The MRCGP revisited

LET me begin with some disclaimers and plaudits. This article is a personal statement. The fact that I have been an officer of Council for the past four years should not suggest to the reader that some sort of shadow College policy is about to be revealed. But the ideas which follow were not conceived in isolation: they have been common currency for some time.

Nor should the suggestion for something new imply a criticism of what has gone before. In particular I would like to pay tribute to the College's panel of examiners, whose ranks I left (exhausted) some years ago. There can be few other groups of examiners who have worked so hard, imaginatively and conscientiously to devise and carry out a fair and comprehensive professional examination. Nothing of what follows is intended to detract from their reputation for excellence and dedication.

What does the examination assess?

An examination sets out to test what has been learned in a course of study. The acquisition of knowledge, skills and attitudes, and by implication the effectiveness of the course in achieving its objectives is assessed. This is not as simple as it sounds, or as some educationalists propose.

A powerful examination—that is, one in which success or failure materially affects the career of the candidate—exercises the most paradoxical effect on learning. The examination, whose intentions are to assess what has been learned, becomes itself the curriculum. It is the content of the examination, not the course, which the candidate strives to learn. Excellence in performing the tasks of the examination becomes the goal, not excellence in performing the tasks for which the educational programme was meant to be a preparation.

Knowledge, skills and attitudes—the gold standard of educational objectives—are complex qualities, whose assessment is far from simple. Knowledge is not simply a matter of facts. In medicine, many of the so-called facts are simply statements of probability, or they are interim bulletins from a continuing programme of research.

Skills include not only psychomotor manipulations, but also thinking skills. These so-called cognitive skills embrace logic, imagination, intuition and risk-taking. It is relatively easy to identify poor cognitive skills, faulty problem-solving; it is much more difficult to define good-quality thinking. The way in which each individual doctor solves a problem may be as much a function of his personality as the way in which he cooks a meal. Judgement of either task will be as much a function of the personality of the assessor as of the assessed.

Attitudes reflect social and professional values whose meanings may begin to fragment under the pressure of unambiguous definition. A readiness to ask the patient to return may be interpreted by one pundit as exhibiting concern and responsibility, and by another as creating dependency. Nor is it difficult, as a matter of examination technique, to learn to mouth the required dogma. After gaining a distinction in the general practice examination, one of my students at Leicester confided: 'Every clinical department has a party line. You soon learn how to toe it.'

A professional examination such as the MRCGP does not pretend to look directly at the tasks which doctors carry out. Rather, it is designed so that the examiners may infer from an assessment of examination performance something about the way in which the candidate is likely to perform in his professional life. The link between these two performances remains an act of faith. And there is a further problem.

The closer an examination comes to looking directly at the complexities of clinical work, the less replicable and less fair that assessment is going to be. Examiners are anxious to be fair—particularly to be fair as between one candidate and the next. The tests are designed to be as reliable and as free from interobserver variability as is humanly possible. All this is laudable but it results in two unwanted effects: first, because the answers to questions of factual recall are easily replicable and can be seen to be fair, tests of knowledge are preferred to tests of cognitive skills and attitudes; Secondly, the attempt to become replicable in assessing cognitive skills and attitudes leads to a premature sense of certainty.

The MRCGP may be a sensitive assessment of candidate compliance in training for the examination. Compliance is not, however, a desired end in itself. For example, compliance with medication is desirable only when the diagnosis is appropriate and the treatment is helpful.

General professional training

The College has consistently argued, at least since its evidence to the Royal Commission on Medical Education (1968), for a period of general professional training.

Recently, in its response to the General Medical Council's proposals for basic specialist training, the College suggested that much of what we now call vocational training for general practice is *de facto,* a period of general professional training.

A working party of the College's Membership Division is currently experimenting with a Part I examination which is designed to test the basic knowledge and cognitive skills thought to be a prerequisite for vocational training. It is intended to use the assessment as an aid to more appropriate learning rather than as yet another career barrier. Such a Part I could be developed as a diploma conjoint with other colleges who may become involved in general professional training, and might thus be a formative instrument in enhancing this period of medical education.

The working party are testing the predictive validity of this Part I in terms of MRCGP scores. If the predictive validity is high, as they hope and expect, this will constitute yet another powerful, though unlooked for, argument in favour of abolishing the MRCGP.

Is there an alternative?

The MRCGP examination is based on a laudable desire to be fair. But if we take a different view, if we decide that the validity of the assessment is more important than its reliability, that fairness is a poor virtue if the fair judgements are irrelevant, an exciting prospect opens up.

