EVE – Promoting challenge in appraisal

Introduction.

Over the past decade appraisal in Wales has undergone many changes and it could be viewed that as part of its own development plan HEIW has endeavoured to promote excellence in its appraisal teams. An example of this is the development of the Appraisal Discussion Assessment Method (ADAM) tool (Rowlands and Rees, 2011), which serves as a means of assessment and self-assessment of appraisal skills within the appraisal discussion. This has been seen as a useful means by which the Appraisal Coordinators (ACs) have been able to encourage good generic appraisal skills in their teams. The ADAM tool has proven to be most useful and, for example, a 'Modified ADAM' tool (MADAM) has been developed to assess candidates applying to become new appraisers and undertaking a role-play assessment as part of the recruitment process.

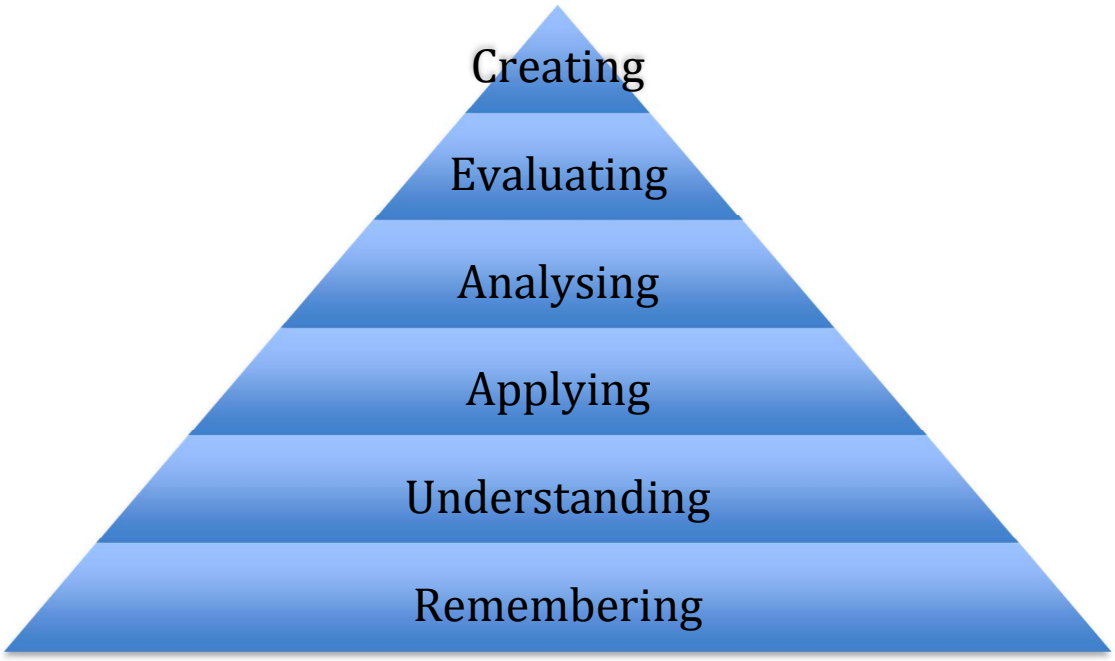
One of the perceived cornerstones of an effective appraisal involves the introduction of 'challenge' into the discussion. Though most have a sense of what is meant by *challenge* in this context not all appraisers have felt entirely comfortable with the concept. It has become apparent during discussions with appraisers during regional meetings or annual performance reviews that not all were clear of its meaning. In response to this it was suggested that the core agenda for a recent regional meeting should involve appraisers sharing examples of *challenge* within recent appraisals in order to illustrate the point. In the seven regional meetings of Spring 2015 Welsh appraisers discussed a variety of examples and these were compiled in the minutes and used as a material source for a potential future project on the subject of *challenge* in the appraisal discussion.

A common theme from discussions was the vague nature of the term *challenge* itself and some were rather concerned about the 'confrontational' interpretation of the term (e.g. as in a rugby match) and clarity was sought as to how this, as a concept, relates to the educational benefits of a developmental appraisal.

