The Review

Formative assessments in medical education: are excessive, and erode the learning and teaching experience

Over the last decade I have had the privilege of being involved in medical education as a postgraduate trainer and undergraduate tutor. In that time much has improved in terms of standard setting. However, an excessive focus on writing up reflective case studies is proving time-consuming for all concerned, impeding both learners and teachers.

In 2007 the examination for Membership of the Royal College of General Practitioners (MRCGP) changed format, and became a compulsory exit exam to practise within our specialty. The key tenets of postgraduate education are building on the relevant within the basic sciences and clinical specialties, and linking theory with practice. Most would agree that knowing the distribution of the saphenous veins, or the pathophysiology of heart failure, are highly relevant to clinical care, while a detailed recollection of the Krebs cycle is not. To that end, the summative components of the MRCGP are sound. The applied knowledge test (AKT) reasonably tests the application of factual knowledge, while the clinical skills assessment (CSA) is certainly more representative of a consulting practise than the video assessment it replaced.

By contrast the third component, the workplace-based assessment (WPBA) should, I believe, be reassessed. At its hub is the requirement for registrars to keep a diary of case studies with reflective analysis on the ePortfolio, and for trainers to review and comment on these, validating evidence in 12 domains. While a degree of written reflection is desirable, attempting to make it nearer an exact science is erroneous. The categories necessarily overlap, with inevitable repetition in trainers' reports, and the ethos that not everything that counts can be counted should be respected. As Guy Claxton states in his co-authored book *Liberating the Learner*:

*'While the idea that learning demands continual busyness, and that therefore if you are not visibly doing something you cannot be learning anything of significance, disables those vital modes that require stillness, reverie, inwardness, and reflection.'*¹

Put differently, reflection can occur intrinsically without being overtly stated; indeed, like love, it rings hollow when repeatedly and formulaically professed. My

main argument, however, is with the sheer volume of cases. With a recommendation that registrars write up two or three cases per week, this totals about 400 during the 3-year postgraduate course: surely the law of diminishing returns applies to this largesse. Sadly, the undergraduate curriculum replicates this. Medical students arrive in practices rightly keen to consult independently with patients. However, during attachments that are often a little under 3 weeks, they are also required to write up six reflective cases (expanding three into case-based discussions), an audit, and a critical incident. This box-ticking bureaucracy impacts deleteriously on both learners and trainers.

In my experience the requirements of the WPBA induce profound stress in many registrars, with the administrative requirements detracting from their capacity to fully absorb and utilise their working and learning experience. Single-minded pursuit of the examination can lead to silo thinking, and consequently silo working, with interprofessional liaison becoming a casualty. Tutorial time is eroded by the requirement of assessing log entries, rather than more meaningful problem-based learning. Furthermore, the all-consuming nature of the examination leaves scant time for registrars to engage in other professional pursuits, such as developing their own skills in teaching, research, management, or medical politics. Quite apart from being desirable, these have assumed greater importance since the MRCGP has become compulsory, and thus graduates' CVs require other stand-out achievements with which to attract potential employers or partners.

What, then, of teachers? At medical school and in postgraduate education, the memorable nuggets of clinical wisdom were invariably those imparted by frontline clinicians with good teaching skills, whether in the lecture hall, clinic, group tutorial, operating theatre, or post-mortem room. Innumerable able teachers have inspired learners for generations, and some found fame mainly through their published work, including John Fry, Michael Balint, and Julian Tudor Hart in general practice, Maurice Pappworth and Sheila Sherlock in medicine, and Hamilton Bailey and Harold Ellis in surgery, to name but a few. The above were a diverse group, but all had

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large clinical practices, their patients being their raw material. However, I now fear that many clinician-teachers may resign their posts, exhausted by the bureaucracy that fails to appreciate, or properly exploit, their invaluable experience.

Ultimately, the key question is, does current training prepare graduates for their working lives? The increase in administration has occurred in tandem with a significant reduction in their hands-on clinical experience, due in part to the European Working Time Directive, widely condemned by medical educators:² how ironic that many established GPs and hospital consultants are working far harder than their registrars. The WPBA has proved didactic and controlling while purporting to be the opposite, and risks producing a cadre of homogenised graduates, fluent in the jargon of political correctness typical of public sector functionaries, but denied a real platform to hone out their professional persona. As preparation for providing frontline health care to Britain's ethnically and socioeconomically diverse and senescent population, the answer must be no. Junior doctors are intelligent young people who have, in many cases, forsaken far more lucrative careers in professions such as dentistry or law, let alone showbusiness or working in The City, to join our ranks, and they deserve better. On the matter of formative assessments in medical education, less could certainly be more.

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