Before I propose my solution, I want to deploy one other argument. At present the successful conclusion of vocational training for general practice is judged on the basis of statements made by a variety of the trainee's teachers. Because of the variability of these teachers and because they do not constitute a working group like the College's panel of examiners, neither the replicability of their judgement nor their fairness can match that of the MRCGP. The judgements are acceptable, however, because they are almost invariably permissive. Society seems to be prepared to accept the certificate as an assurance of quality. But the College seems not so willing. What do we imply by our double standard in general practice? Do we believe that, at the outset of their careers, general practitioners divide themselves into two classes?

These questions force us now to turn from a consideration of the MRCGP—its methods, its reliability and validity—in order to look at the College itself. We cannot consider the purpose and future of the MRCGP until we are clear about the purpose and future of the College.

Time and again the College announces its wish to improve, maintain and develop standards of care for patients. It does so in a variety of ways: by political acts, by encouraging research, and by enjoining a lifelong programme of education and training on its Members. The attitude of the College to non-Members is ambiguous. By definition, the non-Member has either rejected the College or has been rejected by it. It is inevitable that these doctors should be seen by the College as constituting a second class. No rhetoric or disclaimers can disguise it. Yet if the College is serious about its good intentions for all primary medical care in our society, how does it intend to cope with the three-quarters of that care provided by non-Members? We continue to hope that the attractions of the diploma will provide us with a young membership which will grow.

But what of the young doctors who do not take (or retake) the examination? We announce a willingness to admit non-Members to many of the educational programmes for which the College is responsible. Many of our Members (perhaps a majority) have partners who are non-Members. In the initiatives which we have taken recently for performance review, we have positively encouraged participation by non-Member general practitioners. In so many ways the College shows itself to be an open society, a society whose actions and beneficences are directed at all professional colleagues and their patients.

As for our Members, we place certain obligations on them, but we do little to ensure that these obligations are observed. When was the last time a Member of the College was warned that his continuing membership was in jeopardy because of a delinquent record in devising and monitoring his standards of care? Like the other Royal Colleges, our major effort at establishing and maintaining the quality of care which patients should receive has gone into the devising and operation of our diploma.

And yet in the last two or three years there has been a significant change in what the College has been saying about medical education and its link with the quality of patient care. Performance review, expressed articulately in the College document *What sort of doctor?* and in the Council's Quality Initiative policy, points the way to a lifetime of professional development in which educational method and research rigour continuously contribute to the way in which the doctor practises. If this initiative is to succeed, I suggest that we need a different sort of College.

We need a College which is accessible to all general practitioners. Instead of creating a fair but irrelevant criterion for entry to the College, we should accept the unfair and permissive certificate of completion of training as our ticket of admission. Of course the College would continue to look to the regional advisers to make this certificate more meaningful and discriminating: not simply because the College would wish it, but because society has a right to expect it.

Admission to membership of the College would thus be relatively easy. No doubt there would still be young doctors who would wish to refuse our invitation, but it would be for them to reject us, not for us to reject them at the very beginning of their careers. In contrast, however, continuing membership of the College would be tied to active participation in what has come to be known as the

Quality Initiative. It would be participation in performance reviews (rather than the attainment of pre-set standards) which would characterize an acceptable criterion for membership.

The following model can doubtless be improved upon in a number of ways.

A new model

Associateship should be offered to all doctors who successfully complete their vocational training. Their contribution to the College in the first five years of this associateship will be the development of performance review in their own practices. The support for this will come from the faculties. Five years after becoming an Associate satisfactory participation in performance review will have earned the right to full membership.

Full membership would carry with it an obligation to take part in the wider work of the faculty, including the support of the new Associates. In the succeeding five years the Member would continue to take part in performance review, and to develop his/her professional life in a variety of ways. At the end of these five years, or at any time thereafter, the full Member would be expected to offer himself/herself for selection as a Fellow. Again, admission to fellowship would be based on the Member's record in performance review and the degree to which he had developed the health services of his practice. Judgements about this would be made by a panel of Fellows in each faculty, but the fellowship would become established as the norm for most general practitioners in the second decade of practice. Fellowship would include a number of further obligations to the work of the College.

Conclusion

In making such a radical change, the Royal College of General Practitioners would look increasingly unlike its sister colleges. In their eyes it might appear, in the short term, that we have lost both credibility and status. The General Medical Services Committee might view with some alarm a College which seeks so actively to involve the vast majority of general practitioners in its enterprise. But if the College is to fulfil its function and purpose in improving the quality of care which patients receive in general practice and in developing the very concept of general practice itself, its membership must be based on active participation. The MRCGP examination was born from the earnest desire of the College to establish standards in general practice. I have argued that, both despite and because of its successes, the diploma now constitutes an impediment to achieving the very purpose for which it was created.

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