Editorials

Licensing exams and judicial review:

the closing of one door and opening of others?

LICENSING EXAMS IN GENERAL PRACTICE

The Royal College of General Practitioners (RCGP) has the responsibility to provide a curriculum and suitable assessments to license doctors to work as GP specialists in the UK. The General Medical Council (GMC), as the Regulator, holds the RCGP to account for the delivery of these functions.

As with all health care, the workload of a GP has become more complex. They are responsible for providing primary care to an ageing population with multimorbidity. Increasingly more of that care is delivered within the community rather than in hospitals. Licensed GPs need to have the knowledge and skills to feel capable of this work and patients have a right to safe and effective care. The MRCGP examination seeks to establish the readiness of candidates to look after patients in unsupervised practice. A recent study has demonstrated the relationship between scores on licensing examinations and patient health outcomes.[1]

The GP specialty training programme is only 3 years in duration. The MRCGP examination, which must be passed to obtain a certificate of completion of training (CCT), has three components: the applied knowledge test (AKT) attempted from Year 2, the clinical skills assessment (CSA) attempted in Year 3, and workplace based assessment which runs throughout the entire 3-year programme. The CSA is an assessment of a doctor's ability to integrate and apply clinical, professional, communication and practical skills appropriate for general practice. It is an objective structured clinical examination (OSCE) style examination of 13 stations. Using professional role players, the exam assesses candidates' clinical skills in standardised simulations of typical general practice. Approximately 4000 candidates (including resit attempts) are examined each year. Of those entering a GP training programme approximately 3% fail to complete the programme successfully, a minority of those being isolated CSA failures.

A common criticism of the previous RCGP membership examination was the fact that it did not contain an assessment of clinical skills. The CSA was developed in 2007 in this context, based on best evidence in assessment and was approved by the regulator. External reviews were sought in the early years from national and international experts in assessment. The RCGP carries out extensive analyses of examination data in order to refine and improve their assessments, and publishes an annual report with a full data set. It has always highlighted the relative performance of different candidate groups. These differentials are most marked between candidates whose primary medical qualification (PMQ) is from the UK (UKG) and international medical graduates (IMGs). In UKGs smaller but significant differentials exist in relation to black and minority ethnic (BME) status and sex. Those differentials also exist in other postgraduate and undergraduate examinations.[2,3]

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In the light of these differential pass rates a judicial review of the RCGP and the GMC was requested by the British Association of Physicians of Indian Origin (BAPIO). The basis for the review were three claims: that the RCGP and GMC did not comply with their public sector equality duty (PSED), that the CSA directly discriminates against IMG and BME candidates, and that the CSA indirectly discriminates against IMG and BME candidates.

LEGAL CHALLENGE AND ITS OUTCOME

In April 2014 the Honourable Mr Justice Mitting heard the Judicial Review. In his judgement[4] he dismissed all three claims concluding,

'*I am satisfied that the clinical skills assessment is a proportionate means of achieving the legitimate aim (of protecting the public) identified.*'

In particular, in terms of the claim of indirect discrimination he ruled that:

'*There is no basis for contending that the small number who fail ultimately do so for any reason apart from their own shortcomings as prospective general practitioners.*'

The Judge ruled that the RCGP although not a public authority, has a public sector equality duty (PSED) in respect of the conduct and award of the MRCGP, as it has the power to determine who meets the standards to be a GP in the UK, and this is a matter of public importance because of patient health impact. He suggested that the RCGP should now take actions within its own powers such as continuing to maximise the diversity of the panel of examiners and by using its influence with the training community to improve candidate preparation for the CSA.

The RCGP takes its PSED very seriously and is conducting a College-wide review of equality and diversity, seeking to apply the high standards required by the duty to all its appropriate functions.

DIFFERENTIAL ATTAINMENT: CAUSATION

In order to take action on differential performance by IMG and BME candidates in the CSA it is important to understand its causation. General practice in the UK is heavily dependent on the enormous contribution made by IMGs. In the 3 years from 2010 approximately 31% of those taking the MRCGP had qualified from outside the UK. Most IMGs will complete the Professional and Linguistic Assessment

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Board (PLAB) exam before applying for GP specialty training. Two recent studies looking at the predictive validity of the PLAB exam in relation to MRCP and the MRCGP outcomes,[3] and Annual Review of Competence Progression outcomes in a variety of medical specialties[5] have concluded that the current standard of PLAB is set too low, and is below the competency level expected for a UK graduate completing foundation Year 1 training. Doctors who are not equivalent at entry to GP specialty training are likely to struggle with the MRCGP unless they receive training that addresses their specific needs.

It is harder to understand the differentials that exist between white and BME UK trained graduates, who have received similar training. These differentials are seen in the AKT, a machine marked test, and are mirrored by other studies from within the UK both at undergraduate and postgraduate levels within and without medicine, and despite extensive investigation no cause for these differences has been identified.[2]

While the RCGP is responsible for the curriculum and MRCGP examinations, the deaneries/local education training boards (LETBs) are responsible for GP training. Published evidence has shown that performance in selection tests for training correlate with performance in the MRCGP exit examinations.[6] Peile has suggested that appropriate inductions and support would help graduates from outside the UK.[7] Many deaneries/LETBs utilise selection scores to identify trainees at risk of poor performance in the MRCGP in order to put supportive training interventions in place. While there is considerable good practice in various parts of the UK with regard to targeting training there has been no evaluation of the effectiveness of these interventions.

DIFFERENTIAL ATTAINMENT: SOLUTIONS

The RCGP recognises the pivotal role training programme directors and educational supervisors can play in candidate preparation for the CSA and has developed a number of measures aimed at supporting the training community. These include a programme for trainers to visit the CSA, and new resources for CSA preparation, based on sociolinguistic research by Kings College, London and Cardiff University.[8] Two new e-modules and a book are planned for release in early 2015. The MRCGP exam will continue to develop in line with best practice in assessment to ensure that it remains a robust, fair, and defensible exam. The RCGP is currently working through a number of activities with continued development of quality assurance processes, feedback, and standard setting. As usual any changes will have to be approved by the GMC.

The Judicial review, although expensive and traumatic for all those involved has served to highlight differential attainment by IMG and BME candidates across the whole of postgraduate medical education and to bring together all the major stakeholders with renewed emphasis on finding effective solutions. The RCGP will continue to remain at the forefront of this work.

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