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Reflective practice for patient benefit: an analysis of doctors' appraisal portfolios In Scotland

ABSTRACT

Introduction: Reflective practice has become the cornerstone of continuing professional development for doctors, with the expectation that it helps to develop and sustain the workforce for patient benefit. Annual appraisal is mandatory for all practising doctors in the UK as part of medical revalidation. Doctors submit a portfolio of supporting information forming the basis of their appraisal discussion where reflection on the information is mandated and evaluated by a colleague, acting as an appraiser.

Methods: Using an in-depth case study approach, eighteen online portfolios in Scotland were examined with a template developed to record the types of supporting information submitted and how far these showed reflection and/or changes to practice. Data from semi-structured interviews with the doctors (n=17) and their appraisers (n=9) were used to contextualise and broaden our understanding of the portfolios.

Results: Portfolios generally showed little written reflection and most doctors were unenthusiastic about documenting reflective practice. Appraisals provided a forum for

verbal reflection, which was often detailed in the appraisal summary. Portfolio examples showed that reflecting on continued professional development, audits, significant events and colleague multi-source feedback were all felt to be useful. Reflecting on patient feedback was seen as less valuable because feedback tended to be uncritical.

Conclusion: The written reflection element of educational portfolios needs to be carefully considered, since it is clear that many doctors do not find it a helpful exercise. Instead, using the portfolio to record topics covered by a reflective discussion with a facilitator would not only prove more amenable to many doctors, but would also allay fears of documentary evidence being used in litigation.

Keywords: Reflective practice, appraisal, revalidation, supporting information, continuing professional development.

Introduction

Reflective practice in medicine is considered an essential attribute of a competent health professional.[1] However, its very nature makes it difficult to quantify and evidence to support the promotion of reflection in medical education is largely theoretical.[1] Nonetheless, in recent decades there has been a focus on trying to capture and evaluate reflection – especially through the use of portfolios, which require written reflections from both students,[2] doctors in training and increasingly, qualified practitioners.[3,4]

Some have questioned whether reflection can or should be assessed,[5] and voices within the medical profession have queried the usefulness and value of written reflection.[6] There has also been recent concern about the confidentiality of written reflections. For example, a high profile legal case in England, UK (Bawa-Garba case) has raised concerns that a doctor's portfolio might be examined as part of legal proceeedings.[7] In the light of this, the General Medical Council (GMC), the UK's medical regulator, has recently advocated that professionals' reflective notes should be legally protected (in England).[8] In Alberta, Canada, formative feedback to doctors from the multisource feedback scheme is not allowed to be accessed in legal proceedings.[9]

Reflection is at the heart of many regulatory initiatives globally. In the UK, practising doctors must take part in an annual appraisal, facilitated by a trained appraiser to inform medical revalidation. Medical revalidation is the process by which the GMC confirms that a doctor's licence to practise will continue, informed by a doctor's participation in five satisfactory appraisals.[4] Appraisals provide an opportunity for a doctor to reflect on their practice and performance in order to demonstrate that they remain up to date and fit to practise. After the appraisal meeting, the appraiser produces a summary of the discussion which, once it has been approved by the appraisee, may be made available to a Responsible Officer (RO).[10] This individual, often a medical director, makes a revalidation recommendation to the GMC based on satisfactory participation in appraisal, the appraisal summary and any other clinical governance information available. Supporting information that must be provided by the doctor, is required to demonstrate that they are continuing to meet the principles and values set out in *Good Medical Practice* - a document which describes what is expected of all registered doctors.[11] Central to the process is the concept

of reflective practice; a doctor must reflect on what that information means to them and their patient care and how it might therefore lead to changes or developments in practice. The GMC has produced guidance which sets out the supporting information needed for appraisal (Table 1).[12] Most doctors submit their supporting information via an online portfolio and many different IT platforms have been developed to facilitate this.

