LETTERS

Open letter to the William Pickles lecturer [J. S. Norell]

Dear Jack,

We listened to your lecture and carefully read a copy with great interest. You must be congratulated on your forthright exposure of many sacred cows to the light of discussion — they have been hidden for too long. Perhaps this letter could be regarded as our contribution to the ensuing debate.

In general, we admire your bravery in adhering to anecdote without the doubtful support of evidence; although you suggested that the lecture was based on 'disciplined scepticism', the accuracy inevitably suffered by abandoning scientific principles in favour of personal bias.

General practice education. Your strictures on the 'jerry-built edifice' of vocational training are well directed. But surely, any educational process must include some form of objective assessment; its absence in the present vocational training programme in the vast majority of districts (and nationally) ensures a continuing lack of evidence of achievement of the goals/aims of the programme — even if such goals/aims have been defined.

We would agree that there was initial uncritical acceptance of educational theory and views expressed by outside so-called experts. Progress, however, has ensured that those organizers of general practice education, and general practice teachers worth their salt, have used such outside influence to increase self-reliance. The thrust of your argument in favour of reliance on 'what we already know collectively' is unsound; what we already know may be either insufficient (and unrecognized as being insufficient) or so incestuous as to be positively unhealthy. Surely education should not 'reflect changes in the way we practise' as you suggest; by definition, education should stimulate behavioural changes so as to compel such changes in our practice of medicine. Until we can identify criteria to demonstrate change, then the effectiveness of vocational training will remain unassessed. Membership Division has initiated a study of the predictive validity of the MRCGP examination which will also reflect the validity of vocational training.

Your discussion of the differences between 'training' and 'education' resurrects a hoary old problem, which will continue to be unresolved until we agree that it is irrelevant; the analogies for 'training' are highly selected and false — surgeons and teachers are also 'trained', but would you suggest that these groups remain 'uneducated'? Semantics always was a dangerous basis for apparently reasoned argument.

In your espousal of the apprenticeship system of education, you ignore the fact that the 'laissez-faire atmosphere' is often a cloak for total inactivity on the part of both teacher and taught. Pat Byrne successfully demolished the credibility of the apprenticeship system more than 20 years ago, with his vivid description of the cotton-weaving apprentice automatically 'picking up all Nellie's bad habits'. There must be an amalgam of all methods of education, whether formal or informal, and a happy medium in who learns what from whom — academic, trainer, non-trainer, trainee, or patient. Again you offer no evidence to support your view that classroom instruction is an inadequate substitute for experience; we shall demonstrate in later paragraphs that your assumptions about performance in the MRCGP are inaccurate.

Continuing education. This section of your lecture was the most disappointing, coming as it does from one who held the post of Dean of Studies for three years. You omitted any reference to the College's 'Quality initiative' — an educational exercise in itself — whilst singling out three irrelevant College pronouncements. The prime importance of prescribing is beyond question, but you display a certain naivity in complaining that the pharmaceutical industry is not interested 'in joint research into the effects of advertising'.

MRCGP examination. It has never been suggested that the examination is a substitute for, or an alternative to, experience in general practice. It is a method of objective assessment of attainment of goals at one stage during the continuum of general practice education; it has not professed to measure competence in general practice for at least six years. Passing the examination implies that the candidate possesses the necessary basic knowledge and skills allied to behaviour accepted as typical of a group of his peers, in order to benefit himself and his patients from his continuing experience in general practice.

You quote the results of armed services candidates in support of your criticism that classroom instruction is no substitute for general practice. In doing so, you imply that the examination fails in its aims stated above. Perhaps you would allow us to give you the details of the performance of armed services trainees; this evidence was available for the asking (Table 1).

Table 1. Posts and total pass rate (percentage)

	1979/80	1980/81	1981/82
GP principal	*51.8*	*54.1*	*50.7*
Trainee	*70.3*	*76.9*	*77.9*
Armed services	*65.7*	*50.0*	*55.0*

Since 89 per cent of the armed services candidates were trainees, the performance of this group can be directly compared with the performance of non-services trainees.

From the figures in Table 1, we think you will agree that the examination continues to discriminate effectively against the armed services trainees, and perhaps does recognize lack of experience in general practice. The examination patently does not allow success to be gained on the basis of 'classroom instruction' only.

