Evaluation procedures for membership of the Royal New Zealand College of General Practitioners

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SUMMARY. Membership of the Royal New Zealand College of General Practitioners is by examination. The criteria for membership and form of the examination have changed over the years. The latest examination includes two parts, part one including a multiple choice questionnaire and a simulated patient interview. Experienced practitioners can be excused this part. Part two includes a clinical diary and a visit to the practice during which the examiner watches consultations for half a day.

Introduction

THE New Zealand College of General Practitioners was first established by a small group of enthusiasts in 1953 as a branch of the British College of General Practitioners formed a year earlier. In a few years a co-ordinating Council developed and four faculties were established. In 1974, with the agreement and active co-operation of the British College, the New Zealand Council sought to sever the umbilical cord from its parent and achieve complete independence. This followed another milestone, when the Medical Council of New Zealand accepted membership and fellowship of the College as additional registrable qualifications. The New Zealand College had indeed come of age.

Criteria for membership

The admission procedure for membership of the New Zealand College of General Practitioners has changed markedly over the years. Initially the only criteria of membership were a willingness to pay the small annual fee and a desire to promote better quality general practice. Within a short time, however, it was felt that it was not appropriate to admit any general practitioner regardless of his standards of practice, and applicants were asked to provide recommendations from two colleagues of good standing and to submit to a practice inspection. Later, candidates were also required to submit some original work such as an article on practice management or a case review.

When the College in Britain produced an examination as a prerequisite for entry, New Zealand felt that it should follow suit and it was agreed that New Zealand should establish its own Board of Censors and conduct its own examination. In fact, New Zealand went a step further than the British College and was the first country to introduce a two-part examination, a system which since then has been adopted elsewhere.

At first the examination was made available to any doctor with a medical degree who had worked for two years in approved hospitals. Although it was possible to take the examination without having any experience in general practice, it was understood that the examination would test particularly those aspects of hospital training which had special relevance for general practice.

However, later it was decided that membership should be available only to doctors who had been qualified five years, and that a minimum of two of these years should have been spent in rotating house officer posts in hospital and a minimum of two years should have been spent in general practice, while the other year could have been spent either in hospital or in general practice or a combination of both.

Doctors who had qualified before 1969 were not required to take the preliminary examination and sat just for the final membership.

Preliminary examination

The preliminary examination originally consisted of two written papers of essay type, one of which broadly covered the medical aspects and the other the surgical aspects of the candidate's experience, but as time went on, it changed its character and moved away from long answer questions to a series of short answer questions designed to cover a wider range of topics. In this way it was hoped that more objective marking would be achieved.

At first this examination was set and marked by invited specialists with members of the College examination committee acting as referees, but a few years ago the College examiners felt they could dispense with specialist help and they assumed full responsibility for both this and the final examinations.

The final examination

The final examination consists of two three-hour papers followed by an oral examination two weeks later. The first paper originally consisted of all multiple choice questions in the hope that this paper would identify those candidates whose general medical knowledge had not been maintained since graduation. It was devised in such a way that the proportion of questions on any particular aspect of general practice approximated to its incidence in typical practices as shown by morbidity surveys.

However, after some years' experience it was felt that the same purpose could be equally well served by a two-hour paper of approximately 170 questions, and a further section was added, lasting an hour, consisting of essays on the theory and philosophy of general practice. In this paper, taken in the morning, questions are asked about such topics as practice management and the consultation, whereas in the afternoon candidates are examined on clinical aspects of general practice.

The oral examination

In the oral examination, the candidate is required to interview a simulated patient and this is designed, not as a diagnostic exercise, but to test history-taking skills. About two thirds of the whole time (20 minutes) is allowed for this, and if the candidate has not made the correct diagnosis by then, he is given it and spends the rest of the time explaining the nature of the complaint and his plan of management to the patient. In this way the management and educational skills of the doctor are evaluated.

Subsequently, there is a brief discussion on a number of colour slides of common conditions met in general practice.

