



# The GMC's Tests of Competence - what happens now?

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**T**he General Medical Council (GMC) regulates doctors in the United Kingdom. Its purpose is to protect, promote and maintain the health and safety of the community by ensuring proper standards in the practice of medicine. It has powers under the Medical Act to take action against a doctor's registration by

- Preventing the doctor from practising
- Suspending the doctor from the register
- Placing conditions on the doctor's registration.

## WHAT HAPPENS TO DOCTORS REFERRED TO THE GMC?

If a doctor is referred to the GMC a review takes place in two distinct stages: **investigation** and **adjudication**. During investigation the GMC assesses whether the doctor has a case to answer. During adjudication those doctors who have a case to answer attend a public hearing held before the Fitness to Practise Panel.

This review will now concentrate on the investigative stage of the assessment and in particular the test of competence.

## INVESTIGATIVE STAGE

Each complaint is first assessed by two trained case examiners. If they conclude that further investigation is required they can refer to the investigation committee. This committee then decides what further investigation is appropriate. Since new legislation introduced last year<sup>1</sup> this investigation can consider all aspects of a doctor's fitness to practise (Table 1).

One of the options for further investigation is to refer the doctor for a performance

**Doctors who have a case to answer attend a public hearing**

**In peer review,  
doctors are  
visited at their  
place of work**

**Table 1.**

Misconduct
Deficient professional performance
A conviction or caution for a criminal offence
Adverse physical or mental health
A determination by another regulatory body responsible for health

assessment (previously called performance procedures).

**Performance assessments**

The performance assessment comprises two parts: peer review and tests of competence.

**Peer review**

In peer review, doctors are visited at their place of work by a team of trained peer observers. The observers' role is to look at the local environment and to observe the doctor's practice overall. This observation includes a clinical record review, interviews with the doctor and his or her colleagues, a case based discussion using one of the doctor's own cases, and a direct observation of his or her practice (e.g. an out patient clinic).

**Tests of competence**

Objective tests of competence were originally proposed in 1994 after concerns were raised regarding the competence of some doctors. Although there was reluctance within the profession, a working party was set up by the GMC to review this problem. After two years of deliberation it recommended the establishment of performance procedures which could identify gaps in a doctor's knowledge and clinical skills. Unfortunately these methods or instruments had not at that time been developed in any part of the world.

Over the next few years Professor Dame Lesley Southgate developed a team which in conjunction with the individual



specialties' respective colleges produced the methods and instruments which form the basis of this assessment.<sup>2</sup>

In the majority of specialties the assessments developed have three different clinical components: first a written test of knowledge, secondly practical skills and clinical method and finally communication and consultation skills.

These assessments have gained worldwide recognition as providing 'the leading edge of direct assessment of performance'. In her review of these procedures during the Shipman inquiry Dame Janet Smith praised the quality of these objective tests of competence.<sup>3</sup> Dame Deirdre Hine in her capacity as the Chairman of The Fitness to Practise Policy Group also states that: 'For the first time the GMC has at its disposal reliable and



internationally recognised tools to assess fairly, consistently and accurately the standard of a doctor's professional performance.'

Since 1997 there has, however, been considerable progress in the development of this type of assessment.<sup>4,5</sup> We are therefore currently reviewing these instruments to ensure that they provide as valid, reliable and fair a test of competence as is currently possible.

## PROPOSALS FOR THE DEVELOPMENT OF THE TEST OF COMPETENCE

We aim to develop a template of a 'standard examination' which will provide consistency in clinical standard and instruments used throughout all specialties. It is anticipated that in each of the clinical components there will be a standard number of specialty-specific questions with a further set of questions being selected to address a specific area in which the doctor is thought to be deficient, or an area of super-specialisation.

To ensure that these assessments remain up to date we are establishing strong links within each Royal College which will review the questions on a regular basis. There now follows a summary of the proposed changes for each clinical component.

## WRITTEN TEST OF KNOWLEDGE

In accordance with the guidance provided by The Postgraduate Medical Education and Training Board (PMETB),<sup>6</sup> 'the methods of assessment used will be selected in the light of the purpose and content of the assessment.' Methods will be chosen on the basis of reliability, feasibility, cost-effectiveness, opportunities for feedback and impact on learning. It is recommended that

to ensure that the *application* of higher cognitive skills is examined the proposed style should include single best answer and extended matching questions.

