Assessment: harnessing change to improve standards

We all carry recollections of examination experiences akin to torture. I particularly remember being hounded into deciding 'whether trichomoniasis can be caught from toilet seats' at my MRCGP oral 20 years ago. I was unhappy with the interrogation and, believe it or not, walked out of Princes Gate determined to see an improvement. Certainly, during my subsequent 10 years as a MRCGP examiner, including 5 as convenor of the orals, there were significant changes in the structure and delivery of the exam. Now, after 3 years as Chair of the College Examination Board, major changes loom ahead.

I have never understood why membership of the Royal College of General Practitioners was not absolutely mandatory to my career as a GP. I had previously attained MRCP. MRCGP seemed just as important. After all being a 'generalist' requires skills over and above those of the 'specialist'. Yet, on the face of it, there were dual standards for this most unique of professions. Over the years, the marriage of summative assessment and College membership has become another personal goal.

We now have the opportunity to harness the present climate of change and resolve the historical inconsistency of the two-tier assessment. The proposals for the Modernisation of Medical Careers (MMC)[1] alongside the introduction of the Postgraduate Medical Education Training Board (PMETB)[2] have catalysed the review of current procedures. The PMETB will carry responsibility for approving training and assessment procedures across all specialities. Worthy standards for assessment, embedded in good medical practice have been defined.[3] The focus is on competency-based testing in the workplace, transparency of assessment procedures with feedback for candidates and inclusion of lay opinion in the setting of standards, and quality assurance of examinations.

The time is ripe to bring the two assessments together and review standards in the light of current change. Modernising Medical Careers will at the very least extend vocational training by introducing a foundation senior house officer year to focus on the development of generic skills. Trainees should have more experience. The new drive to develop competency-based assessments, whereby skills can be signed off as they are achieved, places an emphasis on assessment in the workplace. Change is inevitable. It is time to review summative assessment and the MRCGP in the light of these new developments. The College has established two committees within the Education Network: one to produce a new curriculum for vocational training, chaired by Professor Steven Field, and one to review assessment. The latter is led jointly by Dr Agnes McKnight, Chair of the National Summative Assessment Board (NSAB), and myself.

What does the MRCGP/NSAB working party aim to achieve? The assessment committee has key representatives from UK deaneries and the MRCGP, two lay members and two GP registrars. The plan is to develop a single national deanery-led procedure for selection into vocational training and a unified national system for work-based competency assessment. We recognise that these developments must link with the proposed new foundation years. They must be educational, formative and feasible.

Nor can assessment in the workplace totally replace a summative licensing examination to inform both the licensing process for the certificate of completion of training and, as the two become one, achievement of the MRCGP. A new standard to address these innovations in training and assessment methods will be set. Inevitably this will mean change in both summative assessment and the MRCGP, with uncertainties and feelings of bereavement for all involved. This is a hard price to pay, but there is general agreement that any process that makes College membership all-inclusive is to be welcomed.

It is envisaged that the national licensing examination will have two parts: a test of applied knowledge; and a simulated clinical encounter test, which will include clinical and communication skills. These will need piloting and the aim is to 'go live' in August 2007. Video assessment of consultation skills will move to the workplace, where its formative properties can be fully harnessed. We have recently appointed a College Assessment Fellow, David Sales, to support the piloting of the new licensing test and link with the other developments. David is a GP with more than 15 years' experience of examining for the RCGP and working in assessment for other College examinations and the GMC.

But I have another bête noire! Almost a third of UK GPs are now actively involved in teaching medical students and a significant proportion partake in the assessment process. Are we preparing undergraduate students for these changes in assessment and the move towards more competency-based methods? Do the current procedures in UK

References
1. Modernising Medical Careers. http://www.mmc.nhs.uk/ (accessed 9 Aug 2004).
2. The Postgraduate Medical Education and Training Board. http://www.pmetb.org.uk (accessed 9 Aug 2004).
3. General Medical Council. http://www.gmc-uk.org (accessed 9 Aug 2004).
4. Van der Vleuten C. Validity of final examinations in undergraduate medical training. *BMJ* 2000; **321:** 1217-1219.

medical schools meet the standards set by the PMETB which, surely, although defined for postgraduate examinations, are equally applicable to undergraduate ones? Why do UK medical schools enjoy independence from a national licensing test?

Each year more overseas doctors are accepted for practice in the UK through successful achievement in the GMC's Professional and Linguistic Assessments Board (PLAB) test than register from UK medical schools. Universities are not accustomed to the requirements of clinical competency testing and fitness for purpose. In contrast to the changes in postgraduate training, medical schools continue to enjoy relative individual freedom in developing their curricula and assessments. Can this now be justified given the stringencies placed on overseas entrants through the PLAB test?

