the past, present, and future.	223
Notes tagged in chronological order.	223
A complaints system is in place.	223
The candidate will demonstrate appropriate use of the primary health care team.	223
Demonstrate how patient confidentiality is maintained by staff.	222
Staff should have a contract and job description.	222
Demonstrate how patient confidentiality is maintained by the doctor.	220
Demonstrate rational prescribing for acute illness.	219
Up-to-date summaries are available.	219
The candidate understands the importance of, and can demonstrate, the implementation of effective communication within the practice team.	219
A repeat prescribing policy must be in operation.	219
An appropriate family planning service must be available to the patients of the practice.	219
Defines own learning needs.	216
The doctor refers appropriately.	216
The practice should have a health and safety policy complying with current legislation.	212
The candidate must present evidence of ongoing audit and action resulting from past audits.	210
Candidates will describe out-of-hours care availability.	210
The candidate will present evidence of their continuing professional development, including relevant educational activities with and without colleagues.	209
The candidate should be aware of the evidence for the effectiveness of their interventions.	209
The candidate should demonstrate appropriate use of a range of primary care nursing services.	209
The practice must be able to access child health surveillance services.	209
Demonstrate that continuity is available for individuals.	208
Undertakes learning from appropriate sources.	208
There is an identifiable management structure within the organisation.	208
The practice has a clear patient information leaflet.	207
The candidate will demonstrate the appropriate use of secondary care services.	206
The candidate must demonstrate appropriate use of the range of mental health services.	206
The partnership must have a partnership agreement.	204
The candidate should demonstrate a system of obstetric care, including appropriate use of midwifery services.	203
Demonstrate the practice complaints procedure with reference to recent cases.	202
The doctor considers the autonomy of patients and others as well as his/her own.	201
Demonstrate that patient care and records systems are maintained in doctor's absence.	199
Demonstrates opportunistic health promotion in consultations.	199
Demonstrate training and support services for staff to determine urgent problems necessitating same-day appointments.	197
Demonstrate sensitivity to the varying social, educational, and cultural backgrounds of patients.	197
The doctor shows awareness of the needs of carers and patients' families.	197
Demonstrates an understanding of how the team is used for chronic care with reference to specific cases.	196
Have written management guidelines for chronic diseases.	195
An age–sex register must be available.	195
The candidate must display knowledge of the financial structure of general practice.	193
The candidate should have an appropriate generic prescribing level.	193
The candidate must demonstrate that their prescribing is cost-effective.	193
Evidence of an annual review of repeat prescriptions.	193

continued

Table 1 (continued). Statements expressed as a result of the Delphi rounds.

Statement	Scores[a]
Aware of the professional standards and lines of accountability of attached staff.	192
Demonstrate systems to record health promotion data and demonstrate a system for acting on that information.	192
Demonstrate health promotion activities with reference to changing the lifestyle of patients.	190
The candidate should demonstrate continuing review of their own and their peers' performance.	189
The doctor keeps up-to-date with chronic disease management, demonstrated as part of a learning portfolio.	189
There will be a current video assessment of the candidate conforming to the same standards as the MRCGP.	188
Demonstrate a morbidity/disease register and evidence of appropriate use.	187
The candidate will describe the system for continuing professional development for the practice team.	187
Doctors balance patient demand and accessibility.	186
The candidate should have access to a range of primary care nursing services.	184
The doctor can demonstrate an understanding and application of GMC guidelines to his/her professional work.	182
Describe and demonstrate practice policies for managing acute illness.	182
The candidate must demonstrate appropriate use of professions allied to medicine.	179
Demonstrates that the education portfolio delivers effective education relevant to the needs of patients.	178
Demonstrate arrangements for independent access to members of primary health care team and sharing of information between them.	177
Demonstrate knowledge of local health issues and how personal and practice health promotion activities address them.	177
The doctor should declare any judgements against him/her by GMC or Health Authority service committees.	176
The candidate will demonstrate appropriate use of information technology.	174
The practice should demonstrate that a mechanism exists for patients' views to be expressed.	173
The candidate will be able to discuss the practice's development plan.	173
Guidelines should be agreed with and adopted by all relevant team members.	171
Investigations are quantified and justified.	170
The candidate must be able to list the available services in primary and secondary care serving their patients' needs.	170
Adequate arrangements for the management of the practice finances are evident.	168
The candidate should be aware of his/her, and the practice's, referral patterns.	167
Demonstrate access for patients and other members of the health care team is adequate for all states of mobility.	166
Demonstrate sources of information available to patients within the practice.	165
Show how their guidelines were developed and how they are kept up-to-date.	163
The candidate can demonstrate appropriate use of minor surgery within primary care.	161
Audits of health promotion should be available.	160
Contact with ancillary staff should be efficient and achieve patients' aims.	157
A system is available to monitor rates of referral.	157
The candidate should be aware of, and demonstrate the use of, critical event analysis.	156
The practice must have a morbidity register.	156
Demonstrate a strategy to inform patients using posters/leaflets/health professionals.	155
The records must have evidence of the collection of recent health promotion data.	155
The candidate should be able to demonstrate joint learning activities within the practice.	155
Case presentations of emergency admissions.	149
Participates in video review of consultations.	149
Record systems support those who choose to see different health professionals.	148
Video consultations should include chronic disease management.	148
The practice must show evidence of non-discriminatory policies.	140
Demonstrate the arrangements to provide chaperones.	139
Demonstrates how the practice visiting policy applies to chronic illness.	134
Demonstrate the arrangement and training of staff to allow patients to be seen in a setting appropriate to their needs.	133
Audited waiting times to the next routine consultation.	131
Makes use of available local groups or mentor facilities.	123
There should be a practice formulary in use.	122
The practice has written information for patients and guidelines on common acute illness.	115
Practice has a published policy on waiting times.	109
The candidate should describe and justify their use of complementary therapies.	95
Doctor is available when patients decide they need to consult.	82

[a]Maximum possible score = 256.

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