Do the Royal College curriculum statements guide the assessment and learning for specialist registrars?

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The Royal College curriculum statements should be a vital part of the teaching and learning of specialist registrars, and of their assessments. This does not appear to be the case in the four specialties studied.

INTRODUCTION

The curriculum, and curriculum studies, are important areas of study in education (Stenhouse, 1975; Rowntree, 1982). They are also important, if somewhat neglected, in medical education (Harden et al, 1984). Since the reforms to higher specialist medical training in 1996, there has been relatively little published in the educational literature about this important area. Here, the consultants of the future are being trained (Department of Health, 1996). Does the curriculum, as set out by the Royal College documents, connect with the teaching, the learning and the assessment of these doctors? Does it connect with and influence the assessments they have to satisfy to achieve a certificate of completion of specialist training and go on to become consultants?

'Curriculum' may mean the total programme of study of an educational institution. It may also mean a narrow definition of the content of a particular subject or area of study (Kelly, 1989). In the latter case, it may be equated with a syllabus and so refer to the body of knowledge to transmit to the learners. In the Royal College curriculum statements there is quite a narrow definition of curriculum in some cases.

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There is evidence that all is not well in medical education (Lowry, 1992; Coles, 1993; Metcalfe and Matharu, 1995; Richards, 1997). Postgraduate medical examinations do not always have sound educational evidence behind them (Hutchinson et al, 2002). The central question of this paper is, do the curriculum statements from the Royal Colleges help to produce good consultants, fit for purpose in the modern NHS in the 21st century?

This study looked at the curriculum statements in four postgraduate medical specialties. Do they define the characteristics of a good consultant as outcomes, are they used to govern the teaching and learning, and do they fit with the assessments taking place? In order to do this, the views of both consultant trainers and specialist registrars are important. Therefore a study was designed which looked at the curriculum statements, and researched the views of consultants, specialist registrars and postgraduate deanery staff involved in the management of such education and training.

METHOD

This study examined the curriculum documents for four specialties within the West Midlands Deanery: paediatrics, accident and emergency (A&E) medicine, cardiothoracic surgery and ear, nose and throat surgery. These were chosen to provide a contrast of different specialties both within the nature of the specialty and in the form of training (such as medical, surgical and generalist specialties), within the whole of higher medical training. Curriculum statements were obtained from the appropriate Royal Colleges.

Consultant trainers with expertise in higher specialist training were selected from each of the four specialties. A letter was sent explaining the project and asking if they would agree to be interviewed. They were assured of confidentiality and that any statements made in any publication would be non-attributable. All interviews were carried out by one member of the research team (SW), at a time and place which suited each interviewee. Interviews were recorded and transcribed verbatim. Transcripts were then printed out and sent to the interviewee for verification.

Consultants were asked to identify senior specialist registrars in their specialty. Again, these doctors were sent a letter explaining the project and asking if they would agree to be interviewed. They were assured of confidentiality and that any statements made in any publication would be non-attributable. One specialist registrar in the specialties of paediatrics, A&E medicine, cardiothoracic surgery, and two in ear, nose and throat surgery were approached, and agreed to be interviewed. Again, all interviews were carried out by one member of the research team (SW) and were recorded and transcribed as above.

In addition, three senior members of the West Midlands Deanery management, with responsibility for higher specialist training, were interviewed.

Researchers also visited and sat in on two sets of annual assessment interviews for the specialist registrars as part of the record of in-training assessment (RITA) process for two specialties.

Transcripts of all the interviews were analysed individually by all three researchers, using methods of coding

and content as described by Coffey and Atkinson (1996). These findings were shared in group discussions and consensus was agreed on the key themes and meanings of the information in the interviews. The key learning points from the study and the ways forward for further development were agreed.

RESULTS

The results have been analysed in terms of curriculum documentation, teaching and learning, and assessment issues.

Curriculum documents

The documentation of the curriculum statement is currently being revised in three of the four specialties. The curriculum is not often used by trainers and rarely used by trainees. It is usually not perceived as important in day-to-day work or from a training or examination point of view.

The curriculum statement emphasizes clinical skills. In surgical specialties the curriculum is often written in terms of operations, rather than management of particular conditions. There appear to be gaps in the medical management of some surgical conditions.

'a large number [of medical conditions] require medical management rather than surgical management…and this is unrepresented in the curriculum.'

The curriculum statements do not focus on teaching and learning. This applies to both how consultants and others should teach the content of the curriculum, and how to teach as effectively as possible. Teaching on how to teach others is given a low priority. Ideas about teaching are often said to be arrived at by 'osmosis', in the words of one consultant.

In contrast to teaching, research is given a high profile within the documentation. However, many recognized that the emphasis on research for all and the learning of research skills is often not needed as a consultant.

Softer skills such as management, communication skills (including breaking bad news) and team working featured little within the curriculum statements. However, they are beginning to be seen as more important than they once were.

'You have to be able to tell the truth to patients, give them what you can but do it in a manner which they like and find acceptable. I think a lot of people don't do that very well.'

'I have met technically gifted people who I think deal with people dreadfully.'