An analysis of what we are indeed trying to promote in this concept centred upon the 'added value' that has been encouraged in the Appraiser Comments section of the appraisal summary, as currently represented in the Welsh appraisal system. It was noted that good preparation was important to an effective appraisal discussion and indeed this is clearly identified in the ADAM tool. This process involved a careful evaluation of the doctor's evidence. This in turn promoted a list of appropriate questions designed to promote further reflection by both parties during the discussion phase and resulted in the natural development of ideas, or 'added value' so eagerly sought. This concept, therefore, crystallised around the exercise of 'Evaluating' the 'Evidence', both before and during the discussion and the 'EVE' project was born.

Unfortunately, still missing from this equation was a means of 'stratifying' or assessing the level of learning demonstrated by the doctor's evidence under scrutiny. This was necessary if a tangible means of progress or development were to be

identified. A rummage through some concepts in established educational theory was to prove to be fertile territory. For this purpose the 'Taxonomy of Blooms' (Bloom et al, 1956) was identified as a means of clarifying understanding. The taxonomy, or hierarchy, is illustrated below, but its application was to require examples from real appraisal discussions in which achievements in the doctor's evidence could be identified against various strata in the hierarchy. Potential future learning activities could be demonstrated to have risen through the strata if they were to be truly developmental or to have 'added value'.



In the context of a medical appraisal discussion or evaluation of the evidence an entry may well, of course, demonstrate aspects of cognitive attainment at various levels in the hierarchy but to illustrate this in the context of the taxonomy simplified examples of evidence at each level are listed below.

Remembering (Knowledge). A doctor has become aware (e.g. through reading) of new drugs to treat certain cancers, say, renal carcinoma or pancreatic cancers. That they exist, and that his patients may be prescribed these, constitutes new knowledge but the doctor may be entirely unaware of their mode of action or potential side effects.

Understanding (Comprehension). A doctor has attended a lecture on a new class of drugs (e.g. novel anticoagulants). She now understands the mode of action, indications, side effects etc. of these new drugs and sees the potential for prescribing these to her patient population. Experience of their use in practice is at this stage absent.

Applying. A doctor is quite familiar with prescribing a group of drugs, say Aceinhibitors or Beta Blockers for hypertension etc. but following a useful medical meeting on the appropriate management of heart failure he is increasingly

confident in using them in this context. He has taken the opportunity to review all his patients with this condition and ensured that their treatment was optimised whenever possible.

Analysing. A doctor has familiarised herself with recent arguments for and against PSA blood tests. She has modified her view of when to order this test in the context of the new learning and has now decided to obtain detailed informed consent from the patient before ordering it. She has greater confidence in discussing the pros and cons of this action and is prepared to discuss such issues more knowledgeably within the consultation.

Evaluating. A recent significant event within the practice team revealed that not all partners are managing a common medical condition in the same way. A meeting was called to discuss this and it was decided that at first the practice would run an audit on all patients diagnosed with the complaint in the last six months. A partner is assigned to look up current guidelines and to make recommendations to the group. A review meeting was arranged to study the audit data collection, to hear recommendations from the researching partner and to come to some consensus on management going forward.

Creating. A doctor made a diagnosis of Temporal Arteritis on clinical grounds in one of her patients. She was aware that there were clear guidelines regarding this on arranging a temporal artery biopsy but was dismayed to find that on ringing the local hospital there was no clear pathway on how this would be obtained. In consultation with the local consultant rheumatologist and the department of vascular surgery the doctor liaised to draw up new guidelines suitable for primary care services and arranged for these to be circulated to all practices within the health board area.