The concept of using a portfolio to bring together examples of a doctor's practice is a well-established one. There are different types of portfolio, for example showcase portfolios, which 'showcase' a clinician's best work and skills.[13] There are also learning or training portfolios, to assess specific competencies,[14] plus portfolios aimed specifically at recording and promoting continued professional development, such as the American Board of Medical Specialties Multi-Specialty Portfolio Program[15] and the Royal College of Physician and Surgeons of Canada's Maintenance of Certification program.[16] Portfolios required for revalidation in the UK have a dual purpose: they are intended to both ensure the doctor meets GMC requirements for collecting appropriate information for revalidation but also to support the individual's own learning and reflection.

To date, little is known about the impact on reflective practice of using appraisal to inform revalidation. Undertaken as part of a wider evaluation of the implementation of revalidation,[17] we analysed the supporting information doctors bring to appraisal through examining a sample of online portfolios and combined this analysis with interviews with both appraisers and appraisees. The interviews focused on the opportunities and challenges of supporting information and appraisal/revalidation more widely. Given the importance attached to the production of, and reflection on, suitable supporting information we wanted to explore:

- Is the written reflection doctors submit for appraisal of a high quality?
- What do the portfolios and appraisal summaries indicate about the role of reflective discussion in the appraisal?
- Do the portfolios suggest that gathering supporting information prompts doctors to make changes to their practice and is, therefore, a useful exercise?

The study sought to analyse portfolios/appraisal summaries from Scotland. We chose this devolved nation within the UK as it has a readily accessible portfolio data through the Scottish Online Appraisal Resource (SOAR) submission system.[18] Whilst the GMC does not require doctors to use any specific appraisal portfolio tools or systems for revalidation, SOAR is the national online portfolio used by most doctors in Scotland and managed by NHS Education for Scotland. Elsewhere in the UK, various different appraisal systems operate. For example, England has a fragmented system for documenting appraisal information, with no central submission system. In contrast, Wales and Northern Ireland are similar to Scotland in that they have a single online appraisal portfolio; in Wales the Medical Appraisal & Revalidation System (MARS) fulfils this role.[19]

SOAR has specific areas that must be completed, but there is freedom for the appraisee to populate these areas with a variety of supporting information that reflects their range of practice. The system then encourages the appraisee to reflect on the supporting information they have provided via an overview form. Details of SOAR are provided in table 2.

Methods

This study formed part of a wider evaluation of revalidation[17] which sought to gather information about revalidation mechanisms at all levels of the process using a mixed methods approach. This included literature reviews, online surveys and interviews, as well as portfolio analysis, to build up a holistic picture of how revalidation is working and being perceived by the profession.

Permission to examine the portfolios and summaries of Scottish doctors was sought through an online survey of all UK non-training grade doctors in the summer of 2015. At the end of this survey, doctors were asked if they would be prepared to take part in further qualitative research activities relating to the study – including sharing their most recent portfolio. The intention was to examine 20 portfolios from a good range of specialties as it was considered that this would be both achievable and provide a good breadth of data. The study gained research ethics approval from the University of X.

The on-line survey was sent to 156,610 practicing UK doctors and there were 26,171 respondents, of whom 5,137 initially expressed an interest in receiving information about taking part in further research activities. Subsequently, 238 doctors returned completed consent forms and of these, 27 were based in Scotland, of whom 24 initially opted in to share their portfolio.

To analyse the supporting information that doctors submit for their appraisals, two researchers (SH and JW) developed a template to complete for each portfolio using quality assurance frameworks and processes in Scotland to inform the template design. This template (available from authors on request) was used to describe what supporting

information was submitted (under the six headings listed in Table 1), whether the supporting information showed evidence of reflection and whether any changes or outputs resulted from each piece of supporting information. The template design was sufficiently flexible to allow for differing types of supporting information to be recorded.

An initial sample of five portfolios were examined by both researchers, who completed separate templates for each portfolio to establish the types, extent and quality of the supporting information and appraisal summaries. The templates were then compared to establish that the data were being recorded in a similar way and that findings were consistent. After establishing consistency across five portfolios, all remaining portfolios were reviewed.

