1. Introduction
Examination fairness formed part of a strategic review of the MRCGP in 2012, and the idea of the AKT ‘fairness project’ evolved from this. It had been noted that doctors trained overseas and of non-white ethnic origins had lower pass rates at the AKT. This finding is in common with other medical examinations, both undergraduate and postgraduate. The concept of the project was to recruit doctors with these two criteria from as wide a background as possible, and show them AKT questions to see if they could identify any bias. They would then be shown questions where there was a wide gap in performance to see if they could see any reasons why the white UK-trained doctors were doing better.

2. Participants
Facilitator
Dr John FOULKES (Psychometric advisor to the AKT)

AKT Group
Dr Carol BLOW (Clinical Lead)
Dr Chris ELFES (Deputy Clinical Lead)
Chris CHIVERS (Knowledge Bank Manager)

Volunteers
All of the eleven participants for the project were recruited via the First 5 group (GPs within 5 years of qualification to practise) or through training connections within faculties, and they volunteered to attend for a day at the College to look at AKT questions. They had all taken and passed the AKT within the past 5 years, although not all at the first attempt.

- **Ethnic origin**: as declared by the individuals and listed below

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<th>Ethnic Origin</th>
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<td>White - Any other White Background</td>
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- **Gender**: There were six men and five women in the group
- **Training**: All but one had trained overseas (Pakistan, India, Nigeria, Venezuela, Italy) with one UK-trained doctor.
- **Current role**: They were all working in general practice in a range of roles (finishing ST3 training, locum, salaried GP, GP partner & GP trainer, Armed Forces GP)
- **Language**: Nine of the group had used English as their language of training at medical school, with Spanish and Italian as the other languages of training
- **Previous training**: Three doctors had started surgical training, one medical training and one pathology training before coming to the UK

NB. In this report, IMG (International Medical Graduate) has been used to describe all the doctors trained overseas.
3. **Process**

a) **Purpose of the AKT ‘fairness project’**

Dr Foulkes described the purpose of the day which was to consider the fairness of the AKT in addition to its reliability and validity which are routinely monitored. He described the concept of fairness and gave examples such as candidates knowing what was to be tested and the introduction of the Content Guide to address this, giving feedback on areas of difficulty to all future candidates via the website, and checking for differential performance between different groups of candidates. The purpose of the project is to see if there is any aspect of AKT questions that could unintentionally cause greater difficulties for any specific groups of candidates.

b) **Initial group discussions**

The group was then split into two with CB and CE as scribes, to discuss any potential sources of perceived bias that they could think of, that might relate to where a person had qualified or their ethnicity. After the discussions, a list of areas of potential perceived bias was produced.

**Summary of results**

Some fears about potential areas of difficulty and perceived bias were identified:

- Language – reading speed, fluency, colloquialisms
- Research and statistics – not taught at undergraduate level in many countries
- Different learning and teaching styles – didactic and rote learning more common in India and Pakistan
- Different exam formats – MCQs not used in many Indian medical schools
- Familiarity with UK systems such as DVLA, clinical guidelines which UK candidates will have grown up with
- Change of specialty to GP could compound the problem

c) **Sample items to illustrate potential perceived bias**

Six examples of questions which had been written deliberately to demonstrate possible bias were considered by the whole group. These were not real AKT questions.

The first three used colloquialisms such as ‘down the Legion’ and ‘hunky dory’ and the group clearly recognised these, including some that some members had not even heard of. There was some debate that an IMG would expect to have to learn some such phrases if they were common ones widely used in all or specific regional areas. It was commented that this problem may apply to UK graduates working in different parts of the UK as well.

The next item about cervical cytology related to different procedures in Scotland and was to illustrate that there are different procedures and practices even within the UK that could be seen as making certain questions more difficult for people from outside that environment. However, the group commented that candidates are qualifying to work anywhere in the UK so this is a tension that the AKT has to accommodate.

The next question was about dietary advice for a Jewish patient, which stimulated a lively discussion about whether it was reasonable for candidates to know the specifics of religious practices. There was a feeling that, for example, it was not necessarily reasonable to expect non-Muslims to know the detail of Ramadan whether UK-trained or not.

The final question about access to healthcare facilities required people to know about the geography of London, so again was inherently and deliberately biased against any doctor not familiar with London.
The candidates also volunteered examples of colloquialisms that they were unfamiliar with initially such as ‘spend a penny’, and ‘the black dog’.

d) Review of live items from an AKT (numbered 101-200)
Before this part of the day, Dr Foulkes emphasised the need for confidentiality and security as this was current live material. Everyone agreed to this condition. The group worked in pairs looking at 5 sequential questions (numbered 101-125 in total) and were then invited to comment.

