

The involvement of lay people in selection to general practice training schemes

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SUMMARY

In the UK there has been a government drive towards the involvement of lay people in health service decision-making processes. In the West Midlands, lay assessors are present on interview panels for applicants to general practice (GP) training. The impact of their involvement was explored through analysis of scores (207 candidates in March 2002), and a postal survey of lay assessors (response rate 84%, $n=47$). This paper draws on this study to consider the definition of lay people, and their role on assessment panels.

INTRODUCTION

In February 2003, Pat Lane and Paul Sackin outlined in this journal the advances being made in GP registrar recruitment.¹ The positive developments towards more accountable and equitable selection processes were rightly praised. In this paper, we wish to add to the debate by considering the involvement of lay people in these selection processes. Drawing on experiences from the West Midlands selection process, where lay members are present on all interview panels, we explore both the advan-

tages and challenges posed by lay involvement.

BACKGROUND

There is a growing awareness in the UK of the need to involve non-medical personnel in healthcare management. As part of NHS modernisation, the Department of Health has made a commitment to include patients, carers and the public in health service decision-making processes, and has called on NHS and health organisations to strategically and systematically build patient and public involvement into the way they operate.² Increasingly, lay people are appointed as members to health service committees, and are involved in NHS policy development.³ At the time of the study the National Institute for Clinical Excellence (NICE) included lay members on its Board and on its Partners Council, and the Commission for Health Improvement (CHI) had a lay chair and a majority of lay members on its Board.² Lay people were involved in patient liaison groups of the medical royal colleges and professional regulatory bodies, as well as government advisory committees.³ At the local level, lay people were chairs and non-

executive directors of health authorities, trusts and primary care groups; members of maternity services liaison committees, research ethics committees and audit committees; convenors and chairs of review panels for NHS complaints; and members of community health councils.^{3,4}

Although frequently used, the term 'lay people' is rarely explicitly defined. One definition, developed for lay members of medical ethics committees, is 'a person not practising or trained in any medical or paramedical discipline'.⁴ Lay people are expected to possess the 'ordinary' norms, values and perspectives of society, in comparison with the norms and values acquired by health professionals during their training.³ However, this definition is problematic. Firstly, the role of other health professionals is unclear: nurses are appointed as lay persons on the General Medical Council (GMC), but it has been noted that they are not truly outside the norms and values of the medical profession.³ Secondly, the assumption that lay people retain 'ordinary' values fails to recognise the differences between them: lay people can possess a range of different skills and experiences, and norms and values differ according to age, gender, culture and socio-economic group, but patient participation groups tend to be skewed towards certain sections of the population.⁵ Finally, a definition that focuses on the lack of knowledge or skills that lay people possess may mean that their contributions are devalued by other members. Studies of lay involvement in healthcare decisions have demonstrated that the lay member's voice on the panel is often 'faintly heard', with their role in decision making peripheral, and the unequal power relations between lay and professional committee members increasing the potential for coercion or subversion of lay members' views.⁶⁻⁸

In the West Midlands, lay assessors have been involved in the selection of general practice trainees since October 2000. This meets the Department of Health recommendation that the public should be involved in the planning, organisation and delivery of

healthcare, and 'those processes designed to secure the competence of healthcare professionals'.⁹ Within this region, applicants for either a three-year vocational training scheme (VTS) or one-year GP registrar (GPR) training are entered into a regional selection process. Details of this selection process have been published elsewhere, but briefly, shortlisted applicants are invited to an assessment day, where they are marked at two interview panels and in a role-play situation.¹⁰ A lay assessor sits on each of the two interview panels and, for each candidate, asks at least one of the four questions and marks all four. The questions are designed to assess the attributes expected of a GPR, for example clinical knowledge, empathy and commitment to learning. Owing to the high number of candidates, a number of interview panels and role-play stations run in parallel, so that one candidate may be assessed at panels A1, A2 and in role-play station A3, whilst another is seen by B1, B2 and B3. Prior to the assessment day all assessors attend a training day, where they receive training in marking candidates and discuss the phrasing and marking criteria of the interview questions. Thus, lay assessors also have some input into the development of interview questions.

A previous evaluation has shown that the inclusion of lay people on the panels was acceptable to the candidates being interviewed, but less was known about the involvement and experiences of the lay assessors themselves or about the impact of their involvement.¹¹

METHODS

Two main types of data were collected: scores and questionnaires. A database of anonymised scores was compiled for those candidates going through the selection process in the West Midlands Deanery in March 2002 (selection occurs twice a year, with the largest intake in March). The database contained scores by panel and question for each of the 207 candidates. Candidates were identified only by a code number, and

the database did not contain assessors' names, indicating only which scores were given by the lay assessor on each panel.

A postal survey was distributed in May 2002 to all lay assessors involved in the West Midlands selection process since its introduction in October 2000. The questionnaire had previously been piloted with five lay assessors, and included questions about the respondents' backgrounds, motivations, and reflections on their experiences. The response rate was 84% (47/56).

RESULTS

Profile of lay assessors

The majority of questionnaire respondents were female (80%), and aged between 41 and 65 (62%). Nearly all (45/47) were in paid employment at the time of their involvement, and the large majority (89%) worked in areas directly related to medicine. The largest single professional group was practice managers (40% of respondents), with many others working in medical administration, for example in postgraduate centres or within VTS schemes.