Feedback from experienced appraisers would suggest that they naturally assess their doctors according to these stratifications but without being familiar with the hierarchy itself. The aim of the project, however, is to establish whether a teaching module incorporating the educational concepts emerging from the taxonomy could encourage less experienced appraisers to attain more rapidly the skills of their more experienced colleagues and that a greater understanding of that which endows them with such skills could enhance further the attributes of those so endowed. The methods employed are explored later in this discussion but it was agreed that it should incorporate the following practical concepts:

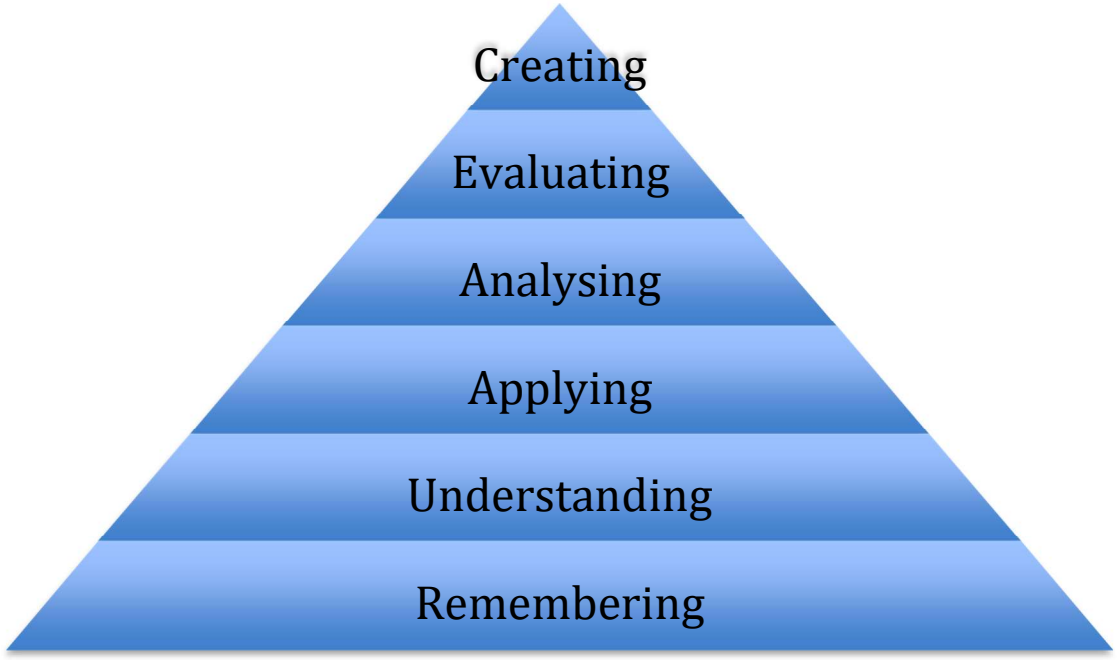
1. Examples should aim to demonstrate stepwise progression through the strata. An appraiser encouraging development in a doctor who is currently working at a lower level in the stratification, for example, showing good knowledge of the potential application of a new drug class (*Understanding*) is likely to be intimidated by the suggestion that he might audit the current management of his patients (*Analysing*) or produce a guidance document for the practice (*Creating*) but could reasonably reflect in next year's appraisal folder on his experience of using the drug in selected patients (*Application*) in the coming year. (The 'over-enthusiastic' appraiser being perhaps as ineffective as her 'unchallenging' colleague in this example).
2. When appraisers miss the opportunity to encourage doctors to move to the next level then the fault may be seen as one of 'collusion' or a missed

opportunity to add value. For example, a doctor who recognises a deficiency in patient care due to inefficiencies identified in the 'system' of care delivery may be poorly served by the appraiser who notes that 'we have similar problems in our locality, but what can you do….' – this a statement of the status quo rather than a Socratic challenge to his colleague. The missed opportunity here is to encourage the doctor to consider, in a meaningful way, possible solutions to the problem, thus encouraging the doctor to consider solutions (*Evaluating*) and possibly developing new ideas (*Creating*).

