Academic health centres: managing the transition from good to great

Editor – The article by Noble *et al* (*Clin Med* February 2010 pp 16–9) describes the high level strategies in four consistently high achieving healthcare organisations in the USA. While the American healthcare system has its flaws, the four organisations in Noble's article are outstanding.

Noble's observation that what unites academic health centres is greater than what divides them is important on this side of the Atlantic. We believe it extends even further: the factors that contribute to greatness apply to NHS acute trusts, where many district general hospitals are larger than academic institutions in the USA.

In contrast with the USA, where organisations such as John Hopkins are able to acquire a national reputation,[1] in the UK we avoid talk of greatness. In *Good to great*, Jim Collins described great companies as organisations with a rigorous attachment to discipline and a relentless focus on key activities that make for success.[2] Great organisations avoid Collins' definition of mediocrity: that is organisations that characteristically manifest 'not reluctance to change but chronic inconsistency'. The NHS generally suffers from this problem of chronic inconsistency.

Understanding and implementing proven, relevant methodologies as well as having guiding principles and strategies and acting systematically on all fronts in a coordinated fashion is what is required to improve. Focusing on the how and applying it in the UK setting is the challenge.

The King's Fund Point of Care hospital programme, recognising the current state in NHS hospitals, aims to work with a handful of hospitals to test specific, system-wide methodologies designed to transform cultures and improve quality of care, ideally without additional cost.[3] Vanderbilt, widely acknowledged in the USA as outstanding in delivering patient-centred care is one of the examples we will be working to emulate.[4]

We recognise that making a commitment to transform quality of care in these hard pressed times, is high risk. But unless we change our thinking and rigorously apply ourselves to working systematically towards the aim of reliable excellent quality of experiences, we will not break free from mediocrity.

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Pericardial effusion – forgotten differential diagnosis of shortness of breath

Editor – I read with great interest Nijjer *et al*'s excellent paper (*Clin Med* February 2010 pp 88–90). Delayed pericardial effusion can also be related to primary lung tumours or haematological tumours.[1] In acute medicine, when a patient with known left ventricular dysfunction presents with shortness of breath, the most obvious diagnosis is heart failure. However, I have recently seen a case of a 70-year-old gentleman who was known to have moderate left ventricular systolic dysfunction and atrial fibrillation. He was admitted acutely with symptoms and signs suggestive of decompensated heart failure. His presenting electrocardiogram (ECG) confirmed atrial fibrillation and had poor R-wave progression. He was started on intravenous diuretics and also rate control antiarrhythmic drugs. He responded slightly to treatment and was also noted to be hypoxic on air. His chest X-ray revealed pulmonary congestion with some right upper lobe consolidation and cardiomegaly. A computed tomography pulmonary angiogram was organised which showed gross pericardial effusion and also a primary lung tumour in the right upper lobe. Retrospective analysis of his serial chest X-ray revealed that his cardiomegaly had worsened markedly in two months.

If this gentleman had a bedside echocardiogram done on his presentation, his diagnosis would have been made immediately and a prompt treatment strategy could have been started. Therefore, it is prudent to consider pericardial effusion in a patient presenting with shortness of breath, globular heart on chest X-ray and poor R-wave progression on ECG, irrespective of past medical history. A suspicion of pericardial effusion should lead to prompt bedside echocardiogram by an echocardiographer or acute physician trained in basic skills of echocardiography.[2]

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A critique of the specialty certificate examinations of the Federation of Royal Colleges of Physicians of the UK

Editor – We welcome John Cookson's interest in our new specialty certificate examinations (SCEs) (*Clin Med* April 2010 pp 141–4). However, his critique was based on a limited selection of the available information, so this correspondence provides a fuller update for readers. Four years on

from the pilot examinations in 2006, after 11 diets in eight separate specialties and with almost 10,000 questions in the bank, there is much to report.[1] The contribution from specialists throughout the UK to this effort has been superb.

Cookson is correct in saying that the pilot examinations were not mapped robustly to the curricula. Furthermore, progressive revision of the specialty curricula during the last two years has presented a moving target for the new examining boards. We have risen to this challenge. From 2009, each SCE blueprint has been mapped to the appropriate curriculum and every usable question related to the relevant curriculum domain. Question-writing groups are giving priority to the remaining gaps.

He criticises the curricula for differentiating between knowledge, skills and attitudes and expresses concern that the SCEs assess only knowledge. Although single best answer questions can evaluate problem-solving skills and clinical judgement, the SCEs were always intended as knowledge-based assessments. They were not designed to test skills or attitudes, which, we agree, are much better evaluated by direct observation and discussion face to face.

Cookson expresses disappointment that the indices of reliability in the pilots were inconsistent. Values of Cronbach's a obtained in examination diets of 200 questions, involving small cohorts with a narrow range of ability, are unlikely to reach 0.9. Indeed, recent research into the use of reliability suggests that the standard error of measurement may be a more appropriate metric.[2] Nevertheless, it is reassuring that in nine out of 11 SCE diets to date reliability values have exceeded 0.8.

We appreciate the challenge of standard setting for new examinations. For information, the SCEs use the same criterion-referencing process (the Angoff method) used for the MRCP(UK) written examinations in recent years. Although many of those involved in the process had no previous experience, their task was made simpler by taking as a consistent yardstick the knowledge expected of a newly appointed specialist.

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In response

It is good to read an update and that data continue to be gathered about the performance of the examination. The progress in question writing is impressive but it will be an ongoing task as some questions will perform poorly, some will go out of date and soon many will be remembered by candidates after the examination and maybe passed around.

It is correct that single best answer questions can evaluate problem solving so it seems a pity that a decision was taken to test only factual recall rather than utilisation of knowledge. The maintenance of validity is indeed not helped by the learning outcomes in the various curricula. My problem is not just that only knowledge outcomes are being assessed. They are written so that they mostly require knowledge recall rather than higher order thinking and further many outcomes are not listed under the appropriate heading so that an examination testing only those listed under knowledge will miss important topics. This shows the importance of designing assessment systems along with the outcomes, something previously neglected in the foundation programme. My anxieties about setting a specialist examination at the lowest level of Miller's triangle remain.

I identified educational impact, cost-effectiveness and acceptability as issues requiring more information and I was hoping this would be forthcoming. It would be a pity I think, if this examination led candidates to acquire most of their learning from books rather than from patients; a survey of their learning strategy would be of considerable interest. There must also now be some robust data on costs. Even if specialists are giving their time freely there is an opportunity cost; if they are writing questions they cannot be doing something else. The publication of robust costings would be a service to all of us who struggle to provide a good examination product for the resources available.

Establishing that standard setting is at the level of the new consultant will certainly be helpful. There must now be considerable information about the consistency of standard setting between the various diets and specialties. Publication of this would help answer the questions raised by the data in the pilot.

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European Working Time Directive (1)

Editor – McIntyre *et al* provide quantitative evidence for the deleterious effects of the European Working Time Directive (EWTD) on junior doctor well-being in terms of a higher sickness rate (*Clin Med* April 2010 pp 134–7). They correctly speculate that loss of cohesiveness of the traditional medical team is a key causal factor behind this increase in sickness, as well as the resultant loss in actual numbers of junior doctors available at any one time. While these factors are very likely to be implicated, another factor of 'work compression' should be appreciated, ie an increase in task density (the number of tasks per unit time) for every junior doctor due to the absolute decrease in work hours (in addition to the compounding effect of