Subsequently, both appraisees and appraisers were invited to participate in semi-structured telephone interviews as part of the wider study, to find out their views on appraisal, revalidation and the gathering of supporting information. Complete transcripts were obtained for each interview. Template analysis was used to analyse the interview data thematically.[20] Template analysis involves identifying initial themes based on a priori codes. The 'template' developed is then expanded upon, with new codes added as necessary to develop a hierarchy of over-arching and sub-themes. Our initial coding template was based on the interview questions and was developed further by coding a sub-set of the interviews, with individual researchers focussing on discrete areas of the interview transcripts. In this way, several researchers collectively built up the coding template, which was then applied to the whole dataset.

Combining an examination of the doctors' portfolios with their views and those of their appraisers, we were able to link analysis of their portfolios to their opinions about the value

of collecting supporting information. The findings are presented under three thematic headings below: quality of written reflection, role of reflective discussion in appraisal and supporting information prompting changes to practice.

Results

Twenty-four doctors in Scotland initially agreed to share their most recent portfolio. Of these, 18 Scottish portfolios were actually obtained. Unavailable portfolios were either incomplete on the SOAR system or not uploaded onto SOAR. The portfolios obtained represented a good spread of specialties, as shown in Table 3. The doctors concerned were aged between 37 and 69, with the majority aged between 48 and 59. The table also indicates those doctors for whom we had additional interview data (17 appraisees, 9 appraisers). The appraisals for these 18 doctors took place between November 2015 and July 2016.

As noted in Table 2, doctors upload their documentary evidence into four electronic folders, or domains. For examples of some of the types of supporting information uploaded into each domain, see Table 4.

Quality of written reflection

The portfolios in this sample varied greatly in how many documents describing a doctor's practice were uploaded. Whilst large numbers of documents were uploaded by a few

177 doctors (minutes from meetings, emails, conference presentations etc.), documents
178 detailing reflection were largely absent. One consultant had submitted 115 documents for
179 Domains 1 and 2 alone. These included a small amount of reflection regarding an audit and
180 what changes might be implemented as a result, but written reflection was on the whole
181 sparse. There was evidence of a number of complaints and the consultant's appraiser noted
182 in the appraisal summary that in future such events could be used as a basis for a significant
183 event analysis (SEA); indicating an attempt by the appraiser to encourage future reflection.

184 SEAs were included in many portfolios, but they usually consisted of a few paragraphs only,
185 with a basic outline of the event followed by a sentence or two to summarise any changes
186 implemented. In a few cases more extensive reflections were uploaded – for instance, a
187 sessional GP who used reflective templates for several SEAs, included a clinical case report
188 proforma, completed a reflective template on their Patient Satisfaction Questionnaire and a
189 reflective template detailing approaches to patients with poor English. Another doctor
190 used an 'enhanced' SEA template[21] to produce a detailed and thoughtful account of two
191 missed referrals with reflections on the several factors responsible and measures described
192 to ensure such incidents would not happen again. However, one appraiser commented
193 that the enhanced SEA template "has not really taken off much (A0021)" in appraisal,
194 speculating that it may just be a question of the longer form proving more time-consuming.

195 Some of the appraisers interviewed indicated that they encountered doctors who find
196 written reflection a challenge. For example, one remarked:

197 "I think doctors can be reflective but they struggle putting it down on paper" (A0215).

Another echoed this, saying that they had to give some appraisees pointers about how to write a reflective piece:

> "they'll put in all their evidence for attending CPD, meetings and things and I'll ask them 'what did you learn from that?' 'Oh, I can't really remember.' They can't reflect back on what they've learnt" (A0060).

Appraisers clearly indicated that they wanted quality rather than quantity in the portfolios and would rather see a few pieces of high quality reflective writing than lots of documents uploaded with little discrimination or reflection. One appraiser thought that appraisees should be asked to be selective and to write a reflective piece on three of the most useful pieces of training they had undertaken the previous year and to explain why and what had changed in their practice.