3. When moving on from one theme to a related area it may be recognised that in order to remain achievable within the time constraints of the year ahead development in the new field may need, initially, to be at a lower point on the hierarchy. As a case in instance from the example above, the doctor with the confidence to produce local guidelines for the management of patients presenting with likely Temporal Arteritis may recognise a weakness in, say, diagnostic skills in Multiple Sclerosis. Next year's realistic learning activity may be confined to the *Remembering* and *Understanding* strata of the hierarchy.

Application

Blooms taxonomy has the test of time and widely applied elsewhere in educational fields.
Appraisal could facilitate the moving through the stages by appropriate evaluation of the stage of the development and challenge to move to higher levels.
Analysis of dysfunctional appraisal discussions might be explained by appraisers moving too quickly through the stages or by wrongly assessing where the doctors current level of attainment is.
Drawing on experience of appraisal in wales over the last 10+ years specific questions to aid lines of enquiry were mapped to the hierarchy. The aim of the questions were to help establish where in the hierarchy the doctor is in their current level of development and to challenge the doctor to move through the stages at an appropriate rate to achieve their developmental goals.



Examples of questions to be used in preparation / during the discussion to add value . Questions will help appraiser to establish where of the hierarchy the doctor lies in terms of their learning, but also to encourage movement up the hierarchy thus adding value to the discussion.

1. Remembering (Knowledge)

Tell me about…

What do you remember from the meeting/ event?

Select one thing from the meeting/event that was new for you?

Was there any new material / information here?

Can you recall what the new knowledge was?

2**. Understanding (comprehension**)

Do you have more confidence in this area / using the drug / this aspect of your work?

Do you consider yourself up to date in this role?

Are you more reassured that your practise is up to date / correct?

Could you now teach this?

Could you demonstrate this to someone else?

Could you summarise how this works in practice?

How does you current understanding compare to where you were before the course?

3. Applying

Have you started to apply this knowledge clinically?

Have any patients benefitted from this?

How many times have you performed this procedure / prescribed this drug / used this technique

Is this now part of your current practise?
How are you using this knowledge in your practice?

Have you implemented this procedure?

Have you (or how have you) changed your practise as a consequence?

Is this affecting the way you train others?

Do you prescribe / examine / investigate in different way as a result of this?

Is your record keeping different because of this?

How have you modified your practise as a result?

4. Analysing

How in your view does this new treatment compare to the old?

Have you encountered any problems with this change?

Do you think this is better for your patients?

Having made changes how confident are you that patients are better off?

Do you envisage any problems with this change?

Can you be certain that this is an improvement?

Can you tell the difference in the practice?

Could you outline the pros and cons of the new services?

Is this change open to criticism in any way?

What would the cynical doctor say about this?

What are the potential criticisms of this approach?

What do patients/ health care professions / colleagues / secondary care doctors think? What do your patient questionnaires say? Have you asked patients what they think? Have you asked the right group of their views?

5. Evaluating

Are you doing what you say you are and how do you know / how are you demonstrating this?

Are you able to demonstrate to others the value of doing this?

Have you demonstrated that you are performing in this way?

Are you meeting guidelines? How are demonstrating that you are meeting these guidelines?

How do you judge that this change is successful?

How are you showing that you critically analyse what you do?

Are you convinced that this is an improvement to your patients care?

How do you demonstrate the value of this intervention?

Can you show others that you are competent in this area?

What are the problems with the intervention in the practice? What could you do about this?

How would you justify this to others?

Are your patients better off because of this?

Could this outcome have been achieved in any other way?

Are you happy that your terms of reference are valid - have you set the right standards - can you back these up.

So what?

6. Creating

How will you develop this in practice?

How could you take this further?

In what way could you take this forward?

Are you interested in trying to improve this service in any way?

Is this piece of work complete - what else could you do with this learning?
Could you construct a protocol /guidance document for others to use?

Could this develop outside of the practice / service /hospital?

Could you share this with other doctors / practices?

Is this generalizable to other aspects of your work - learning style / format of learning / teaching style / something else that needs a similar approach/ a service that needs looking at?

