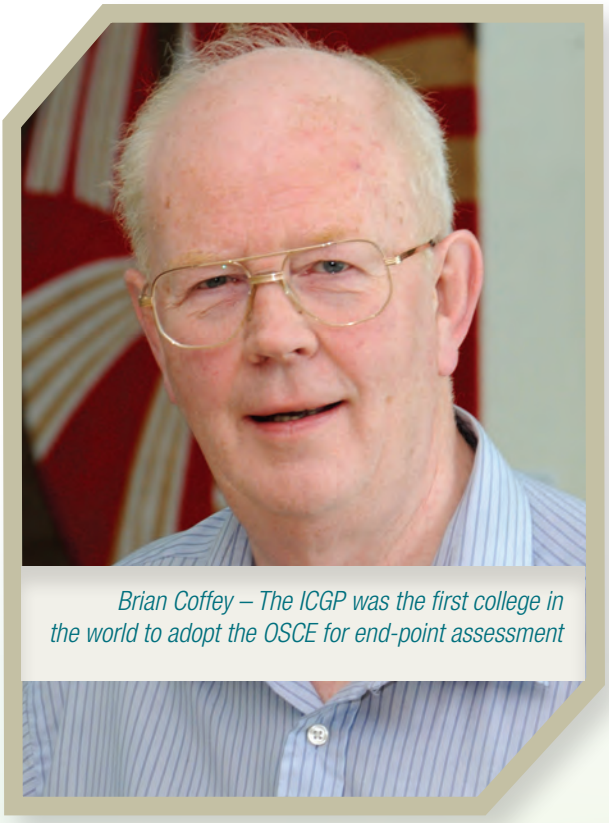
Sowing the seeds for the Irish membership exam

Brian Coffey



Brian Coffey – The ICGP was the first college in the world to adopt the OSCE for end-point assessment

At the first AGM of the ICGP in Kilkenny in 1985, a workshop on examination/assessment was held. Two groups considered open entry to the ICGP to all suitably qualified and experienced general practitioners. However, the consensus was against open entry as such.

Two other groups considered reaccreditation. This was felt to be essential and should include foundation members. It was felt it should be supportive rather than punitive. The remaining groups considered examination as a method of entry to the college. No consensus emerged from this group and there was some degree of hostility to the idea of any exam at all. Among the options considered were:

- MRCGP model
- Some other form of exam, as might be used by other colleges
- Continuing assessment, which should be separate from reaccreditation

The group also felt that the training of a GP, rather than an examination, was what was important.

Following much discussion, the College decided that admission to membership should be by examination only, following the expiry of its foundation period in March 1987.

An examination sub-committee, under the chairmanship of Tom O'Leary, was established to develop and administer this examination. Its terms of reference were: "The formulation of the methods of assessment for future entry to the Irish College of General Practitioners."

This eventually led to the publication in April 1986 of the position paper "The aims and objectives of the MICGP examination." All postgraduate general practice exams that existed were looked at with particular reference to the examinations of the Canadian College, the Royal College of General Practitioners, the Australian college, the New Zealand college and the Hong Kong college.

The "What sort of doctor?" report by David Pendleton for the RCGP was also looked at. In 1985 there were no other general practice examinations in mainland Europe: Norway and Holland were in the process of setting up their own examinations. These were all reviewed with the criteria of reliability, validity and feasibility in mind.

It was eventually decided that the examination format should be broadly similar to the MRCGP examination, but that it should be criterion-referenced, ie. all those who achieved a pre-determined pass mark should be successful.

From the beginning it was felt that there should be a component within the examination that directly assessed clinical competence. The OSCE (Objective Structured Clinical

...produce family doctors of which both our College and our country can be justly proud.

Examination) had been described in detail by Harden and Gleeson in 1979 and had become an increasingly popular method of undergraduate assessment throughout the 1980s.

The sub-committee attended a course at the Centre for Medical Education at the University of Dundee. There was an amazing diversity of colleagues who also attended the course, including senior nurses from the UK, physiotherapists from Germany, a public health doctor from Finland and the minister for health from one of the emerging African nations.

The ICGP in the following year became the first postgraduate medical examining body in the world to adopt the OSCE as a method of end-point assessment.

The first examination for membership of the Irish College of General Practitioners was held in the summer of 1988. The written papers (MCQ, MEQ, PTQ) and orals were similar to those used in the RCGP. Twenty per cent of marks were allocated to each. An OSCE was added, which was also 20%.

Each candidate rotated through the same 10 stations, which required them to perform some clinical task at each one. Each station was eight minutes long and was supervised by a marker who observed the candidate's performance and marked a pre-designed check list.

Eight stations involved actual patient contact. History-taking and communication skills, physical examination technique and candidates' attitudes were assessed.

Examples included the examination of a man with low-back pain, helping a patient to stop smoking, counselling a pregnant unmarried woman, and instructing a child in the proper use of an inhaler. The mean mark was 60.9%, with marks in individual stations ranging from 15-100%. The pass rate in the examination was 78.26%. Forty-six candidates sat the exam and 36 passed.

The exam was deemed to be very successful and during the following years many colleagues came from around the world to observe the OSCE.

