Scenes from Postgraduate Life

Quality assurance

Quality assurance, whether in the domain of structure or process or outcome, is made easier if there is consensus on standards, a variable (or indicator) that can be measured, and if the methods used are well tried. The search for quality in postgraduate and continuing medical education is not made easy by the lack of consensus on standards, other than those set by the Royal Colleges and their Faculties through the higher qualifications, by the difficulty in identifying 'things' which can be quantified and by the absence of well developed methods.

Although the standards set by Colleges and Faculties, through their examinations, and by the Joint Committees, which issue certificates on completion of training, are widely accepted, they are also recognized as imperfect ways and means of assessing whether a doctor has achieved the skills and attitudes, not only the knowledge, which are needed to proceed to the next stage of his/her career. Skill assessment might, arguably, be facilitated by recording, either as a journal or in a log book, what the trainee has done, with what degree of supervision, and with what outcome. (Of course, the log book gives more information than is needed just to assess the trainees' skill; it provides some means of assessment of the trainers and training programme as well.) Assessment of attitude is far more difficult and the higher professional examinations, as presently structured, do not achieve this, nor does the Appointment Committee. It must be hoped that the new breed of medical teacher – the educational supervisor – will be trained, amongst other things, to assess this domain of the educational objectives which should be set for every doctor in training, at all points of his/her career.

The standards required of training posts are described, in general terms, by the Colleges, Faculties and Joint Committees; and visits of inspection are often preceded by an atypical level of concern for the standards, for the trainee and for the educational facilities. Visits by these external bodies are, except in unusual circumstances, arranged every five years, or more when there have been 'administrative delays'. During the quinquennium, ten or more doctors may have been 'trained' in a post, during which time the consultant

staff could have changed, the hospital moved, or facilities reduced. Visits are also brief; they are designed to enquire about structure and outcome rather than on the educational process. If quality assurance between College/Faculty visits is not to be allowed to slip into abeyance, monitoring by others – for example by clinical and specialty tutors from other districts in the same region – is probably necessary.

Intra-regional quality assurance of training posts should not conflict with the principle of review by an external body. On the contrary, these should serve to reinforce the recommendations of Colleges and Joint Committees and ensure that these are put into effect, as is the case with Senior Registrar training, which is closely monitored by the Joint Advisory Committee, in all Regions.

These 'local' visitors could also assure themselves of the quality of the educational process, which is a difficult task for the College team in the brief span of an inspection. For example, timetables, teaching in wards, clinics and theatre and its content, could be assessed as well as the amount of study leave taken (and refused).

Interview with the majority of occupants of a training post, rather than the mere one in five or one in ten, which is usually the case, could ensure that standards were being maintained, and the morale of those in training boosted. Even though they might train for ten or more years, and yet not meet a College/Faculty visitor during that time, they would have had the opportunity to discuss whether and how they were being taught, by whom and to what effect; and whether the teaching programme and their training, in general, was designed and planned to meet their needs.

Quality assurance in postgraduate education will always be made difficult by problems of quantifying the learning and teaching process; and in persuading others that educational performance indicators, which include 'consumer satisfaction' are both possible and valid. Some 'things' which can be measured, such as throughput and turnover in a unit or on a firm, may provide little useful information about quality of either service or training. Measures which might be used include: the subsequent professional development of all previous

occupants of the post, over the past ten years or, the number of research papers published by previous post holders or, the number who have submitted a thesis based on research begun whilst in the post. However, such variables can only be applied to a few posts. Clearly, here is an important researchable question: qualitative measurement of training and education (whatever the distinction is between the two) provided by posts, by schemes and by training programmes. Any measurement should be applicable to vocational training of all kinds, both those with and those without a higher qualification, or certificate, which is conventionally used to mark the completion of a period of postgraduate education. Success in MRCP(UK) is often regarded as an indicator of the satisfactory completion of general professional training; and the issuing of a certificate in vocational training is, by act of Parliament, the important measure of whether a doctor is suitable to become a Principal in General Practice. Yet neither, it can be argued, provides assessment of the training which the doctor has received.

The well-tryed methods used in educational quality assurance are the examinations for the higher qualifications, the inspection of training posts and their recognition either for accreditation or for College/Faculty examination regulations and the individual performance review, such as that for senior registrars. Newer methods of assessment are much needed, and are the focus for educational research. However, whether these newer methods will provide suitable means for appraising the quality of the product of postgraduate education and training is not clear. How can assessment methods be devised to test competency in the domains of communication skills and attitudes? Would not the methods of continuous assessment be a useful addition to the setting of standards by Colleges and Faculties through their examinations? And, as even the previously termed 'exit' examinations move earlier in the years of postgraduate medical education, what new methods,

beyond performance review, can be devised to assess quality of trainee, trainer and training in the years between acquiring the appropriate qualification and consultant appointment. Similarly, what quality assurance is there of the educational process between certification of vocational training and the obtaining of a principalship in general practice.'

Quality assurance in continuing medical education is, at once, both more difficult and easier than in postgraduate medical education. More difficult because there are so many styles of learning, for which it would be difficult to develop performance indicators; easier, because the search for quality in clinical and non-clinical service includes education, according to the dictum - 'evaluate, consult, and educate'. The audit cycle provides opportunity to determine both whether service and education/training can be done better. It provides the opportunity, through the setting of standards and the implementation of the changes needed to achieve these, to both educate and to assess how effective that process has been. Audit also provides the opportunity to evaluate newer teaching methods, such as distance learning, the quality assurance of which is a matter of interest and importance, as more resources are given to this process. Of the three pressures to establish audit (public demand, research, and education) it is the last which should be the motivation for all doctors. For acceptance by doctors of audit and peer/performance review, coupled with research into the ways in which doctors learn best, could guarantee quality assurance in what has been called the 'enduring phase' of medical education.

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