

## **BAD Newsletter, Winter 2008**

### **ACADEMIC DERMATOLOGY**

#### **Assessment of Trainees: an Evolving Process**

It seems only yesterday that consultants and trainees were learning about the 'new assessment techniques' of mini-CEX, DOPS, MSF and PSQ. But wait, there are even newer ones around the corner or even closer! Please make way for Cbd, TOA, AAT and the currently preferred term, 'patient survey' (a PSQ does not guarantee patient satisfaction). These politically-driven changes to specialist training in the NHS will be greeted by some with a certain amount of healthy medical cynicism, but for others the issues are too sensitive to criticize. Whatever your views, one way for busy doctors to deal with the stream of imposed changes is to become well informed about them.

As indicated previously, the first Specialty Certificate Examination in Dermatology (SCE), formerly known as the KBA, is on course for the middle of 2009. To be awarded the CCT in Dermatology, it will be compulsory for trainees who commenced training in August 2007 or later to pass the SCE, but there should be some flexibility regarding precisely when the exam is taken. The SCE may also be taken by pre-August 2007 trainees. You will no doubt be hearing more about this from Richard Groves who is due to chair the first SCE Board in Dermatology at the RCP Federation. My aim here is to clarify some of the jargon and to provide an update on competency-based assessments in order to complement the B.A.D. 'Trainee Assessment for the Assessors' courses at Willan House on Thursday 18 December 2008 and Thursday 19 February 2009. I am most grateful to Sally Ibbotson and Jane Sansom for their help in organizing these.

To recap, the Postgraduate Medical Education and Training Board (PMETB) was established as an independent statutory body in 2005, and is responsible for promoting the development of postgraduate medical education and training in the UK for all specialties, including general practice. As with other medical specialties, the specialty curriculum for Dermatology was developed by our Specialty Advisory Committee (SAC) at the RCP, and received approval from PMETB in 2007. The system for assessment was also approved by PMETB later that year. The specialty curriculum runs in parallel to the continuing generic curriculum which covers important aspects of medical education, focusing on good clinical care, maintaining good clinical practice, relationships with patients and communication, working with colleagues, teaching and training, professional behavior, and management and NHS structure.

#### **What is assessment?**

**Assessment** is 'measuring how much the learner has learned' or in the context of trainees, 'a measure of progress or level of achievement of an individual against an agreed standard'. In the UK, **evaluation** is 'measuring the quality of teaching' (e.g. your own teaching, a course, or the whole institution) and is distinguished from

assessment. However, in other countries such as the USA, the term 'evaluation' may be used as an alternative to 'assessment'.<sup>1</sup>

**Appraisal** is 'a review of progress against agreed objectives'. This should be a positive process, giving someone feedback on their performance, charting continuing progress, and identifying development needs. Reflection is an important part of a trainee's transition towards becoming a consultant.

A good assessment should accurately determine the depth and breadth of learning that someone has achieved, and be seen as fair by the assessors and those being assessed. Other features of good assessment include reliability (consistency), validity (does it measure what it is supposed to measure?) and transparency (is the assessment system clear and understood by both the assessor and trainee?). In addition, trainee assessments should be objective, summative as well as formative, and use multiple assessments involving several assessors, leading to judgements at the time of the encounter. Another important consideration is feasibility. A system of assessment should not be too time-consuming, expensive or labour-intensive.

### **Workplace Based Assessments (WBAs)**

The **mini-Clinical Evaluation Exercise (mini-CEX)** was devised by Norcini and <sup>3</sup> in the USA to assess medical residents, the 'traditional' clinical evaluation exercise (CEX), recommended by the American Board of Internal Medicine in 1994, having serious limitations. In a typical CEX the resident was observed with only one patient by only one examiner over a period of about two hours!

In the mini-CEX, an assessor should observe a trainee doing a focused task with a patient (e.g. taking a history, performing an examination, discussing a treatment plan), over 15-20 minutes only, rating the performance on a rating scale and giving instant feedback to the trainee. Scoring should reflect the performance of the trainee against that which would reasonably be expected at their stage of training and level of experience. Immediate feedback from the assessor to the trainee is important, especially where deficiencies have been identified. The RCP initially recommended a minimum of 4 mini-CEXs per year with a minimum of two different assessors over 4 years.

**Direct Observation of Procedural Skills (DOPS)** assessment was devised by the Colleges. The assessor observes a trainee undertaking a routine procedure for as long as the procedure takes. The period observed is usually a matter of minutes only and will often be part of a larger procedure (e.g. observing suturing technique after excision of a skin lesion). Again the assessor rates performance on a rating scale and gives instant feedback. The RCP initially recommended a minimum of 3 assessors, each observing two cases, i.e. 6 in total for each procedure.