The clinical diary

On application to sit the examination, the candidate is asked to submit a diary consisting of 200 doctor/patient contacts annotated in an approved manner. This enables his assessors to gain insight into his style of work and his methods of handling problems. He is also asked to write an essay of not more than 3,000 words on the content, general or particular, of the diary.

The examiners study the diary in detail before the examination and as a final part of the oral examination they meet the candidate and ask him to elaborate upon selected cases and discuss his management in detail. In this way he is examined on his own practice methods, based not on textbook theories but his own experience.

The clinical diary is another New Zealand innovation, largely inspired by Dr Eric Elder of Southland, and it has proved to be a valuable assessment technique.

Taking stock

For some years the admission procedure remained unchanged. As in many parts of the world, there was some disquiet that only about one third of all the eligible general practitioners sought admission to the College. The fact that those doctors who qualified before 1969 were not obliged to take the preliminary examination was not a great incentive to these doctors because they still had to take a written paper as part of their final assessment. Australia was seeking alternative methods of entry for such doctors, yet it was felt that standards must be safeguarded in fairness to those doctors who had submitted to the full examination procedure. In short, methods might change but standards must not.

The Australasian College of Physicians had recently introduced a system whereby there was one examination relatively early in the training period, with fellowship being granted after appropriate experience and an assessment procedure which did not involve a formal examination. The New Zealand College felt that its entry criteria might well be changed in a similar way, and so there developed the concept of a two-part entry procedure, summarized in Figure 1.

New entry procedure

Part 1

Candidates for this examination are required to have been qualified for no less than three years and to have spent at least two years in rotating house officer posts in hospital. In addition—and this is a basic difference from the former preliminary examination—they are expected to have completed no fewer than six months in general practice. The College hopes that in future most, if not all, candidates will complete an approved vocational training programme. Such programmes are designed to incorporate at least six months of practice experience and so should provide an excellent basis for proceeding to Part 1.

The Part 1 examination will probably consist of several sections. Initially there will be an essay to complete at home on a set subject. The candidate will be