Role of reflective discussion in appraisal

Whether or not doctors submit much in the way of reflective commentary, it is apparent that a significant amount of reflection takes place in the appraisal meeting itself, with some of the summaries produced afterwards by appraisers recording in-depth discussions of supporting information. The summary tends to be a distillation of both the documentary evidence (supporting information) and the appraisal discussion and so in some cases it describes approaches to learning and reflection which cannot be gleaned from the portfolios alone. For example, one appraiser noted in the summary that for a particular doctor:

> "reflection on learning tends to be in a variety of ways, including contemporaneous entries into electronic diary and setting personal task lists. In 2015 started using Twitter as a tool for learning…" (R0005).

There was nothing in the portfolio to evidence this, highlighting the importance of the appraisal discussion in drawing out the detail of a doctor's approach to learning and practice.

The interviews indicated a greater enthusiasm for verbal reflection at appraisal in comparison to written reflection. For example, a consultant in Mental Health observed that reflection is especially useful in their specialty and they preferred to discuss issues at appraisal rather than fill in reflective templates:

> "I don't necessarily do it (reflection) using a form…but I do bring it up in my appraisal meeting, things that may have happened and reflect on it" (R0030-Int).

A few doctors explicitly mentioned that talking through SEAs at appraisal had been helpful – not just to understand what had gone wrong but also to consider the things that the doctor had done well in that situation. Therefore, the appraisal allowed what may have been very limited written documentation to be discussed, expanded and reflected upon - in effect supplementing the portfolio. This was helpful from the appraiser's point of view:

> "often within an appraisal interview you can go through a case and draw that out so that effectively you're reflecting within the appraisal" (A0196-Int).

There was evidence that the appraisal discussion was used to "flesh out" a thin portfolio. For example, one GP submitted no evidence for Quality Improvement (QI) or SEA and although he claimed 50 credits plus 20 impact credits[22] for CPD there was very little CPD

evidence uploaded (just three certificates). As a result, the appraiser noted in the appraisal summary that the learning credits were difficult to accurately quantify, but it is clear that he was happy after the appraisal meeting that the appraisee had demonstrated a broad range and type of learning through discussion (and he noted that they had discussed ways in which the appraisee could use data already held at the practice to develop QI and audit projects in the future). In his interview, this appraisee noted that his appraiser:

> "teased out more reflection and the realisation that I was doing things that I wasn't necessarily acknowledging" (R0133-Int).

However, the extent to which the appraisal discussion should be used to supplement the portfolio and help with completing the appraisal summary form was questioned by one appraiser:

> "In the past I would use the supporting information I have and glean a lot from the actual appraisal interview and document that it's been through discussion and accept that; but I'm becoming a little bit more, I'm questioning myself about, should I have something a bit more concrete as evidence of it?" (A0215-Int).

So it seems an appraiser may be unsure about how much weight should be given to written reflection as opposed to verbal reflection and there can be uncertainty over the extent to which a detailed and reflective appraisal conversation should be allowed to make up for a lack of reflection on the submitted supporting information.

Supporting information prompting changes to practice

Whilst portfolios provided written (often brief) evidence of what doctors have learned and what they will do differently as a result of various activities - such as CPD or a quality improvement project - it was difficult to assess the extent to which gathering supporting information was beneficial for the doctor. Indeed, the evidence suggests that including copious amounts of reflective writing in a doctor's portfolio does not necessarily indicate a translation of reflective writing into reflection in and on practice. A sessional GP who had made the most extensive use of reflective templates observed that, although they had uploaded reflective pieces for "every part of appraisal," this was only because it had been:

> "…thoroughly drilled into me by my previous appraiser, and my current appraiser said I didn't actually need to do it, it wasn't compulsory" (R0021-Int).

Their views on written reflection were actually not positive:

> "I'm not sure it helps me, but it helps me present it to the appraiser in a form that seems acceptable" (R0021-Int).

Therefore, at face value, this doctor's portfolio seemed to indicate an enthusiasm for reflective writing, but in reality, it was a regimented exercise undertaken more out of duty rather than as part of a personal developmental journey.

