Assessment: harnessing change to improve standards

We all carry recollections of examination experiences akin to torture. I particularly remember being hounded into deciding ‘whether trichomoniase 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) alongside the introduction of the Postgraduate Medical Education Training Board (PMETB) have catalysed the review of current procedures. The PMETB will carry responsibility for approving training and assessment procedures across all specialties. Worthy standards for assessment, embedded in good medical practice have been defined. 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 vital 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
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
methodology4 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 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

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 eradiated 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 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 ...