Professor Fergus Gleeson, who with Ronnie Harden, pioneered the whole concept, was a tower of strength in those years. Mention must be made of the Dublin Support Group. These were a number of Dublin GPs, who, although not examiners, organised and trained their patients to be the role-players in the OSCE.

Many of our fellow examiners in the RCGP at the time became ICGP members and acted as examiners for a number of years. Jeremy Brown and Rob Walker are still with us. David Haslam, currently President of the RCGP, wrote an article for the British medical press at the time entitled

"If the ICGP can have a clinical component in their exam, why cannot the RCGP?"

The exam secured recognition in 1992 from the GMC in London. A number of changes in the format occurred over the following years. The log/diary (practice experience questionnaire) was removed from the orals and the three long questions in the PTQ paper became six shorter essay-type questions in the SEQ.

A major change took place when a move to modularise the exam occurred. This meant that the registrars could sit the written parts of the exam before they started their practice year. This removed a huge problem for the programme directors and the GP trainers, as it had long been felt, quite rightly, that preparing for the exam had come to dominate their practice year to the detriment of their training.

The OSCE was held for the last time in 2005. Although a much-lauded and unique part of the exam, it was a huge logistical problem to run successfully and it did not discriminate very well between the candidates, as they performed very well overall and practically nobody ever failed it.

It is aimed to replace those things it set out to examine in the revamped Certificate of Satisfactory Completion of Training procedures.

The first major review of the MICGP examination since its inception has been completed in 2009 and includes a commissioned report from external experts on assessment. Work has commenced on changes to the MCQ module, the standardisation of the orals and further standardisation of the marking of other examination modules.

It is anticipated that there will be further changes to the written papers in 2010 and 2011, with the introduction of a clinical skills assessment in place of the oral module after 2011.

The lighter side

A sense of humour has always been a desirable attribute for an examiner, and the exam has contributed greatly to this over the years.

Just before the first OSCE was due to start in Blanchardstown Hospital OPD and the panoply of examiners, markers, supervisors, candidates and role players were ready to go, a nurse rushed in and said we couldn't go ahead, as a nurse had to be present in case somebody got ill.

I believe that on that day not one, but two, terrible beauties were born. They became known as health and safety and political correctness, a marriage truly made in hell.

That night, we all went out to celebrate the successful running of the exam. We unfortunately neglected to pay the bill in the Chinese restaurant, and got the Dart back to town. One of our overseas colleagues was presented with the bill, which he naturally refused to pay. Rumour has it that a machete was eventually produced and he duly paid.

A question on chlamydia in the essay paper produced the following:

"I will be honest and say I know very little about chlamydia" (He/she was right!)

"She may show you the yellow stains on her nickers (sic). You may then be quids in with a diagnosis"

The MEQ produced the following. The question was: "A patient collapses in the waiting room, what do you do?" Answer: "Put the other patients in the treatment room and lock the door. Take a history from the collapsed patient and give two aspirin." Another answer: "Go into the waiting room and tell them all that if they don't stop smoking and drinking the same will happen to them."

Another question concerned a demented 80-year-old man found to have blood in his urine. What would you do? Answer: "Enquire about sexual behaviour, any incest, any STD, will need history from daughter. Refer to VD clinic."

A few one-liners:

"I would examine them and all that rubbish."

"In the lower social classes there is a high degree of depravity."

"Look for signs of drug abuse, you know, wearing dark glasses and long sleeves."

The orals show great breadth of thinking sometimes.

Examiner: What are the disadvantages of an ECG machine?

Candidate: (After a long pause) It might be too heavy to pick up.

Candidate: Transactional analysis involves parent and child…

Examiner: (prompting) Yes and…?

Candidate: Er, the foetus?

Examiner: What are the disadvantages of showing anger to the patient?

Candidate: They might get violent and stab you.

Examiner: The senior partner keeps cancelling meetings. Why might this be?

Candidate: Perhaps he has piles and can't sit for long.

My personal favourite, however, is this:

Examiner: What strategies do you have for managing somatisers?

Candidate: It depends what time of day it is.

Examiner: How do you mean?

Candidate: Well, if it's 4.45 and I am going fishing at five they're in and out.

Examiner: Fishing?

Candidate: ...or pigeon shooting!

The future

The examination has achieved its present status because of the hard work over many years of the panel of examiners. The convenors have included Tom O'Leary, Brian Coffey, Johnny Cuddihy, Brendan Day, Pat O'Dwyer, John Delap and Kevin Quinn.

The ICGP staff have been tremendous and particular mention must be made of Dermot, who has been involved from the very beginning, Martina in the earlier years and Sylvia most recently.

I have been privileged to have been involved in postgraduate general practice examinations over the past 25 years in Ireland, the UK and Bahrain. The changes that have evolved have been great.

The young doctors now are more knowledgeable and better trained and this is due to the calibre of their training schemes. Are they better doctors? I don't know. Will they be good doctors in the future? One can infer but one can't be sure.

Standard-setting is essentially a political process, (and always has been). The ultimate aim is probably to achieve a defensible result, (A) defensible to challenge (B) defensible to the public and the profession.

I believe our examination has achieved much more than this and will continue to maintain the high standards of our training schemes and produce family doctors of which both our college and our country can be justly proud.