Nonetheless, there is evidence that for some doctors, the process of documenting and justifying their activities was helpful in focussing and planning. For instance, a sexual health consultant included a CPD diary which provided good summaries of what they had learnt from various workshops, conferences and other events plus the impact of the learning. In interview they observed that for them, CPD was the most important supporting information, noting that:

> "the CPD stuff …I think it is helpful …and I don't mind justifying that, and time to reflect on your learning and what you've done and illustrate how you changed things" (R0049-Int).

Another consultant included a short, written piece to summarise the benefit they had gained from various conferences/meetings and noted that reflecting on CPD could lead to a greater focus:

> "it's good to reflect on your CPD, see where you've learnt from it, see where it might go constructively in the future rather than just flailing about …it's quite a good way to plan yourself a bit more" (R0085-Int).

So there is a suggestion that for some doctors, the discipline of having to document, justify and reflect on CPD activities was leading to a more focussed approach to learning.

Written accounts of QI activities - notably audits – gave clear indications that positive practice changes had resulted from these activities. An audit by a GP of the ultrasound service provided by their practice was noted as improving awareness of certain aspects of undertaking scans, whilst a prospective audit of breast cancer waiting times by an oncology consultant had led to beneficial changes to the treatment pathway. Again, though, it is difficult to know whether documenting the activity for appraisal acted as any kind of catalyst for change. In their interview, the oncology consultant observed:

> "And the audit's good 'cos you either realise that you're doing quite well, or you think 'oh dear I haven't done very well this year, I'd better sort a few things out,' so it does give you a wake-up call" (R0085-Int).

This suggests that, possibly, the process of writing up the audit results might crystallise an awareness of areas of practice that needed future attention.

SEAs were included in many portfolios and where included suggest they may have led to changes in practice. Examples include: a change in approach to discussing weight issues with patients; a realised need to be more assertive with hospital staff; giving patients better information about warfarin doses and improvements to the way prescription requests are written at the practice. The key factor seems to be the quality of the reflection, with one doctor noting in interview that if SEAs are written up well, they prompt the most reflection in terms of the supporting information doctors are required to gather:

> "if they're (SEAs) done properly and the topic lends itself to it, then it can be very informative and insightful" (R0215-Int).

A few others concurred, finding the process of writing up an event helpful, with a hint from one that doing it at the time (rather than just prior to the appraisal meeting) can make it more impactful:

> "I find reflective logs, sitting and writing … how you felt in different circumstances, at the end of a difficult meeting, or having dealt with a difficult colleague, is kind of important for me" (R0057-Int).

Formal patient feedback, in the form of a recognised questionnaire filled in by patients, is required only once every five years and so many of the doctors in this sample did not submit patient feedback as part of their written evidence – only five of the 18 did so. Of these, there is little indication of reflection/resultant change to practice. For example, a locum GP used the CARE[23] questionnaire, obtained 29 responses, wrote a reflective piece on the results but planned no changes as they were satisfied with the feedback. A consultant in Mental Health (R0030) included only seven patient feedback forms, but again the feedback

was good and no changes were planned. Interview data supports the view that patient feedback was of limited value, with one doctor noting that it is:

> "pointless, they seldom say anything negative and they very seldom say anything that's constructive, they make nice comments and the tick boxes are no use at all" (R0085-Int).

By contrast, it tended to be colleague feedback that led to more reflection and plans for change, usually because it tended to be more specific and critical. Interview data supported its potentially useful impact:

> "I think for me the multisource feedback was probably the most emotionally powerful (type of supporting information)" (R0057-Int).

> "I find it (colleague feedback) a very positive and constructive exercise" (R0133-Int).

Specific changes were mentioned by some as a result of colleague feedback, for instance one doctor noted that they had changed how they engage with certain services within the hospital and another mentioned that it had led to a greater awareness of how they come across in meetings.

