MCNZ Multisource Feedback

- *Report from Dr David Bellamy*

Dear Colleagues,

On the 26th of June, I attended a MCNZ meeting about the upcoming multisource feedback; I was representing the NZRDA along with Dr Sam Holford and Melissa Dobbyn. Multisource feedback is going to be rolled-out as part of the PGY1/2 prevocational assessment process and the key points from the discussion are as follows:

1. Concerns were raised by the RDA representatives, and the main point was that there must be significant effort taken to ensure that the tool developed would add value to the learning experience of interns, provide useful and specific feedback, and not become another check-box exercise. Additionally, the tool's questions must be aimed at the target audience (allied staff, non-clinic team members, etc) and not be unhelpfully vague and generalized.
2. It was agreed that a tool specific to New Zealand would be developed using a combination of the EDGECUMBE 360° Colleague Feedback and the GMC Colleague Questionnaire, both commissioned by the UK-based Royal College of General Practitioners. It was noted that significant deviation from the existing questionnaires would invalidate the current "evidence-base" of the tools, although there was agreement that the tools would need to be adjusted to ensure their applicability to the specific situation in New Zealand. A smaller working group was arranged to workshop the questionnaires.
3. There was agreement among the group that the aim of the tool was to provide formative feedback for interns, and would be seen alongside the other intern assessment components. There was to be a commitment that the information collected would not be used in a way that would negatively impact an intern's career, and that the information would not be used for research without explicit permission. The interpretation of the results from the MSF would fall to the intern's prevocational supervisor, and there was agreement that the results should be made available to only the supervisor and the intern. There was concern raised from prevocational supervisors that the report should only be available to the intern from the time of their meeting to provide support for the intern.
4. The frequency of completing MSF feedback was discussed, with the consensus being that once during PGY1/PGY2 years was sufficient, as not to overly burden interns or supervisors. There was much debate about optimal timing for completing the MSF, with suggestion that Q2 and Q3 of PGY2 was potentially the best, as PGY1 is important for focusing on job basics and Q1 PGY2 is difficult because it includes the holiday period.
5. It was agreed that there should be a variety of staff members completing the feedback, including allied health, nursing, administrative staff, RMOs, SMOs and potentially TIs. It was suggested that some guidelines be put in place, such as minimum two responses from non-clinical staff or less than half being RMOs. The number of responses was debated, with a decision to be made in light of evidence showing the validation of the tool; a number between 12 to 15 was suggested.
6. There was discussion around whether the introduce MSF to a pilot group of interns or all interns, and whether it be voluntary or compulsory in the initial stages. This is to be discussed further at the next MSF meeting.
7. The action points of the meeting were for a small group to work on developing a variation on the currently available tools targeted at NZ doctors, and provide a draft document for RMOs explaining the process of MSF. These will be discussed in October, and a decision will be made around how the roll-out will look.

MSF is going to be an inevitable addition to the PGY1/PGY2 feedback process, and, with some reservations, the NZRDA supports its inclusion, providing that it proves to have a positive impact on learning, providing useful, specific feedback that can be used to further intern education. We plan to have ongoing input to further these goals.

Dr. David Bellamy