**Multisource Feedback (MSF)** was initially referred to as assessment, involving collection of data from stakeholders in a doctor's performance such as other doctors, allied health professionals, nurses, and secretarial and clerical staff. In the RCP pilot study 20 raters were used and this number is recommended to maintain validity and a mix of assessors, although reliability was achieved with smaller numbers. The RCP

initially suggested that trainees might expect an MSF assessment in their first, middle and penultimate years, depending on the length of their training.

## **New Workplace Based Assessments**

Case-based discussion, teaching observation assessment, the audit assessment tool and patient survey are currently being piloted by the RCP. Here is a brief introduction that I hope will be useful to those not involved in the pilot studies. An e-portfolio for Dermatology, currently in use for core medical training in all UK deaneries, is also being developed at the RCP.

**Case-based Discussion (CbD)** is a formal way of doing what many doctors have done for a long time. CbD is designed to assess clinical decision-making and the use of medical knowledge. It provides systematic assessment and structured feedback on regular discussion of suitably complex cases (e.g. 6-8 per year). The trainee selects two case records from patients they have recently seen, and the assessor selects one of these for the CbD session. CbD enables discussion of the ethical and legal framework of practice.

As with other workplace based assessments, the trainees are encouraged to drive the process and to select the assessors. However, these should include the directly-supervising consultant.

The purpose of **Teaching Observation Assessment (TOA)** is to help trainees develop their teaching skills and to form part of the overall assessment process. Prior to the TOA, the assessor(s) should establish the trainee's previous teaching experience, the subject matter to be covered, what teaching techniques will be used, and what they would like the learners to take away from the session. After observing the trainee teaching, there is an RCP assessment form to complete (with rather detailed descriptors of competencies), and the assessors should give immediate feedback, especially where deficiencies have been identified.

The **Audit Assessment Tool (AAT)** is designed to assess competence in completing an audit. It may be based on a written report or a presentation at an audit meeting, and when possible there should be more than one assessor for the same audit. Assessors should score the trainee on the appropriate RCP form, reflecting the performance of the trainee against that which you would reasonably expect at their stage of training and level of experience. Again feedback should be given to the trainee there and then.

The RCP **Patient Survey (Patient Satisfaction Questionnaire, PSQ)** form 'What did you think of this doctor?' emphasizes that 'the questionnaire is only about the doctor you have seen today' and asks patients not to comment 'about other members of staff, the NHS system, or waiting times'. Of relevance to discussions on what are acceptable consultation times for new, follow-up and complex patients in Dermatology, traditionally a high-volume specialty, we should all be aware of questions like: Did the doctor listen to what you had to say? Did the doctor give you enough opportunity to ask questions? Did the doctor answer all your questions? Are

you involved as much as you want to be in the decisions about your care and treatment?

### **Educational Supervision and the ARCP Process**

Many will have come across the recent distinction in hospital medicine between a Clinical Supervisor and an Educational Supervisor, the latter being similar to the well-developed system of 'Trainers' in the general practice setting. Hospital trusts are currently organizing local courses to bring consultants up to speed on this rapidly evolving process. Educational Supervisors will be expected to undertake appraisals, conduct workplace based assessments and to write the supervisor's report, as part of annual planning. Educational Supervisors should aim to meet regularly with their trainees for mutual feedback (e.g. at least 4 times a year), monitor trainee progress towards agreed objectives, identify shortcomings and arrange to address them, provide liaison with others involved with the trainee, and provide careers advice.

The ARCP (Annual Review of Competence Progression) has been developed by the deaneries and replaces the RITA process. The ARCP will be informed by evidence from assessments, preceded by the Educational Supervisor's report. The evidence provided should lead to an annual assessment outcome of progress with curriculum targets. ARCP outcomes include: satisfactory progress, unsatisfactory or insufficient evidence (trainee required to meet panel), inadequate progress (trainee required to meet panel, additional training required), release from training programme (sustained lack of progress), incomplete evidence provided, out of programme time, training completed.

### **A few words of caution**

There has understandably been much criticism of Modernising Medical Careers (MMC), which sought to reform postgraduate medical education and training to speed the production of 'competent specialists'. I have real concerns that trainees will receive too much assessment, which could be stressful and distract them from other activities, including research and, in some ways, patient care. One of the things emphasized by the Tooke was that 'the service contribution of trainees needs to be better acknowledged'. Pendulums have a habit of swinging too far and the level of regular assessment of trainees will require regular review.

The sentiments of the Tooke enquiry into MMC were well received: 'The structure of postgraduate training should be modified to provide a broad based platform for subsequent higher specialist training, increased flexibility, the valuing of experience and the promotion of excellence'. The way we assess trainees should be modified as they progress from core medical training to higher specialist training, with more attention to facilitating their transition towards becoming an 'experienced consultant'.

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## References

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