Discussion

Requiring doctors to collect supporting information about their practice in portfolios is seen as a key objective in achieving the aim of ensuring that doctors reflect and, where appropriate, change their practice for patient benefit. This study reviewed the quality and quantity of supporting information submitted for 18 online appraisal portfolios in Scotland

from the appraisal year 2015-16 and examined how this documentary evidence was summarised by the appraiser. Supplementary data from interviews with the doctors concerned and their appraisers helped to provide context and additional insights into the gathering and discussion of supporting information. While other studies have examined appraisal summaries and PDPs,[24] and assessed patient and colleague feedback gathered by GPs,[25] to our knowledge this is the first full analysis of portfolios for revalidation.

Despite the objective to support reflection, we found that, for this sample of doctors, the demonstration of reflection on their practice was generally only superficially apparent in their supporting information for appraisal. Written reflection was often brief and lacking in detail and interview data suggested that many doctors would rather reflect verbally, either at the time with colleagues or with their appraiser in the appraisal meeting, a finding backed up by the wider literature.[1,6,26,27] For their part, appraisers wanted doctors to be selective in the documents they chose to include in their portfolios and would prefer to see a few examples of high quality reflection rather than many documents submitted somewhat indiscriminately and with no commentary on their impact or meaning for a doctor's practice. There are already moves to support a focus on quality over quantity when submitting supporting information.[11]

The GMC states that the key purpose of providing supporting information for appraisal is to encourage a doctor to reflect on what has been learned from the documented activities and what they intend to change as a result.[11] In this sample of doctors, written evidence from the portfolios indicates that SEAs, QI activities and CPD activities were noted as most often resulting in changes to practice (as evidenced by written intentions or self-reported changes to practice). There is an indication that patient feedback can be rather anodyne and, in this

sample of portfolios, provided little useful feedback to work with; colleague feedback seemed to provide more useful and targeted feedback. This echoes other findings: a survey of ROs found that they considered participation in QI and responses to significant events as the most effective methods of improving doctor performance;[28] the large online survey conducted by UMbRELLA found CPD was the most commonly reported change as a result of appraisal;[17] another survey of GPs also cited QI and SEAs as important in prompting changes, with colleague feedback also regarded as important in helping deeper reflection on their work (though it should be noted that they valued patient feedback almost as much).[29]

The latest GMC guidance emphasises the central role of reflection in appraisal and describes it in terms of a twin process, stating that: "your appraiser can facilitate further reflection, as needed but it is your responsibility to demonstrate examples of your reflective practice."[11] So firstly, each doctor needs to produce written reflective accounts and then there is an expectation that this will be reflected upon further in the appraisal - both to increase the depth of the learning and satisfy the appraiser that meaningful reflection has taken place. However, now that written reflection forms part of the requirements of revalidation, it would appear that many doctors approach it as a necessary hurdle to satisfy the appraiser, rather than through an appreciation of its importance for professional development. Few would argue against the importance of reflective practice in medicine. However, a reluctance to document one's reflections may not indicate a lack of reflective practice – especially if written reflection is regarded as mandatory, there is a risk this may be formulaic and lead to basic storytelling and a tendency to write what the appraisee perceives is required by their appraiser and their regulator.[30] Thus the regulatory agenda may turn

written reflection into a product undertaken in a reductionist and ritualistic manner which runs counter to the "intended transformative notion of reflection."[31]

The inclusion of written reflection in a doctor's portfolio has become a more fraught issue with the recent Bawa-Garba legal case[7] in which there was a concern amongst the profession that this doctor's written reflections had been used in evidence against her (although the Medical Protection Society has stated that her reflections did not, in fact, form part of the evidence considered by the court and jury.[7]) Given the concerns about this and recognising the important role appraisal can play in reflection, one solution could be for an appraisee to highlight in their written documentation what areas they wished to discuss and reflect upon verbally with their appraiser. This would allow the content of the reflection to remain confidential and embed the appraisal meeting as an active component of the reflective process.