Table 2. Posts and pass rate for those candidates born and educated in the UK (percentage)

	1979/80	1980/81	1981/82
GP principal	*63.8*	*66.7*	*62.0*
Trainee	*76.2*	*80.1*	*82.1*
Armed services	*65.7*	*52.8*	*57.2*

The figures in Table 2 show that group difference continues to be maintained even when the possibly disavantageous effect of undergraduate education is removed.

Table 3. Quality of performance. Proportion of each group failing the examination (percentage)

	Failed written			Failed oral		
	1979/80	1980/81	1981/82	1979/80	1980/81	1981/82
All candidates	*20.8*	*16.4*	*15.8*	*19.0*	*19.3*	*16.6*
All armed services	*11.4*	*16.7*	*26.8*	*22.9*	*33.3*	*19.5*

Table 3 shows that a consistently higher proportion of armed services candidates fails the oral examination. The emphasis in the oral examinations is very much on skills and attitudes, which reflect experience. Perhaps the examiners are capable of failing candidates with inappropriate experience. In addition, recent performances suggest that 'classroom teaching', which you equate with education of armed services candidates, is not transmitting sufficient relevant knowledge to produce a better performance in the written papers, where knowledge plays a relatively more important part. This tendency is emphasized in an analysis of performance in individual parts of the examination: during 1979–82, armed services candidates scored 3–5 per cent less than other candidates in the multiple choice questionnaire (MCQ) paper, while in the second oral armed services candidates scored 0–3 per cent lower than other candidates (mean marks).

You state that 'we know better now' than to equate higher marks in the examination with increased competence as a general practitioner. Who knows? And on what evidence is this knowledge based? To the best of our knowledge, the predictive validity of the examination has not been tested; the study mentioned earlier is about to start. Until such time as the predictive validity is proved or disproved, it seems sensible not to claim the examination as a test of competence.

In discussing the failings of the examination, you suggest that many 'able' trainees are unsuccessful. On what criteria do you base your judgement 'able'? Is there a positive correlation between success in the examination and lack of 'ability'? At what level of significance?

The performance of experienced practitioners in the examination is advanced by all its opponents as evidence of the lack of relevance of the examination. This totally ignores other factors which are acting at a far higher level of significance than mere age (assuming a direct relationship between age and experience).

Table 4. Age and pass rate (percentage)

Age of candidates (years)	1979/80	1980/81	1981/82
27	*79.0*	*86.1*	*86.1*
28-30	*69.5*	*72.7*	*77.9*
31-34	*58.8*	*60.2*	*58.3*
35-39	*39.0*	*38.4*	*44.3*
40-49	*30.0*	*40.0*	*28.3*
50-59	*60.0*	*41.1*	*30.7*

The figures in Table 4 would appear to support the thesis that experience correlates with failure in the examination. But how can you explain the improvement in performance over the age of 50 years? We doubt if increased motivation (with greater preparation) can be the only explanation.

Table 5. Education and pass rate (percentage)

Post	Academic year	Born and educated UK	Born overseas, educated UK	Born and educated overseas
Principal	1979/80	*63.8*	*64.7*	*5.2*
	1980/81	*66.7*	*56.0*	*12.2*
	1981/82	*62.0*	*50.0*	*9.5*
Trainee	1979/80	*76.2*	*61.5*	*6.3*
	1980/81	*80.1*	*72.2*	*35.2*
	1981/82	*82.1*	*72.0*	*45.6*

It is obvious from Table 5 that the source of undergraduate education is of paramount importance in predicting success in the MRCGP examination; perhaps this confirms 'what everyone knows' — education in a different system (probably a different language) is not conducive to success in a peculiarly UK examination. But further analysis of Table 5 suggests that the source of undergraduate education contributes even more greatly to the failure of principals than to trainees, and is therefore an important factor which must be eliminated before you can claim that increasing age/experience is the bar to success in the examination, and that therefore there is a fundamental design fault in the examination. Table 5 further suggests that vocational training can largely overcome the handicap of overseas basic medical education — which confirms our contention that the MRCGP examination is achieving its present aims (see earlier).