Do you need to share this with others in the practice / department / wider health care community?

How will you integrate this into your current service provision?

How will you provide this service within your health service - does it need to train others?

Are there any adaptations to your current practice that will need to be made to accommodate this?

Are there any potential problems with introducing this? Have you considered where it might go wrong? Can you predict any problems?

VIDEO SECTION

Could overlay taxonomy terms i.e. remembering to creating over the screen whilst the video is playing to emphasise the way the appraiser is leading the discussion Could use colours (traffic light type) to identify functional or dysfunctional progression or lack thereof.

Scenario 1
Doctor has attended meeting on NOAC, has reflected on the functioning of the drugs but has no clinical experience of prescribing them in practice.

Evidence submitted
Activity - attended meeting with local consultants, latest update on new drugs, indication and potential problems with the drugs in practice.

Reason - new class of drugs available to be initiated in primary care.

Reflection - Previously aware of the group of drugs but knowledge limited as not available to be initiated in primary care then had not feel the need to update. Change in guidance to allow for initiation in primary has stimulated interest. Since the meeting have become aware of the indications, side effects and problems in prescribing for patients with renal impairment.
Outcome
1. Greater confidence in initiating the drugs
2., Prepared to switch patients from warfarin to NOAC according to guideline
3. Aware of problems with impaired renal function

Supporting documentation - certificate of attendance / notes made during the meeting

Videos

1. Video - Ineffective discussion
Acknowledges new learning but no added value - at end of the discussion no changes agree, no action plan, reproducing material in folder only
Appraiser - repeats information in folder - colludes over prescribing and moves on to another subject. No added value - repeats the information in the folder - no action plan.

2. Video - Poor judgement of level - leads to over challenge
Appraiser is over enthusiastic and starts to make suggestion on audit of all the patients on warfarin / or AF/ suggests developing practice guidelines Jumps to level of evaluation when little practical evidence of use

Tries to push for audit and practice guideline but doctor has not even prescribed - appears to recognise this to bring it back at the end to something more realistic. Pushes for audit but recognises doctor feels uncomfortable and brings it back rather reluctantly

3. Video - appropriate level
Appraiser encouraged doctor to reflect on learning - use the drugs, offers suggestion on how the doctor might apply and reflect on their use on selected patients.
Encouraged reflection in next years' appraisal - develops an action point Very doctor lead - facilitative - gets agreement

Scenario 2
GCA example - attached

4. Video
Appraiser colluding - not challenging - just reiterating that things not great - nothing to do - reiterated the knowledge and understanding but does not go anywhere else with this.
Colludes - does not seem to address at all - brings out more situations where collusion happening rather than seeking guidelines

5. Video
Appraiser recognises potential to make changes to the services. Challenges doctor to change the local protocol - get something to work - agree a realistic action plan.
Same scenario but comes up with suggestions and a plan to address issues

6. Video
Following on from previous discussion about GCA - doctor mentions issues with a patient presenting with DVT that did not have any investigations performed in secondary care to rule out an underlying cause. - Appraiser demonstrates skills at appropriate level in the hierarchy for future development.
Follows on from previous video - takes it back to level of knowledge rather than starting at the top as in previous entry.

Conclusion

This is a novel application of an educational theory to an important area of the appraisal process, which will require further evaluation to establish its effectiveness. Achieved descriptors of the challenge process to help appraisers establish when ineffective or over challenging - to achieve appropriate levels of challenge

Adapted this to an online training package with video clips to demonstrate the theory in practice and will form part of a larger advanced appraisal skills teaching module and will lend itself to future evaluation to asses the validity of the process.

References:

Bloom, B. S.; Engelhart, M. D.; Furst, E. J.; Hill, W. H.; Krathwohl, D. R. (1956). Taxonomy of educational objectives: The classification of educational goals. Handbook I: Cognitive domain. New York: David McKay Company.

Rowlands M and Rees L (2011) Developing a tool for analysis of recorded appraisal discussions. Education for Primary Care 22: 241–52