
‘This house believes that it is not necessary to provide *evidence* for *all* the curricular *competences*’

“...*evidence* of competence...”?

- Surely this means “*valid assessment*”?
 - Curriculum (decision aid) expects wpba as “*evidence.*”
 - But is this *valid* assessment of ability?
 - eg miniCEX...was devised and validated for teaching/feedback/formative assessment only
 - valid as summative assessment only by intensive, repetition with calibrated assessors
 - is “abused” as summative in the CMT curriculum, and was also in early Foundation curricula.
 - Large UK literature (Foundation) has revealed dismal miniCEX experience
 - Foundation 2012 curriculum now has it right!
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“.....*all* the competences” ?

- Curriculum (Decision aid) demands that almost all(24/24, 34/40) be “evidenced”
 - Yet *syllabus sampling* is a respected, valid assessment model eg MRCP, like a biopsy, allowing generalisable conclusions.
GMC also advises this.
 - Transferable skills and abilities, on a sound knowledge base, reveal a good physician.
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“.....the curricular *competences*”

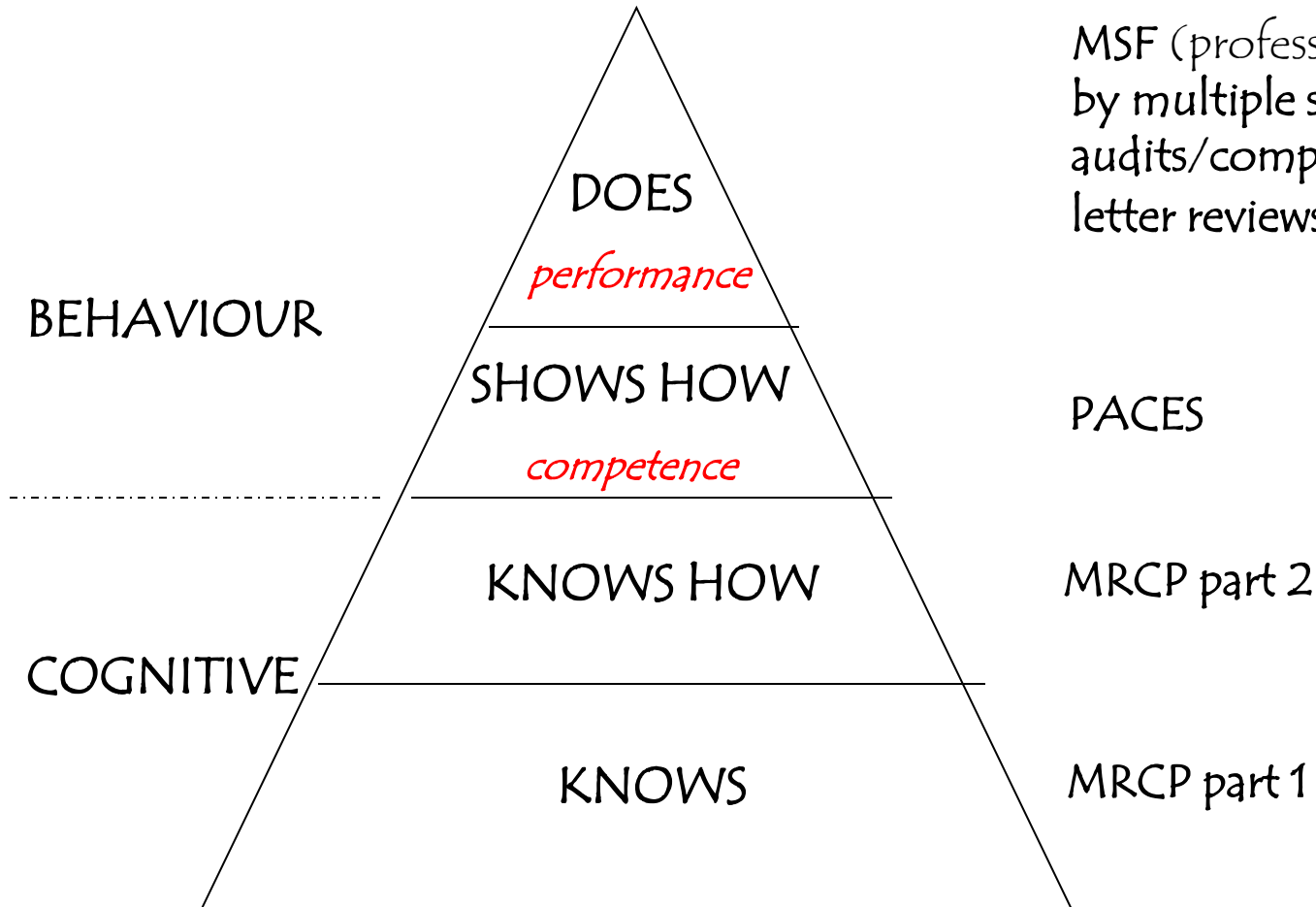
- Is “competence” curriculum the right model?
 - Is a physician simply a “competent technician”?
 - Is a well filled EP evidence of a good physician?
Do *you* trust this? How do *you* spot a poor doctor?
 - Should we *ever* tell trainees they “have all the competences?” What message is this?
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so if not “wpbas to assess numerous clinical competences” then how?