These questions will be either be written specifically for this examination, adapted from previous questions or attained from the item bank of the relevant college. Each examination can be tailored to the individual's experience and current work practice to include questions which are generic to all doctors, questions specific to the appropriate specialty and, if applicable, very specific super-specialty questions.

## PRACTICAL SKILLS AND CLINICAL METHOD ASSESSMENT

Currently practical skills and clinical method are assessed in an OSCE (objective structured clinical examination) style test using appropriate anatomical models, manikins and simulated patients. The doctor's performance in these tasks is assessed by two doctors within the appropriate specialty using a detailed checklist. A lay person also assesses the performance in these tasks and provides general feedback.

During our review we hope to achieve several goals. First of all we are identifying 'core' skills such as basic life support that could be used in several different disciplines. We aim to tailor each examination according to doctor's subspecialty and experience (ie SHO's will not be expected to perform laparoscopic procedures and consultants will not be assessed on their intramuscular injection technique). The marking schedules are being adapted to include a global rating scale rather than a very detailed checklist as it has been shown that experts perform poorly on tests with detailed checklists whereas inexperienced medical practitioners do 'better' as they are more thorough at going through each step.<sup>7</sup>

We are also reviewing the instruments used to perform these assessments. It is anticipated that in less than 10 years practical skills will often be assessed using specially designed simulation suites, but at present this technology is not sufficiently advanced for inclusion at this stage. There are, however, a variety of assessments using virtual reality and computer assisted programs which have been developed and assessed for

**These assessments have gained worldwide recognition**



Dr Harold Shipman, who is thought to have killed between 215 and 260 patients over a 23-year period in Hyde and Todmorden, West Yorkshire.

validity, reliability and feasibility within a research setting.<sup>8-10</sup> The GMC is currently piloting some of these programs to assess whether their inclusion provides a more accurate and representative assessment of each doctor.

## COMMUNICATION AND CONSULTATION SKILLS

Currently these skills are assessed using simulated patients and a clinical scenario. Each specialty has a different number of stations varying from between 0 to 12 stations. Whilst it is acknowledged that some specialties do perform fewer consultations than others it is felt that these doctors still need to be able to communicate to colleagues, management and the general public and each assessment should therefore contain a minimum of four stations assessing this skill.

The range of consultations skills to be assessed has been recently reviewed and will be increased to incorporate all aspects of the guidance provided within the GMC's Good Medical Practice.<sup>11</sup> The range of topics included in these simulations is shown in Table 2.

Although the current scenarios work well, we aim to improve and

### Table 2. Topics included in simulations

- History taking
- Negotiation of a management plan
- Explaining a procedure/obtaining consent
- Discussion of a diagnosis
- Discussion of illness beliefs/health promotion/lifestyle advice
- Explaining a complication
- Dealing with conflict
- Dealing with barriers to communication e.g. language, hearing impairment
- Leadership/collaborative skills

update them by developing marking sheets that are generic between specialties and have more emphasis on a judgement grading. The information provided to the Standardised Patients (SPs) will also be more detailed to prevent any variations within the interpretation of their role. The current database of scenarios is being reviewed and those that are suitable for more than one specialty are being cross-referenced. In those specialties that do not have scenarios that examine all the domains we are setting up specialised writing teams to provide new scenarios to examine these areas.

## CONCLUSION

The 'tests of competence' in GMC assessments have gained worldwide recognition as being 'reliable and internationally recognised tools to assess, fairly, consistently and accurately, the standard of a doctor's professional performance in any major branch of medicine'.<sup>3</sup>

Since their development there has been a lot of growth in the knowledge and technology used in this form of assessment. We are undertaking a review of the instruments available to ensure that the assessment of doctors whose fitness to practise is called into question is able to provide a valid and reliable assessment of competence and performance and also to ensure that there is a consistent standard between specialties. The GMC is working steadily on keeping its assessment instruments up to date and fit for purpose.

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