In other words, there should be flexibility in approaches to reflection within appraisal, with written reflection just one option for a doctor to evidence their practice. This point has been highlighted in a recent editorial in the British Journal of General Practice which argued that GPs and appraisers should agree what to bring to the appraisal, choosing from a variety of options including: an observation of the GP's video-recorded consultations or a selection of cases to discuss or a multiple-choice questionnaire.[31] The key point would be to highlight learning needs, not to assess performance as such. The authors found that the most popular option was verbal reflection on cases outlined (briefly) in advance to the appraiser. This seems a sensible option and our study suggests that some appraisers are already accepting verbal reflection where written reflection is limited. In this way the appraiser's role as mentor becomes especially important – an appraiser needs to stimulate a discussion

that will 'help prompt, challenge and make sense of the complexity of experiences.'[32] However, it must be recognised that appraisers currently hold dual responsibilities, to provide formative support whilst also ensuring revalidation requirements are met, which may at times be in conflict.[33] Appraisal providers could work to ensure the appraiser's role as mentor is protected.

Our study has demonstrated that doctors may pay lip service to written reflection because they deem it to have little benefit, so the emphasis needs to shift towards meaningful verbal discussion which, through being less time-consuming and formulaic, may open the way to a deeper and more meaningful process. If doctors can have more flexibility and control over how they choose to reflect then, given goodwill, the process might prove more impactful and insightful.[34]

Further research might usefully examine successive portfolios for a sample of doctors, submitted over a number of years. This would allow an assessment to be made of whether changes planned as a result of reflection on practice were actually implemented. Interviews with the doctors concerned could allow exploration of when and how they reflect and what support they might welcome to make reflection during the appraisal process more impactful.

Conclusion

The written reflection element of educational portfolios needs to be carefully reconsidered because, it would appear, that many doctors do not find it a helpful exercise. Instead, using the portfolio to just record that a reflective discussion has taken place with a facilitator

would not only prove more amenable to many doctors, but would also allay fears of documentary evidence being used in litigation. However, it is also clear that an annual reflective written or verbal exercise undertaken for appraisal is limited in scope and reflection needs to be an ongoing mental activity embedded into the complexities of daily practice. Further research needs to be carried out to establish the best ways of encouraging on going reflection.

Limitations

The sample size (18 portfolios) was small and only consisted of Scottish portfolios. Whilst the choice of Scotland allowed ease of access to portfolios because of the national appraisal toolkit in use, this meant that the large variety of appraisal toolkits and different ways of presenting supporting information which exist in the rest of the UK were not represented.

Lessons for Practice

There is still work to be done in making explicit what evidence is required, and how much, for each appraisal.

Appraisers should value verbal reflection at appraisal if this is deemed to be of more benefit to the individual doctor than written reflective accounts.

Appraisees could highlight in their written documentation the areas they would like to discuss and reflect upon with their appraiser, allowing the content of the reflection to remain confidential.

Appraisers may need more guidance regarding how far a thorough and reflective appraisal meeting can be allowed to make up for a sparse portfolio and may need guidance in how to facilitate reflection.

Further research might usefully examine successive portfolios for a sample of doctors. This would allow an assessment to be made of whether changes planned as a result of reflection on practice were actually implemented.

TABLES

Table 1: GMC Guidance on supporting information

Type of supporting information	Examples of what may be provided	Frequency with which the supporting information is required
Continuing professional development (CPD)	Evidence of participation in College/faculty CPD scheme Certificate of attendance at conference, training workshop	Every appraisal
Quality improvement activity	Clinical audit Review of clinical outcomes Case review or discussion	Depends on nature of activity – e.g. participation in a full national clinical audit might be appropriate once every revalidation cycle, case review more regularly.
Significant events (SEA) or untoward or critical incident	Reflective template outlining incidents/events & what was learnt	Any significant events involving the doctor should be discussed at every appraisal. It is what has been learnt, not the number that is important, as in some years doctors may not have a SEA to report.
Feedback from colleagues	Standard questionnaire that complies with GMC guidance	At least once every 5 years
Feedback from patients	Standard questionnaire that complies with GMC guidance Student evaluation of teaching delivered	At least once every 5 years
Review of complaints and compliments	Reflective writing about a complaint and how it was dealt with Complimentary emails/cards from patients	Any changes made as a result of complaints/compliments should be discussed annually. Numbers of complaints may vary across specialties and some doctors may have none. It is how the complaint has been dealt with, rather than the number that is important.