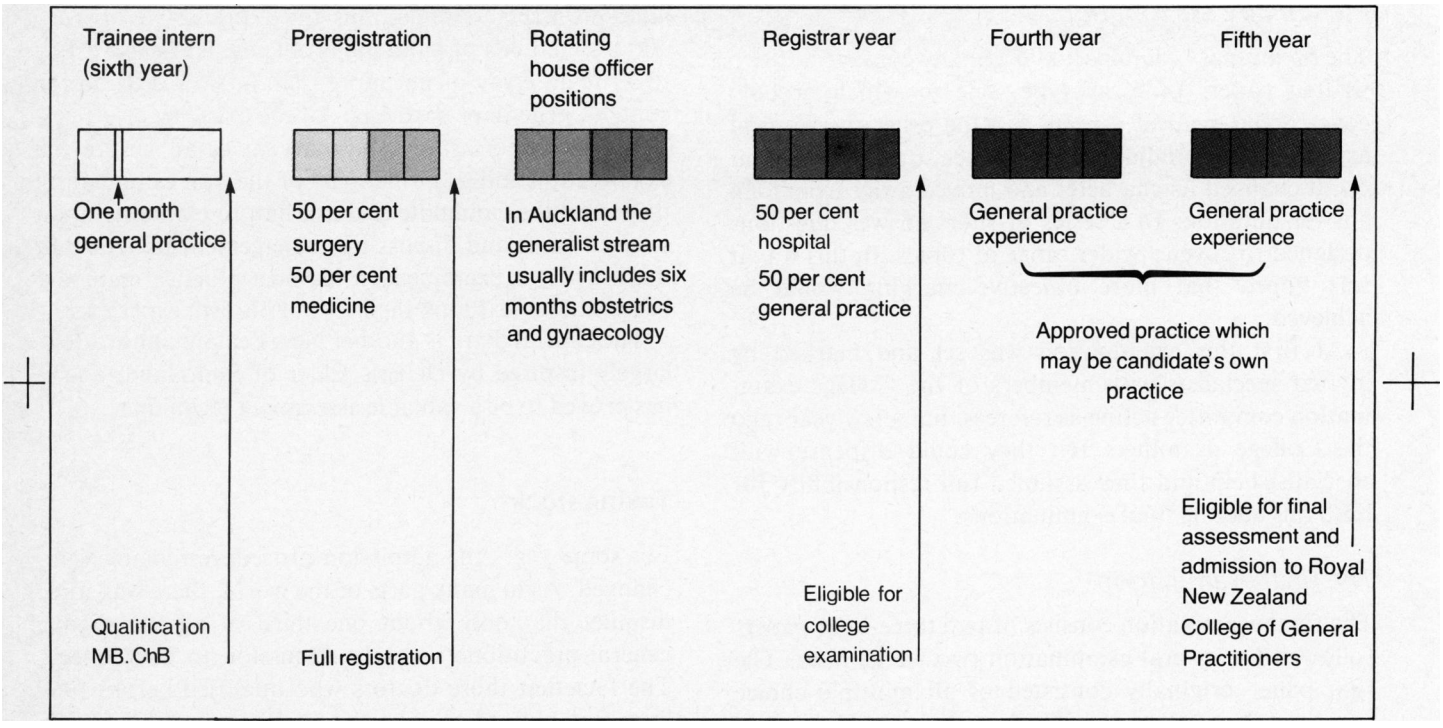

Figure 1. *Summary of system for entry to the Royal New Zealand College of General Practitioners.*

Table 1. Suggested specimen sheet for clinical diary.

Patient No: Date:	Problems	Examinations
Sex: Age: Ident:	Investigation and assessment	Treatment and education

allowed one month in which to complete this. Subsequently the candidate will attend the examination centre for a two-day evaluation which will probably incorporate a multiple choice questionnaire and a simulated patient interview (a diagnostic interview).

As a means of encouraging senior practitioners who are reluctant to sit an examination of a formal nature, general practitioners who have been qualified and remained in medical practice for 10 years may be excused Part 1 and be required to submit only to the three sections of Part 2.

Part 2

Once Part 1 has been achieved the candidate is expected to work in general practice and after a minimum of two further years is eligible to apply for Part 2. During these years in practice his work will be monitored loosely by the College and he will be expected to participate in continuing education programmes acceptable to the College. At the end of this period the candidate will be required to submit to further assessment which will be in three sections.

Section A: the clinical diary. This will be submitted two months before the date of the practice visit (Section B). The format of the clinical diary is the same as for the previous examination procedure (Table 1) and as before is to be accompanied by an essay relating to some aspects of the content of the diary.

The diary requires:

1. A tabulation of patients seen, each identified by a number (the same throughout). The headings to be used are: Date/time; Age/sex; Problems; Examinations; Investigations; Diagnosis; Treatment and management. Ruled sheets will be provided through the Faculty Censor, punched for clipping in a ring-folder and reading as a double-page spread.

2. A file of reports and communications bearing on cases of interest, indexed to patients by their numbers. Photostats or typed copies are required and these are expected to be clipped or bound separately.

3. Discussion of matters arising out of the cases listed, indexed to patients by their numbers. This section is limited in its total length to 20 quarto pages of double spaced typing. Within this length it may be used entirely at the candidate's discretion. This section also should be clipped or bound separately.

The same marking sheet is used for the essay but the overall weighting of the diary as compared with the essay is in the proportion 3 to 2. Section A will have a possible maximum of 20 marks.

Table 2. Marking sheet showing the relative weighting given to each parameter of the candidate's practice.

Applicant's Name:
Address:
Examiner:
Date:

	Knowledge and skills	Interpretation	Problem definition	Affective
1. *Rapport* leading to patient communicating easily and normally. Candidate relaxed, confident, interested and perceptive of barriers.				15
2. *Subjective data collection.* The complaint(s). History including psychosocial, past and family history (including data revealed in well kept notes) and exposing relevant hidden data.	15	15		
3. *Objective data collection.* Examining clearly, systematically, considerately.	15			
4. *Assessing existing data and planning.* Further data collection. (Investigation, observation). Not undue specificity of 'label'.		15	15	
5. *Communicating with patient.* a) 'Labels' b) Regime and getting co-operation c) General health education			15	15
6. *Taking medical action.* Prescribing, referring, requisitioning.	15			
7. *Special factors.* Organizing office and staff to help patient to good outcome (includes preventive plan).			15	
Total	45	30	45	30

Section B: the practice visit

The examiner will sit in with the candidate in the candidate's own practice during a half-day's consultation. Every effort must be made to make this a typical session and patients should not be selected. The session will be evaluated on standard rating sheet which is available for the candidate's inspection (Table 2).

