Letters to the Editor

Dear Editor,

PROMOTING UNPROFESSIONALISM IN THE UAE?

The slogan of the Royal College of General Practitioners (RCGP) is ‘Promoting excellence in family medicine’,1 which it does through development of the MRCGP International (Int) exams. However, exporting certain assessment formats from the UK may sometimes be inappropriate.

The MRCGP Int (Dubai) includes a video assessment of consultation skills similar to that of the ‘old’ MRCGP.2 This assessment uses the same performance criteria as those used in the UK exam, which have been criticised in the past.3–5

The majority of doctors who take this exam in the United Arab Emirates (UAE) will be consulting with Arab patients from a conservative Muslim background. Many of the female patients will be wearing a face veil. None of them (male or female) are used to the concept of being videoed. Few agree to being recorded.

The models upon which the performance criteria are based were developed from research into a Western English-speaking population,6,7 whose culture and language are profoundly different from those of the UAE. Unfortunately, there is minimal research into communication skills within the Gulf region. It is uncertain how applicable the performance criteria from the UK are to the UAE context. Doctors here report that it is difficult to get patients to demonstrate these criteria.

Many primary care doctors in this region have no postgraduate qualification and are desperate to get the MRCGP Int to enhance their professional and financial status. I have heard of candidates (some of whom have actually passed the MRCGP Int) who stage ‘false’ consultations with English-speaking colleagues/friends. Such practice has been alluded to in the UK.8

I would suggest that videoed consultations should be used only as a formative learning tool at present in this region. At the same time, the College could encourage and support its local partners to start their own qualitative research into communication skills. By introducing summative assessments that are inherently impractical, the College is partly responsible for resulting unprofessionalism.

Yours sincerely,

DR DEEN M MIRZA
Assistant Professor in Family Medicine
Faculty of Medicine and Health Sciences, UAE University
PO Box 17666, Al Ain, UAE
deenmirza@doctors.org.uk

References

Dear Editor,

Over recent months there has been growing interest in the management and quality of GP specialty training in the light of the requirements set out by the Postgraduate Medical Education and Training Board (PMETB). Recent editions of Education for Primary Care have carried three papers that present different perspectives on the quality assurance of training – Kibble et al,1 Layzell and Poll,2 and Smith and Wiener-Ogilvie.3 We would like to share with readers another project currently under way in the Wessex Deanery that concerns end-of-post feedback, and present some issues we have identified.

The annual PMETB National Trainee Survey generates data about the quality of training. It assists deaneries in monitoring the quality of training, and data from it inform their quality assurance processes. The survey opened a new chapter in the management of general practitioner (GP) specialty training; for the first time, a publicly available national bank of data was cre-
ated, providing standardised information on the experience of training for general practice. These data have raised the quality assurance agenda from a local to national level, and for the first time allow comparisons between hospitals, trusts and deaneries.

The annual PMETB survey generates a static 'snapshot' of data, which can be used by educational teams to assess the quality of GP training placements. We have, however, identified an issue with the data capture process, which impacts on the usefulness of this information. The issue concerns the availability of responses with direct relevance to GP training. In order to ensure the anonymity of responders, the PMETB survey dataset only reports if there are at least three trainees in the department sample. This presents issues for GP trainees located in smaller specialties, as their data may not necessarily be available for reporting. Indeed, the data for those in larger specialty teams may also be difficult to identify, as the responses for GP trainees may be subsumed into those for the whole cohort. Specialties with small numbers of GP trainees may therefore be more reliant on their own local processes for assessing the quality of such posts. Granted, in such cases the PMETB data could be aggregated over a period of three years and then reported; however, the trends over time would be lost and the opportunity for action on the data would suffer a time lag.

Issues such as these may be addressed by deaneries, either by attempting to make completion of the PMETB survey compulsory, or by collecting additional local data to supplement the PMETB data. In Wessex, the latter strategy was chosen, and a questionnaire is in development to address these concerns. The aim of the project is to design a questionnaire to gather feedback on GP specialty training posts with specific relevance to the local teams of programme directors.

The issue, raised by Kibble et al., that deanery quality assurance structures need to reflect those of the PMETB and the Quality Assessment Framework, was also taken into account by our work. Historically, post evaluation has been developed locally by deaneries, with the result that a range of different questionnaires and approaches exists, representing historical and local evolution of such tools. A brief tour of deanery websites demonstrates this well. In the course of developing our approach to post evaluation, we looked at all 22 deanery websites and identified nine different end-of-post/training questionnaires available online. Using a similar method to Kibble et al., we merged all the questionnaires into a single document to compare and contrast them. We considered each question item and allocated it to the relevant PMETB domain. We found that some domains were very poorly represented by questionnaire items – in particular domain 2 ('quality assurance and review') and domain 8 ('local resources and capacity'). In addition to working through the items from all the available questionnaires from other deaneries, we developed a small number of new questions to reflect recent changes to training and to take into account our local feedback needs with respect to GPST1/2 training as well as GPST3. For aspects of training where we had multiple or duplicate questions, we reduced and/or reworded these. We then developed two sets of questions to reflect differing training contexts, one for GPST1/2 and one for GPST3. In addition to aligning the questionnaire to the PMETB domains, we also mapped each question item to the RCGP Standards for GP Specialty Training and PMETB indicator score groupings, where appropriate. Using a Delphi technique, we emailed out the question set to all our programme directors and associate GP deans across the Wessex Deanery, in order to obtain a ranking of each question in terms of perceived relevance. The final set of questions is currently being reviewed in the light of this feedback, and will be reduced to a maximum of 30 questions distributed across the nine PMETB domains. The final end-of-post survey will be realised in web format and linked to the Wessex Deanery's database of trainees.

We will be piloting the electronic GPST1/2 and GPST3 end-of-post feedback questionnaires in May 2010. The pilot will be evaluated and we intend to share our findings with colleagues, as this area is prompting much interest at present. We hope that this work will provide a stimulus to other deaneries, and contribute to improving the management and quality assurance of GP specialty training.

Yours sincerely,

DR CLARE WEDDERBURN
Associate GP Dean for Dorset, Wessex Deanery

DR SAMANTHA SCALLAN
Wessex Research Fellow in Primary Care Education

References


