The New Objective Based Curriculum and New Methods of Assessment

In 1999 I was invited to join the education sub-committee of the Cardiology SAC. Its remit was to draw up a new Objective Based Curriculum for cardiology. Since then I have also become involved in developing new methods of assessment with the education department of the Royal College of Physicians. The following is a brief summary of where the whole process is to date, and what we might expect in the future.

Background
In 1999 the Education Sub-group of the JCHMT felt that in line with current educational thinking the curricula for specialist registrar training in all medical specialties should be reviewed and changed to Objective Based Curricula. All Colleges/ Higher Training Committees were instructed to develop objective based curricula by the Specialist Training Authority.

As a result of this the Cardiology SAC set up an education sub-committee with the specific task of developing the new curriculum for cardiology. The members of the Cardiology group are:

Dr P Mills    Chairman, Curriculum Sub-committee
Professor S Cobbe  Academic and Scottish representative
Dr D Patterson   Educational Adviser
Dr A Wragg     SpR cardiology
Dr H Gray      British Cardiac Society, I.T. Committee
Dr N Brooks    Chairman, SAC Cardiology

(The General Medical SAC has also drawn up a specific curriculum for General Internal Medicine).

The whole purpose of re-writing the curricula was to bring it into line with established educational principles. Obviously the overall content is very similar to the previous curricula although the emphasis is quite different. All of the new curricula will include the following:

- Background
- Aims
- Objectives
- Content (divided into knowledge, skills and attitudes for each Objective)
- Teaching and learning methods
- Assessment methods

Rather than having long lists of diseases the new curricula will have the content based on clinical presentations e.g Chest Pain but will also include important diseases and relevant investigations and practical procedures. The cardiology curriculum has now been written and is awaiting approval by the STA. An example of what one of the pages may look like has been attached (figure 1).
Learning methods
Learning methods are unlikely to change from the present but will be defined in each of the curricula:

Self directed and distance learning (Journal, textbook & internet sources)
Knowledge of current clinical trials (Evidence Based Medicine)
“Apprenticeship learning” (experiential learning)
Formal training at regionally organised Study Days or Postgraduate Courses
Attendance at national and international conferences

New Methods of Assessment
Rather than the new curricula the biggest change in specialist registrar training is likely to be in the areas of assessment. At present there is no reliable objective way of assessing progress during training or assessing competence upon its completion. This is an area which is likely to have the most change over the coming years, not just for SpRs in medicine but, in all disciplines and also throughout the professional life of consultants.

One of the problems is that there is no single assessment method that covers all aspects of competence. As a result of this the Royal College of Physicians has been actively pursuing and developing new methods of assessment.

Is there going to be an exit exam?
This is a commonly asked question. Although some of the medical specialties are in favour of an exit exam it is generally the feeling of the JCHMT at present that this is not likely to be the best method of assessment. Although MCQs, for example, are very good at assessing knowledge (and the ability to do MCQ exams) they are not good at assessing clinical skills and overall clinical competence. It is the assessment of variables such as interpersonal and practical skills that are generally perceived as being more important, especially in the light of a number of high profile media cases. Not surprisingly it is the assessment of these ‘variables’ that is much more challenging. However, although certainly not final there is some pressure to have some form of knowledge based assessment. This is likely to be a MCQ early in the training program and will assess what would be expected to be ‘core knowledge’ that all cardiologists would be expected to know. I must emphasise that this is by no means final and is still being actively discussed.

Concerning other new methods of assessment under development for Specialist Registrars these include

1. The 360. This is collecting feedback from colleagues and other non-medical staff about the trainee’s performance. The emphasis will be on performance of generic skills rather than specialist skills and may include structured feedback from other allied professionals such as nurses, cardiac technicians and peers. A similar system may ask your patients to provide feedback. This method is almost certainly going to be introduced for consultants.
2. Directly Observed Assessment of Practical skills
3. Directly Observed Assessment of Clinical skills
4. Portfolio of achievements
5. Other methods such as clinic letters and clinical notes review and videoing consultations are being considered by other medical specialties.

As cardiology is such a practical based specialty there will be considerable emphasis on the assessment of practical skills. Although most people agree that having lots of quality experience is a good thing, it is generally felt that a numbers based approach to training is no longer sufficient. The new-curriculum will probably not recommend the numbers of procedures required to reach competence as this varies considerably between individual trainees and no doubt is dependent on the quality of their trainer/training. Therefore a competence based assessment, as mentioned above, is likely to become more important than a log of numbers. The log book will still be an integral part of the process but trainees will have to have regular assessments of their skills throughout training.

I would like to emphasise that all these new methods are at the very early stages of development by the Royal College of Physicians. However, it is inevitable that there will be change in due course. The RCP is planning pilot projects to assess these new methods and these will be starting shortly.

It is inevitable that any new methods will require more time on behalf of the trainee and trainers. However the modern climate that we work in demands that we have a more objective and competency based training.

**What might the benefits be to individual SpRs?**

Although all of these new changes may seem to be of little benefit for the trainee there hopefully will be some advantages. For most trainees they will achieve their CSST regardless of the above changes. However some trainees should benefit from a more objective assessment of their progress and this will hopefully lead to a more structured approach to their training, especially when they are not performing well. One would hope this would give them the opportunity to focus on any problems they may have and also dictate that their local training authority addresses any deficiencies at an earlier stage in training. This would hopefully turn them in to more ‘employable doctors’ at the end of their training and help improve the training of others who follow. In addition if during the career of a consultant there was ever a question over their competence as a clinician then robust documentation of the assessment of their competence would hopefully be of considerable value. It is also hoped that objective assessment of trainees will eventually lead to improved training opportunities as local deficiencies are identified.

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