Generally credit is being given to these important areas. However, some still believe that communication skills cannot be taught, learned or assessed competently.

'You can't change their attitude and personality.'

'I don't think it's something that can be taught.'

Nevertheless most consultants and specialist registrars realize the great importance of communication skills and teamwork in many areas of their work.

The knowledge, skills and attitudes of the good consultant are again not fully described in the curriculum statement. As described above, there is much concentration on clinical skills, to the relative exclusion of other important attributes. Nevertheless, there is a great understanding by both the consultants and the specialist registrars of the differences between the good doctor (with an emphasis on clinical skills only) and the good consultant. This relates to the consultant's ability to manage a team, teach, identify and troubleshoot problems and so on. Little emphasis is made of these core attributes in the curriculum.

Teaching and learning

In the West Midlands there has been a big emphasis on teaching the teachers courses over the last 3 years. All were aware of these courses, which are paid for by the Deanery. Many have attended them.

One of the changes of the Calman reforms to higher specialist training in 1996 has been the provision of protected teaching sessions. Most specialties now had regional teaching sessions in protected time, happening monthly or weekly. There were also medical and surgical meetings, case presentations, journal clubs and audit meetings, all of which have educational importance.

A great deal of learning was service based. This included teaching in the ward, outpatient clinics, A&E department and theatre, usually on an informal basis. Service-based learning was well understood by all. Many talked of the apprenticeship model. Until the Calman reforms of 1996, this apprenticeship model was the main educational method of UK medical training for at least the last 100 years. Consultants and specialist registrars all recognize the role of service-based learning.

'The service element, the learning in service is of vital importance.'

'Almost every time we have a junior with a child, a case, you should use that as a learning opportunity.'

Teaching and learning can and does happen in the wards, outpatient clinics, A&E department and the operating theatre. In addition, best practice in service-based teaching and learning is indeed recognized. This is illustrated when specialist registrars described step-by-step teaching of the fundamental processes of an operative procedure (Hargreaves, 1996). One-to-one teaching and learning was recognized and valued, but often this does not happen.

'Sometimes the lists are booked very heavily and…if there isn't time for you to be taught doing the case, then your training actually suffers.'

Some talked of reflective learning: the importance of reflection was made, and the experiential learning cycle (Kolb, 1984) of do – review – learn – apply was understood and described.

Nevertheless, although used, most consultants and specialist registrars thought that not enough was made of service-based learning. It was felt that a wonderful opportunity to pass on 'tricks of the trade' learnt through years of experience was being lost. One consultant described this kind of instruction:

'I've found a technique you won't see in the books – this little corner here, if you just swing it round.'

The main reason for this seemed to be the overwhelming service workload. Service workload was often a big problem. Sometimes it seemed to be so

high that it overwhelmed everything as people struggled to cope.

'…there was masses of stuff that was interesting and new to me, but yet they were so busy that you didn't have time to be trained and be taught, because of the service commitment.'

In these situations, teaching and learning seemed to be put aside in an effort to just get through the work, survive, and come to the end of it.

Interestingly, most trainees talked of teaching rather than learning. There seemed to be an expectation that people should be taught everything, although some commented on the idea of adult learning, with the learner taking control of and responsibility for their own learning (Brookfield, 1986). Consultants were clearer about the role trainees had to play in directing their own learning:

'They are meant to be self-motivated adult learners…If they see something they don't know then I don't think it's too outrageous to expect them to either go and look it up in a book or to look it up on the Internet.'

Assessment

Assessment processes in higher specialist training should be competency based, structured and interactive, and should allow progress to be measured against published curricula (Calman et al, 1999). However, in the four curriculum statements examined, there did not appear to be strong links between the published curriculum statements and the assessment, which instead seemed almost entirely unrelated and independent of each other. In addition, it was not clear whether a defined curriculum model was being followed, i.e. whether the assessment focused on performance of skills or on deeper understanding.

The main assessment mechanism was the annual RITA. There was some confusion about the purpose and structure of the RITA process, recognized by a member of the higher specialist training management team, who said:

'I think that some of the consultants and some of the trainees have a very vague idea of what it's all about.'

The RITA largely relies on structured trainer reports. A particular concern of the consultants was the degree to which the RITA addressed the issue of the under-performing trainee. Comments reveal the suspicion that trainers tend to be lenient on borderline candidates:

'Most human beings find it very difficult to be critical to the person's face.'

There were some suggestions that the current process fails to warn trainees at an early stage if they are failing to achieve a high enough standard. It was thought that this should occur early in the training, before candidates had committed several years to the specialty:

'Nobody seems to be prepared to haul up a trainee and say, "look, I don't think you're good enough". My feeling has always been that that should be done at an early stage'.

Some specialties had exit exams, which included tests of knowledge and some clinical skills. However, there was no objective assessment of operating skills for the surgical specialties, and in paediatrics there was no exit examination, with progress determined solely by the RITA.

Assessment in the workplace was raised as an important concept, allowing assessment to more closely reflect performance. This 'authentic' assessment would be conducted by an external examiner, of work performed in real time and on real patients, and was warmly received by trainees:

'...your surgical confidence is best measured by someone watching you do an operation, that's how they'll know if you're any good or not.'