Table 2: Scottish Online Appraisal Resource

Scottish Online Appraisal Resource (SOAR)

- **4 electronic folders**: corresponding to the four domains of *Good Medical Practice:*[2]
  - Domain 1: Knowledge, skills and performance;
  - Domain 2: Safety & quality;
  - Domain 3: Communication, partnership & teamwork;
  - Domain 4: Maintaining Trust.

- **Form 3 overview** – list of documents uploaded with box for appraiser to tick to indicate that each piece of evidence has been viewed. Space provided for appraisee to explain and reflect on the material uploaded in each Domain. A series of health and probity questions must also be answered.
- **Personal Development Plan (PDP)** section allows appraisee to review their progress against last

year's PDP and identify areas for development that they would like to undertake over the next year.

- **Form 4 appraisal summary** - completed by appraiser soon after the appraisal. Checked and agreed to by appraisee.

470

471 **Table 3: Doctors' roles & specialties**

ID	Specialty	Role	Interview with Appraisee	Interview with Appraiser
R0005	Sexual & Reproductive Health	Consultant/Manager	Yes	Yes
R0011	Accident & Emergency	Consultant	Yes	No
R0021	General Practice	Locum	Yes	Yes
R0030	Mental Health	Consultant	Yes	No
R0048	General Practice	Partner	No	No
R0049	Sexual Health & HIV	Consultant	Yes	No
R0057	Medical Education	Manager	Yes	Yes
R0060	Community Paediatrician	Associate Specialist	Yes	Yes
R0065	General Practice	Locum (retired)	Yes	Yes
R0075	Addiction Psychiatry	Specialty Doctor	Yes	Yes
R0085	Clinical Oncology	Consultant	Yes	Yes
R0133	General Practice	Principal	Yes	No
R0149	Public Health/ Sexual & Reproductive Health	Senior Lecturer/Specialty Doctor	Yes	No
R0164	General Practice	Locum	Yes	Yes
R0169	Reproductive Health	Consultant	Yes	No
R0171	Upper Gastrointestinal Surgeon	Consultant	Yes	No
R0196	Public Health Medicine	Consultant	Yes	Yes
R0215	General Practice	Principal/Medical Education	Yes	Yes
Total	18		17	9

472

473 **Table 4: Overview of what supporting information was presented**

Electronic folder	Examples of supporting information uploaded
Domain 1: Knowledge, skills & performance	College CPD templates – recording what activity was undertaken, why, what was learned, what will be done differently and how many credits are being claimed. (1 credit = 1 hour of CPD) Annual 50 credits (or 250 across five years) is widely adopted as a requirement. Most appraisees in this sample managed to achieve 50 credits.

Domain 2: Safety & Quality	Summary of an audit including what has been learnt, any planned changes in practice. Case reviews. Not all the doctors in our sample see patients. One doctor involved in medical education (R0057) submitted information regarding a research project about trainees; a public health doctor (R0149) provided a teaching evaluation from students. Significant events – sometimes using standard SEA template.
Domain 3: Communication, partnership & teamwork	Colleague and patient feedback. As would be expected, this was less frequent than other types of supporting information: seven appraisees submitted colleague multi-source feedback (MSF) (range of raters 9-15); five appraisees submitted patient feedback (range of raters 7-50). Where formal feedback from colleagues and patients was not required, appraisees submitted complimentary emails from colleagues, course evaluations, letters of thanks from patients etc. In several cases this folder was left empty.
Domain 4: Maintaining Trust	Certificates/letters showing there were no complaints. Ethics approval for research studies. Information about private practice. This domain presented the most difficulties in terms of finding suitable information to upload; almost half of these 18 doctors left it empty.

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