

To date, little work has been carried out on the evaluation of audit projects and no studies have been published on the assessment of general practitioner registrars' audit projects. Several simple frameworks do exist, however, and one such framework⁷ provided the basis for the development of the instrument in the present study. This framework focused on the assessment of individual audit projects without necessarily considering wider issues, such as the setting in which the audit took place, which would have been difficult to verify.

Other models had been considered at the first workshop. Bhopal and Thomson's model was designed to evaluate papers published on audit.⁸ It was constructed from the opinions and responses of a number of clinicians attending an audit workshop similar to those run in the present study and again focused on individual audit projects. Walshe and Tomalin, looking specifically at how to evaluate the funding of audit projects, considered five issues relating to objectives being met and resources being used.⁹

One benefit of a criterion-referenced model is its relative simplicity: each criterion is either passed or failed. The aim in testing the reliability of the instrument is to reduce to a minimum the judgement required for each decision. A form, issued to all registrars before they started their projects, with each page headed with the criterion to be judged, has two major advantages. First, it limits confusion among registrars as to what is being tested. Secondly, it limits the amount of writing submitted, thus helping the assessor.

There has been some debate about the nature of practical work to be submitted for summative assessment (Toby J, personal communication). Some have argued for breadth, suggesting that registrars submit a literature review, a critical event analysis, a business plan or a piece of research perhaps carried out during the hospital component of vocational training. However, it was felt that the ability to produce a single tool that would reliably detect a registrar of below minimal competence could only be achieved by using a method familiar to all training practices in the region, hence the decision to use audit.

Understanding of audit methods is still at an early stage for many training practices. This emphasizes the advantage of taking into account trainers' opinions on what constitutes essential or desirable criteria for a minimally competent registrar. These opinions will reflect the trainer's current ability to guide and support the registrar audit project. Once techniques for developing criteria to assess audit projects are in place, they should not be changed without involving the trainers. As experience with audit increases, however, there will be a need to revisit the criteria to reflect the increasing ability to complete the audit cycle, a criterion which trainers in the west of Scotland still feel may be difficult to achieve. This is likely to be a result of inexperience with audit methods, particularly in deciding on a project of realistic level which can be easily completed in the training year.

It is interesting to note that time, staff and money — often raised as issues crucial to the execution of an audit¹⁰ — were scored least often by the trainers as criteria considered to be essential/desirable in a registrar's audit project.

The marking schedule is now undergoing rigorous testing to assess its reliability and the consistency of the assessors in using it. It is hoped that the issues raised in the paper will open discussion nationally about the best way forward for assessing practical work for summative assessment of general practitioner registrars.

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Clinical performance assessment

THIS paper is from the *Family Medicine* series 'core concepts in family medicine education'. In it the author sets out to describe the state of the art in the use of standardized patients in clinical performance assessment in the United States of America. There are a number of interesting comparisons with the United Kingdom.

The standardized patient is a particular method of patient simulation that has been increasingly used in the USA to provide objective observational data about clinical skills. It is used in the USA and UK in two main formats: the objective structured clinical examination (OSCE), which was developed by Professor Harden in Dundee, and in the simulated clinical encounter which is in some ways analogous to the simulated surgery development which has been taking place in the UK. These techniques are mainly used in teaching clinical skills to medical students and in assessments of those skills at that level. There seems to be little use of these techniques in the USA in the assessment of high levels of training, nor in the performance of practising doctors; both types of applications have been considered in the UK.

The theory that seems to underpin the approach is that of the assessment of a specific domain of skills; the design of the simulations has that purpose in mind. It is therefore different from the current 'whole consultation' concept currently being developed in the UK, using both videorecorded and simulated patients, for the assessment of consulting skills of vocational registrars (trainees). There is also no thought in the paper for using the simulator's own view of the performance of the doctor, which is a concept that is becoming increasingly interesting in the UK.

As a review article this is a good primer for anyone who is interested in clinical performance assessment but has little knowledge of simulated patients.

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