- **Assess performance!!**



Valid ASSESSMENTS

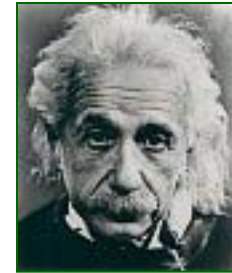


MSF (professionalism), observation
by multiple seniors (clinical)
audits/complaints/random OPD
letter reviews etc

So what's my proposal?

- Use wpba (miniCEX, CbD) to **teach**
 - Use MRCP and trainers' reports to **assess**
 - Gather, and respect, trainers' judgements of trainees' work (eg by local faculty group). Rely on the resulting, informed, ES reports for ARCP
 - Use the syllabus as “standards/map”, not as “to-do list/marching orders”
 - Stop demanding scores of ticked boxes, linked to *invalid* wpbas, as “evidence”, assess global ability
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**Not everything that can be counted
necessarily counts;
not everything that counts can
necessarily be counted.**



Albert Einstein.

I propose we should **not demand
“**evidence**” for “**all**” the “**competences**”,
as demanded by the present
CMT curriculum!**

We can do a lot better than that!





Two central purposes of assessment

- For society's benefit.

“Is this trainee OK to progress/qualify?”

Screening/summative

- For the trainee's benefit.

“How am I doing?”

Feedback/formative

What about “competence gaps”?

- Trust, respect the trainee
 - Trust, respect the physician as educator
 - Trust the principle of sampling
 - Do not trust invalid “assessments”
 - Is “you have all the CMT competences” ever the *real* truth?
 - Emphasise the importance of doctors working within their limits and acting professionally
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The virtues of LFG performance review.

- True clinical performance assessment
 - Multiple observations of multiple episodes
 - Responds to real 2011 NHS work patterns
 - Allows informed feedback to trainees
 - Supports ES in identifying poor trainees
 - Truly valid, defensible assessment, unlike wpba!
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So how are we doing with WPBA? In Foundation? (where it began in UK, 2005)

- Foundation curriculum:

(specifies miniCEX, DOPs, CBD, MSF as wpbas)

“An evaluation of the miniCEX in the Foundation Programme”

Jackson, Wall, Hospital Medicine Oct 2010.

196 FY1 miniCEX analysed 6 months into the year

- *Only one score “below expectations for FY1 completion”*
 - *12% done by consultants*
 - *38% “rarely or never observed by assessor”*
 - *Trainee satisfaction 3.8 on 10 point scale*
 - *Trainees regarded it as a “tick box exercise”*
 - *Assessors thought it “did not give a realistic insight into trainee performance”, as did 70% of trainees.*
 - *Assessors found the 6 point score ill defined and complex*
 - *“potential benefit” widely acknowledged*
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So how are we doing with WPBA? In Foundation?

- Foundation curriculum:

EP data from NES, first year (in press, PGMJ) Tochel et al.

- 2489 FY1 posts, 15 wpba done on each of 92% trainees
 - 2339 FY2 posts, 6 wpba done on each of 87% trainees
 - Rating scale of 1 (v unsatisfactory) -7 (v satisfactory)
 - Results?
 - <5 in 1% FY1
 - <5 in 3% FY2
 - ie overwhelmingly *better than* “very satisfactory”
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An emerging “new model” for WPBA?

- For teaching only (SLEs): miniCEX, CBD
 - For teaching, *then* for assessment: DOPs
 - For assessment : MSF, ACAT, LFG reports
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