It would essentially be an extension of the workplace assessment currently conducted by trainers, but the introduction of an external examiner would relieve some of the pressures of 'failing' a colleague raised earlier.

One trainee thought that workplace assessment could also be used to measure communication skills. Three consultants and two trainees thought that there was a need to assess 'softer' skills, e.g. communication, team working and attitude. However, others, who thought that communication skills and attitudes could not be taught, were sceptical.

'How do you assess attitude? How is one person's attitude better than another's?'

Another important development was the use of 360-degree feedback, as an assessment tool for assessing attitudes, communication skills and team working (Whitehouse et al, 2002). Here, trainees receive feedback on their performance from a variety of colleagues, including, for example, nursing and secretarial staff. This is currently used in some specialties as an appraisal mechanism, identifying areas for trainees to work on, rather than as a formal assessment mechanism.

'The only appraisal that I've considered worthwhile has been 360-degree appraisal, and it's been done to me twice now, properly, and it's very useful.'

However, others questioned its worth:

'People can be very well liked, popular with all the staff, and they can by abysmal decision makers, or very poor surgeons.'

DISCUSSION

We were pleased to find the generally high levels of understanding of educational matters. Teaching and learning were valued and understood, including concepts of reflective learning, service-based learning and assessment issues. The West Midlands Deanery teaching the teachers courses were well known, and most of the doctors at both consultant level and specialist registrar level had been on such a course. 360-degree appraisal was well understood, and in active use in two specialties.

However, we need to keep up the progress in many areas. At present there seems little to link curriculum documentation, teaching and learning, and assessment. Each seems to exist on its own.

We recognize that regular revision of the curriculum takes place, and needs to continue in order to keep up with changes in medical knowledge and skills, new treatments and the establishing of other core skills in the whole of medical practice.

Regarding curriculum content, the curriculum needs to develop to be

more than just a list of clinical knowledge, skills and operations. The Kennedy report (Department of Health, 2001) emphasizes the need for teaching in softer skills, e.g. communication skills and team working. There needs to be a recognition that the purpose of the curriculum is to produce a 'good consultant'. What is seen to be a good consultant will be contested, but some effort needs to be put into moving towards an agreement on the key features, such as clinical skills, knowledge, attitude, team working and teaching. These then need to be reflected in the curriculum. The concepts discussed here fit in very closely with the study by Khera et al (2002). They looked at the specialist registrars' perspective of what constitutes the ideal hospital doctor, and identified many of the softer skills mentioned here. Surely these must be included in the new curricula.

Teaching methods and skills have low priority. This needs to change. The curriculum needs to include how areas should be taught and learned, drawing on best evidence medical education (Hart, 1999). In addition, consultants and specialist registrars should be taught the basic concepts of teaching and learning from a medical education point of view. Courses should be provided for these doctors, which should also include assessment and assessment methods. Consultants also need updating on such educational principles.

For the methods of teaching and learning, there needs to be a better understanding of service-based learning, and increased emphasis on learning rather than teaching. Consultants as teachers need to be kept up to date with modern concepts in medical education, including service-based learning, reflective learning, best evidence medical education, and the passing on of hard-won knowledge, skills and attitudes to the next generation.

Assessment is very important. More recently, the quality, reliability and validity of postgraduate medical examinations has come under critical review (Hutchinson et al, 2002). These authors found very few papers on assessment issues from the UK Royal Colleges (except the Royal College of General Practitioners), despite 6 years of the new specialist registrar grade and the renewed emphasis on setting assessment criteria. In most areas, there did not seem to be overt links between assessment, curriculum documents, and teaching and learning methods. Assessments need to be improved from the present chaotic state. They must be fit for purpose and follow best practice (Jolly and Grant, 1997).

In line with Hutchinson et al (2002), we call for assessment methods to be developed, piloted and established as best practice. Despite all this, we were encouraged by the development of 360-degree feedback. It is being used as an appraisal method (to give feedback to trainees) and also as a pass or fail assessment method in specialties outside this study. Courses and training in assessment principles and methods must be developed and provided. Assessment in the workplace must be looked at, and the ideas of structured observation should be developed and piloted.

This may have an adverse impact on waiting lists and performance targets in trusts. Such a strategy needs to be spelled out to chief executives and medical directors. There may be a case for having training and non-training hospitals; after all, a great deal of money goes into hospitals for training purposes. Case selection for trainees deserves more care and consideration for both patients and doctors in training.

Finally we all need to watch the workload, so that it does not swamp everything including the learning. The UK is still seriously short of doctors to serve the needs of the population. The point about training and non-training hospitals (as we have training and non-training practices in general medical practice) needs further consideration. **HM**

KEY POINTS

- The curriculum, teaching and learning and assessments are not joined up, but appear to be largely independent of each other.
- Assessment methods that are valid and reliable need to be developed.
- Service-based learning is good but increasing workloads risk overwhelming the learning altogether.
- 360-degree feedback for the assessment of communication skills and team working is a good idea and needs further promotion.
- Authentic assessment in the workplace in real time needs to be developed.

Conflict of interest: none.

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