

Colleague questionnaire

for Dr _____

Licensed doctors are expected to seek feedback from colleagues and patients and review and act upon that feedback where appropriate.

The purpose of this exercise is to provide doctors with information about their work through the eyes of those they work with and treat, and is intended to help inform their further development.

Please do not write your name on this questionnaire.

Please answer all the questions. If you feel you cannot answer any question, please tick 'Don't know'.

Please mark the box like this with a ball point pen. If you change your mind just cross out your old response and make your new choice.

Please write today's date here: / /

Please rate your colleague in each of the following areas by ticking one box in each line.

		Poor	Less than satisfactory	Satisfactory	Good	Very good	Don't know
1	Clinical knowledge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Clinical decision making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Treatment (including practical procedures)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Prescribing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Medical record keeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Recognising and working within limitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Keeping knowledge and skills up to date	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Reviewing and reflecting on own performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Teaching (students, trainees, others)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Supervising colleagues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Commitment to care and wellbeing of patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Communication with patients and relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Working effectively with colleagues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Effective time management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please decide how far you agree with the following statements by ticking one box in each line.

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Don't know
16	This doctor respects patient confidentiality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	This doctor is honest and trustworthy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	This doctor's performance is not impaired by ill health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19 This doctor is fit to practise medicine Yes No Don't know

20 Please add any other comments you want to make about this doctor. Please note: No one will be identified when this information is given back to the doctor.

The next questions will give us some basic information about who took part in the survey.

21 Are you: Female Male

22 Age: 16 to 19 20 to 29 30 to 39 40 to 49 50 to 59 60 or over

23 Your professional role (please tick only one box):

Doctor If you are a doctor, are you in a training grade? Yes No

Registered Nurse Health Visitor/Midwife Pharmacist

Administrator/Receptionist/Secretary Allied Healthcare Professional Health Care Assistant

Non-clinical Manager Other (please specify): _____

24 How recently have you been familiar with this doctor's clinical practice?

Current colleague Within the last two years Between two and five years ago

Between six and ten years ago More than ten years ago

25 During this period of your familiarity with this doctor's clinical practice, how often did you have contact with the doctor?

Most days Weekly Monthly Less often

26 What is your ethnic group? Please choose one section from A to E, and then tick the appropriate box to indicate your cultural background.

A White	B Mixed	C Asian or Asian British	D Black or Black British	E Chinese or other ethnic group
<input type="checkbox"/> British	<input type="checkbox"/> White and Black Caribbean	<input type="checkbox"/> Indian	<input type="checkbox"/> Caribbean	<input type="checkbox"/> Chinese
<input type="checkbox"/> Irish	<input type="checkbox"/> White and Black African	<input type="checkbox"/> Pakistani	<input type="checkbox"/> African	<input type="checkbox"/> Any other
<input type="checkbox"/> Any other white background	<input type="checkbox"/> White and Asian	<input type="checkbox"/> Bangladeshi	<input type="checkbox"/> Any other Black background	
	<input type="checkbox"/> Any other Mixed background	<input type="checkbox"/> Any other Asian background		
Please write in <input type="text"/>	Please write in <input type="text"/>	Please write in <input type="text"/>	Please write in <input type="text"/>	Please write in <input type="text"/>