In summary
- The group felt the questions were fair and much of the debate was about the medical content which they largely felt was quite easy and reasonable to ask. One question on the types of epilepsy was thought to be quite specialised for GPs in general but not particularly IMGs.
- Research and statistics questions were a recurring theme as only the doctors trained in Italy and the UK had learnt this as undergraduates, whereas they felt UK medical courses had it embedded as part of the curriculum. The group was shown the Content Guide which was not available when they took the AKT, and this was felt to be helpful for both research and administration sections. There were a few comments about the College providing education in this area but that it was probably best provided at a local level. They felt it needed to be flagged to Deaneries as a significant area where they could help IMGs.
- There was debate about the length of questions. In the initial discussions, this had been identified as a possible area of bias if IMGs are reading more slowly. When the live questions were seen however, some scenarios were thought to be very short. There was quite a lot of disagreement within the group on this topic.
- Another example of possible language bias was in the use of the word vodka - candidates would need to know that it is alcohol and with a high alcohol content. Again some in the group felt that if you had been working in the UK for at least 3 years that it was reasonable to know this, so again there was no consensus.
- Giving normal values for results of investigations was a recurring theme with disagreement in the group about whether these should be provided for common results such as full blood count. However, they did not feel that this was a specific bias against IMGs.

e) Individual work on AKT (numbered 126 - 200)
Half the group looked at questions 126-164 and the other group at questions 166-200 with the defined task of identifying anything they considered as biased. Then each person was invited to select an item to discuss and say why they thought it was biased.

Summary of comments
- Skin photos – all were of white skin and the comment was that perhaps there should be different skin colours on photos. The group agreed but felt that this could make it more difficult for all candidates, as the appearance of common skin conditions can be very different in different skin colours. This is recognised as a problem for specialist dermatologists let alone for GPs.
- Unfamiliar words – ‘shutter’ ‘dockworker’ ‘preclude’ - the group felt there would be a wide variety of language ability and some people would have more difficulty than others.
- Legal areas such as Freedom of Information, data protection, health and safety, certification etc may not be applicable to their country of training, but that if the doctor is working in the UK, then it is reasonable to have to know about it. There was a group feeling that this was a reason for not taking the AKT too soon, as doctors in the hospital part of their training would not have experienced much of this area. They also felt that UK graduates were also often unaware of this type of administrative question as well, but that it is a very important part of GP work.
- Research and statistics questions – The group reiterated their previous comments about lack of training on this topic at undergraduate level, and the need for support and training.
- Length of questions – although some questions were longer and therefore IMGs may be slower reading them, the group also noted how short some questions were which compensated overall.
- Other members of the group could not identify bias in the questions they looked at.
In summary, only one question out of 100, (not all the group knew what a dock-worker was) was identified by more than one person as showing possible bias.

f) Questions with differential performance statistics between UK and non-UK graduates
As part of routine analysis of the AKT questions, differential performance is identified. None of the questions where there was a marked difference in performance between UK graduates and IMGs had been identified by the group as showing bias.

Examples of these questions from a recent AKT were then discussed by the group to see if they could identify any reasons for the difference in performance.

- MRSA – The group thought this may be because this issue would not arise in their own country and candidates may not be aware of it. They would have seen MRSA management in hospital in the UK but may not be familiar with community care, especially if they took AKT in ST2. They did not consider that it was bias because it is a significant problem in UK.
- Safeguarding children scenarios - The group thought that this question was quite lengthy to read and every detail was important so it may take longer if an IMG read more slowly. (Actual timing of this question was checked and did not fall outside the normal range of time taken). They also felt that this topic was not covered in their undergraduate training, and that there were different perceptions and practices in different countries. If the AKT was taken when in ST2, all GP registrars may not have same awareness of safeguarding in general practice. One of the group gave an example of different cultural practices which would be acceptable in the home country, being seen as unacceptable in UK. There was unanimous agreement that the question was reasonable as it is based on UK practice.
- Paraphimosis - Circumcision is very common in many overseas countries so this condition may not have been seen. However the group felt it was important to know for UK practice and therefore not unreasonable or biased.

g) Concluding group discussions
The two original groups were then reconvened to discuss whether, having thought of possible areas of perceived bias in the first discussion, they felt that they had seen examples of this in the live AKT questions they had examined. Again their discussions were documented by CB and CE.

Summary of results from the verbatim discussions
- That overall the AKT was seen as fair
- That IMGs need to identify their areas of need and rectify them to practise medicine in a different country
- That language used in the AKT should be clear and not be colloquial
- That research and statistics are areas where IMGs may need specific support in training

Dr Foulkes concluded the meeting by thanking all the participants for their time and enthusiasm in helping complete the project. The report on the day would be submitted to the Assessment Committee and would be circulated to the group. There would be a summary of the report on the Exam website in due course.

Dr Carol Blow
AKT Clinical Lead
23 August 2013