

Diploma in Geriatric Medicine (Glasgow and Hong Kong): an update

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The Diploma in Geriatric Medicine (DGM) of the Royal College of Physicians and Surgeons of Glasgow was first established in 1991. The DGM is administered from the Royal College of Physicians and Surgeons of Glasgow, but the Glasgow College also does this on behalf of the Royal College of Physicians of Edinburgh. The examination is designed for doctors with enhanced experience and knowledge in the care of older people, and the level of competence is that expected of a general practitioner with a special interest. Candidates must be a minimum of 16 months post-graduation, and have had a minimum of 4 months' experience of geriatric medical care. Currently the examination is held in Scotland twice yearly, in May and November.

Initially the examination comprised traditional short and long cases, with essays for the written examination. Over the years a number of modifications have taken place—core competencies have been defined, there has been more of an emphasis on problem solving, and marking is criterion-referenced.

In 2003 a group of consultants and specialist registrars met in the College, to discuss possible changes to the examination, and the outcome was that a major revision has taken place. The main changes are as follows:

1. Written examination—this now comprises one 90-minute paper with two sections. The first section comprises 13 short-answer questions. These are based around 10 core competency themes, and comprise a short lead-in followed by two questions, for which there should only be one correct answer, which can be given in a few words. The second section comprises nine extended matching set questions covering the

same range of themes. Examples of both of these types of questions can be found on the College website at www.rcpsglasg.ac.uk.

The new written examination is much less subjective from the examiner's point of view, and therefore both easier to mark and fairer. We hope, in due course, to have the extended matching set questions marked using a scanner. Despite the fact that the examination is now much shorter, this format also allows us to examine a wider range of candidates' knowledge.

2. Clinical examination—this has been changed to a four-station carousel, based on the MRCP PACES model. The four stations are as follows: chronic disabling disease, ethics, communication and sensory impairment, and electronic data interpretation. Each station lasts 20 minutes with a five-minute interval in between, so that 4 candidates can be examined at any time point. The normal plan is to examine a maximum of 12 candidates daily, i.e. three cycles, although in the inaugural examination held on 17th November 2004 at the Southern General Hospital, Glasgow, 16 candidates were examined. This is feasible, but it is a long day for all concerned.

Briefly, station 1 allows a targeted history and examination (on the same patient), who might have e.g., stroke, Parkinson's disease, arthritis or chronic obstructive pulmonary disease. The interview can include issues such as falls risk assessment, drug management, and prognosis.

In station 2 the candidate interviews a surrogate carer/relative, under the observation of the examiners, who then explore the issues in more

depth with the candidate. We feel that there is no shortage of suitable scenarios for an ethics station in geriatric medicine, and host examiners in the three sessions held so far (including Hong Kong) have devised relevant and challenging ethical scenarios to test the candidates.

Station 3 comprises two 10-minute interviews, the first being with a patient with either cognitive impairment or dysphasia. The second part comprises bed-side assessment of a patient with either hearing impairment or low visual acuity. Patient selection is obviously important in these stations, but in the initial examinations, station 3 has proved to be at least as good a discriminator as the others.

Station 4 comprises a PowerPoint presentation of 10 consecutive slides, which are viewed for 2 minutes each. These might include a video clip of a gait disorder, an electrocardiogram, skin rash, an image of an eye with cataract, or an X-ray, etc. This is perhaps a slightly controversial station (this is not a radiology examination), but it does allow us to extend the examination to cover a number of common-problem areas, which may not be easily included in the clinical stations.

As with all new examinations we learn from experience, and it is likely that minor modifications will be introduced over the coming years. Nevertheless, it is felt that the DGM examination is now much more in line with current educational thinking, as outlined in the November 2004 press

release in the UK from the Postgraduate Medical Education and Training Board (PMETB).

A separate but very important development has seen the establishment of an overseas centre for the DGM in Hong Kong. 16 candidates signed up for the inaugural examination, and 3 Scottish examiners travelled to Hong Kong in June 2005 to examine local candidates in tandem with our geriatric medicine colleagues from Hong Kong.

The pass rates in Glasgow and Hong Kong were very similar—all candidates did well in the written examination; while, as ever, a small number in both centres found some difficulty at the clinical stations. Analysis of the clinical results reveals that no particular station proved more difficult (or easier) than the others. The administrative arrangements for the inaugural DGM (Hong Kong) were first class, and the general consensus is that this has been a highly successful joint venture.

As for the future, early stage discussions are underway to see whether some degree of harmonisation can take place between the DGM (Hong Kong) and the Postgraduate Diploma in Community Geriatrics, as we are examining the same group of doctors on the same range and depth of knowledge of geriatric medicine.

Finally, after all the effort that has gone into changing the examination, it would be good to have a steady flow of applicants. The Glasgow College welcomes this opportunity to bring the DGM examination to the attention of all doctors who have an interest in good medical care of our older citizens.