Your experience of the examination — to suffer three times could be counted as downright foolhardiness — is, as you say, strictly limited. We are pleased you noted a shift away from factual knowledge, which is very effi-

ciently tested by the MCQ and therefore accounts for only 20 per cent of the total mark, but we would suggest that more patients suffer from their general practitioner's lack of knowledge than from his aberrant attitudes. Your analysis of the very complex interactions in the oral examinations was facile and superficial, to say the least. If your results were so poor on the third occasion, Jack, why should the examination take the whole blame? Perhaps the examination produced a true reflection of your performance at all levels — something about 'motes' and 'beams' springs to mind!

Your return to the question of a 'clinical component' (no magic panacea for the ills of the examination) betrays a lack of appreciation of the reasons why this form of assessment cannot be introduced at present — Keith Hodgkin answered the criticisms very clearly and succinctly;[1] we should merely like to point out that the validity, reliability, and feasibility of a clinical component are all highly suspect. In addition, you make no reference to the Modified Essay Question (MEQ) as a test of the practice of family medicine; it is justifiably regarded as highly relevant by the majority of candidates.

Where is your evidence that the examination is divisive? Or that entry to the College by examination only is wrong? If any factor is 'divisive', surely it is the very existence of College — if the GMSC response to College comments on deputizing services is a typical example. You imply that the examination keeps colleagues out of College, but where is your evidence that they want to come in? Your sneer at Associates was unworthy of you — Associateship is surely a respectable and viable alternative for those colleagues who do not wish to sit the examination. If nothing else, the examination confers some respectability on the College in the eyes of sister disciplines.

Alternative methods of entry. Inclusivity of all general practitioners is a worthy aim, but is it practical, or sensible? A pious hope that all members will 'undertake to conform to basic principles of education and practice' conveniently ignores the fact that those who enunciate the principles will still be exposed to the criticism of elitism, and is no substitute for objective assessment of agreed criteria. It would seem to us just as logical to eliminate the once-and-for-all nature of the alleged hurdle to membership by introducing re-accreditation.

Your uncritical acceptance of 'What sort of doctor' as a route to membership begs many unanswered questions. It might be the 'natural way forward' for general practice education. It is also illogical, ill thought out, imprecise, and untested against all the generally accepted criteria of a method of assessment — is it valid? is it reliable? is it feasible?

In conclusion, may we express once again our appreciation of the service performed by your lecture. Will Pickles was also an individualist, but he at least presented a scientific, factual, logical basis for his caring medicine. It would seem to us that the Panel of Examiners are at least as close to being his natural successors in general practice as any other present claimants.

ANDREW BELTON
Examinations Secretary
JOHN LEE
Chairman of Membership Division

Reference

1. Hodgkin K. The format of the College examination. (Letter) *J R Coll Gen Pract* 1983; **33:** 825, 827.

The 1984 William Pickles Lecture

Sir,
I have mixed feelings about the response from the two College officials. Naturally, I am gratified that the criticisms contained in my lecture should be considered serious enough to warrant such a detailed reply. But I am also sad that these apologists for the MRCGP examination should have felt so desperate as to employ hollow arguments garnished with dubious statistics about whose inadequacies every schoolboy knows, never mind every doctor.

In denouncing the ideas in 'What sort of doctor?' as 'illogical, ill thought out, imprecise, and untested', methinks Dr Belton and Dr Lee protest too much. Can they really feel so threatened at the prospect of a practice-based assessment which attempts to get the measure of a colleague under everyday working conditions, and in the setting of the very place from which he works and which he has played a part in fashioning? Others have been impressed and have thought the ideas worth exploring; and Professor Donabedian — who knows a thing or two about the subject — has said publicly how moved he felt at the direct and unpretentious approach of 'What sort of doctor?'

Had it been my purpose — which it was not — to destroy the credibility of the MRCGP examination, I might now lean back in the knowledge that Drs Belton and Lee had made my case. It is their line of thinking which helps to give the examination its bad name. And they have demonstrated by their arguments, better than I could every have done, its divisiveness. They may not know it, but a gulf separates the examination *apparatchiks* from ordinary practitioners.

However, I have to concede that the 1984 William Pickles Lecture was based on a false premise. Its title should have been, 'What every doctor (other than those on the Panel of Examiners) knows.'

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