Medical schools are being relatively slow to encompass some of the standards set down for the PMETB, such as lay representation on university committees and standard setting processes for pass/fail decisions. Should we be preparing our students more for the work based assessments they face in both foundation and vocational training years? Lack of university resources is threatening the feasibility and cost of undergraduate examinations as student numbers increase and the stringencies of the new consultant and GP contracts place pressure on examiner availability. Yet innovative development of test methodology[4] and resources for assessment are not necessarily seen as the priority. Will we eventually have an Undergraduate Medical Education Training Board?

As for the present, the PMETB should be embraced and not viewed as a threat. Current methodologies for both the MRCGP and summative assessment are not perfect. The standards written by Lesley Southgate and Janet Grant for the PMETB[2] are sound, sensible and achievable. The prospect of MRCGP as an endpoint for all in vocational training and the support and enthusiasm of the UK deaneries in achieving this is to be welcomed. The hope is that Modernising Medical Careers and PMETB will positively impact on training standards. We need to ensure this is the outcome. The development of a new national standard for vocational training, informed by patient opinion and appropriate for Membership of the College for all completing training, is a worthy goal.

Val Wass

pandora

Forget 'Am I a Good Doctor?' I'll settle for 'Am I a Competent Doctor?' or, shall I put it another way 'Could the RCGP do something useful for a change ...?'

In my foolishness I once held the post of a parent governor at my child's school. The singularly most useful experience in the entire 4 years was the discovery of the following concept — that there are four states of competency/consciousness:

- Unconsciously incompetent
- Consciously incompetent
- Consciously competent
- Unconsciously competent

As a part-time GP of 15 years' standing (well, sitting down mostly, as my derrière can pay tribute to) a husband and three children to my credit, a home to manage and multiple interests outside medicine, I am able to say without any shadow of a doubt that I am most definitely unconscious.

But unconsciously what? Competent? Incompetent? A bit of both? Enough of one but not too much of the other? Who knows? Well, my appraiser would. My uncertainty and self-doubt would be eradicated once and for all.

As I looked forward eagerly to my appraisal date I started to suspect that such need for external affirmation of my competence may be singularly related to my proud ownership of two X chromosomes. Those peers less fortunate seemed really quite confident, felt in no need of monitoring and resented the idea of being scrutinised. Amazing what a difference one chromosome can make. But alas! No joy. The day came and went and I was none the wiser.

I enjoyed the process, though. I even found it helpful and supportive. But it didn't answer my burning question. Forget the 'Am I a good doctor? I'll settle for the simple 'Am I a competent doctor?'

Well, it seems revalidation is only around the corner so I guess someone wants to know. I keep glancing at articles here and there about 'revalidation' and 'fitness to practice.' I keep thinking 'I must read that and find out what the official opinion is before I write this article'. But why? Surely my opinion is as important as anyone else's. After all, I am 'the profession'. I'm not an academic or a political animal or anything special. Just an ordinary front-line regular 'Jo Soap' GP.

So how do I think are they going to find out about my competency?

Well, I only have the usual smattering of trivial complaints to my name. That must count for something. I've never knowingly made a major mistake. My colleagues are still willing to work with me (just!). Will someone publish quality markers of my clinical ability? You know the sort that says that 95% of all my asthmatic patients have had their peak flow recorded in the last year. Does that make me competent? Competent at what? Tapping buttons on the computer? Has anyone assessed my consultation skills in the last 15 years? Has anyone tested my knowledge base? Has anyone investigated if I know how to read a paper and evaluate the evidence with my own little brain. Umm ... no!

But this time next year they will have.

And how? Well, I have elected (and paid £1100 to boot, since the College wouldn't reduce their exam fees for such a project) to re-sit the MRCGP exam in its entirety AGAIN. I passed it first time round 13 years ago. The aim? To prove to myself that I do have some measurable level of competency.

It still may not be the answer I'm looking for, but think of it another way. It is a well validated quantitative and qualitative assessment. It says so on the RCGP website. If I (we!!) all did it every 5 years that would reduce the bill to the NHS for appraisal and revalidation fivefold. Food for thought.

It might even be said that the RCGP were doing something useful with our subscriptions for a change ...

Will Pandora succeed in her bold quest? Is passing MRCGP still possible in one's dotage? Can MRCGP tutors and examiners withstand the withering gaze of maturity. Or immaturity? To be continued ...