After this consulting session, which is expected to take about three hours and which may include domiciliary or hospital visits, the examiner may use the clinical diary as a basis for a further oral assessment. It is felt that this part of the assessment will be particularly valuable if the consulting session has been less than typical. Thus, the extent to which the clinical diary will be used will vary from one candidate to another.

Section B has a possible maximum of 30 marks.

Section C

The candidate will be required to select and submit one or more of the following options:

1. A review, or scientific or original medical article(s). The standard will be set by two examiners from the Board of Censors. Maximum possible marks 20.

2. Suitable general practice teaching. The Board of Censors will set standards. Maximum possible marks 20.

3. Practice management. This will be limited to the single-handed practitioner or the individual in a group practice largely responsible for this aspect of the practice. It would have to be of outstanding merit, containing original work that had been carried into effect, to deserve consideration. Maximum possible marks 20.

4. Community involvement. The involvement will have to be substantial, medical in nature and outside the normal confines of general practice. Maximum possible marks 10.

5. Hospital clinical appointments. The requirements will be set by the Board of Censors. Maximum possible marks 10.

6. Development, organization, and evaluation of an approved educational programme for health personnel. Maximum possible marks 10.

In exceptional circumstances outstanding work in a suitably approved subject may be accepted as a major contribution to the assessment.

The maximum possible marks in Section C are 50.

Marking system

The candidate must obtain a clear pass (minimum 50 per cent) in both Section A and Section B.

This means that a candidate who has achieved a bare pass in Sections A and B will have a total of 25 marks and will be required to obtain a further 35 marks in Section C in order to gain the 60 marks necessary for membership.

Conclusion

It should be stressed that the original entry procedures described above are still available and the new methods have not yet been put into effect, but will be phased in gradually. Although the new system is untried it is believed that properly administered it will help to maintain the standards required for admission to the College and act as an incentive to more experienced general practitioners to join.

Medicine and the law

A consultant psychiatrist was asked by a firm of solicitors to write a report on a woman for use in access proceedings to her children. He was asked to report on her condition and whether in his opinion her recovery would be assisted by resuming access to her children. The solicitors undertook to pay a reasonable fee for such a report. The consultant wrote the report but the solicitors asked him to exclude certain passages in which he had stated that "access should not be enforced against the wishes of the children themselves, who are in a position to express their views". The psychiatrist felt that it would be wrong to omit parts of a report which were less palatable to those who had asked for it and he refused to change what he had written. The solicitors then refused to pay the fee, claiming that the consultant had breached the terms of the contract. The Medical Protection Society took up its member's problem as a test case. The fee was agreed to be reasonable, and the court had to consider whether or not the psychiatrist could insist on his fee or whether the solicitors were right in asking for the report to be amended. The case was heard at Bloomsbury and Marylebone County Court before His Honour Judge Curtis-Raleigh on 20 July 1979.

The judge found for the plaintiff psychiatrist. The report had been prepared for the purposes of access proceedings and it was right, in the court's view, that the report should have covered the relationship between parent and children. The terms of reference allowed the doctor to express the views that he did, and the judge did not accept the submission that the doctor had dealt with matters strictly medical but had merely given an opinion on how the court should approach the question of access. The two matters were held to be interacting. The doctor was in his rights to refuse to amend his report. The judge concluded that "it would be of no assistance to the courts if doctors were encouraged to abandon their professional approach and write reports designed to achieve particular objects at the behest of the patient or anyone else".

Reference

Lancet (1979). Independence of medical reports to solicitors. **2**, 918.