The lay assessors surveyed were highly motivated to be involved in the selection process, with 49% willing to be involved periodically and a further 47% willing to be involved every time, a twice-yearly commitment. The main motivational factors, identified in an open question, were that involvement complements their current work and experience (61% respondents), and personal interest in the process (32% respondents). One respondent wrote: 'I'm glad this process exists and lay people have a say in who becomes a GP'. Stated benefits of involvement included an increased understanding of the West Midlands recruitment process (43%), and increased experience in recruitment (34%).

Scores

It is interesting to explore the lay assessors' own perceptions of their scoring. The survey

asked whether they thought they marked the same as, or differently to, the medical assessors, and whether they felt they marked independently or were influenced by the medical assessors on the panel. The results reveal a division of opinion, with 53% indicating there was no difference between how they marked and how the medical assessors marked, and 47% suggesting there was a difference. Of those who thought they marked differently, 16 provided further written comments stating that they focused more on non-clinical attributes, such as communication skills and attitudes. The majority of lay assessors (70%) felt that they marked all questions independently; 23% stated that the medical panel members had some influence on their marks at first; only 6% felt there was an influence on their marks throughout the assessment day.

Exploring the marks given to the candidates, overall comparison of the scores reveals very similar marks awarded by the medical and lay assessors. Figure 1 shows the overall distribution of marks across the full range (0–5). The patterns of marks given by lay and medical assessors were almost identical, and the average of the marks awarded by medical assessors was 3.351, and 3.357 for lay assessors. As expected, a paired t-test between the lay assessors' marks and the average of the two medical assessors was not significant ($t(206) = 0.271$, $P = 0.79$). It may be argued that it is inappropriate to use the t-test as marks are clustered within panels and so are not independent. However, a multilevel analysis of our data indicated that the lay:medical difference was non-significant ($z = 0.214$, $P = 0.83$) and that the clustering within panels only accounted for 0.3% of the variance between marks. Therefore the clustering effect does not have a major impact upon our analysis (these considerations also apply to the subsequent t-tests and correlation). Our analysis therefore suggests that lay assessors did not mark consistently higher or lower than medical assessors.

Further analysis was undertaken to explore whether lay and medical assessors

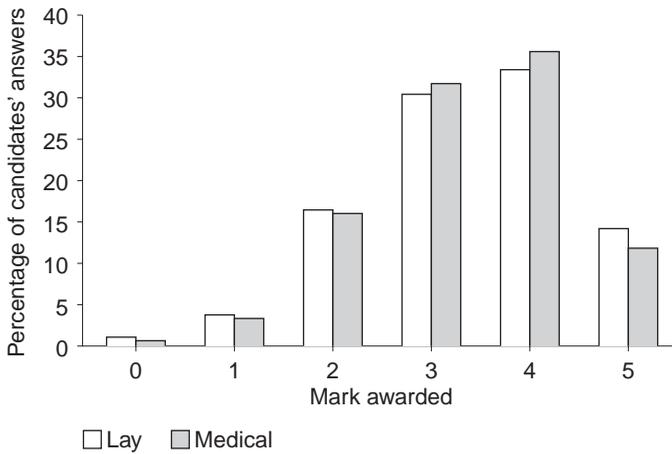


Figure 1 Score distributions for all questions

marked differently (i.e. by assigning high marks to different candidates), or whether they marked individual questions differently. The Pearson correlation coefficient between the lay and the mean of the medical assessors' marks was found to be 0.924 ($P < 0.001$). This very high correlation indicates high agreement between the lay and medical assessors, showing that the lay assessors awarded high marks to the same candidates as the medical assessors.

The possibility of a difference in the marks awarded by lay and medical assessors

to candidates who qualified in different places was also explored. As shown in Table 1, this was not the case: there was very good agreement between the lay and medical assessors for all places of qualification. For example, both lay and medical assessors awarded candidates who qualified in the United Kingdom a mean of 3.74, and the mean mark for candidates who qualified in Asia was 2.65 from lay and 2.64 from medical assessors.

To consider whether the lay and medical assessors marked differently on some of

Table 1 Scores by candidates' place of qualification

Place of qualification	N	Mean lay mark (SD)	Mean lay mark 95% confidence interval	Mean medical mark (SD)	Mean medical mark 95% confidence interval
UK	120	3.74 (0.60)	3.62–3.85	3.74 (0.53)	3.64–3.83
Europe: other	14	3.09 (0.68)	2.69–3.48	3.17 (0.61)	2.81–3.52
Africa	13	3.15 (0.78)	2.68–3.62	3.14 (0.69)	2.73–3.56
Asia	50	2.65 (0.71)	2.45–2.85	2.64 (0.71)	2.44–2.84
Central and South America	3	2.83 (0.38)	1.89–3.78	2.92 (0.24)	2.33–3.50
Middle East	4	2.78 (0.16)	2.53–3.03	2.55 (0.35)	1.99–3.11
Unspecified	3	3.38 (1.02)	0.83–5	3.08 (0.92)	0.81–5
Total	207	3.36 (0.79)	3.25–3.47	3.35 (0.76)	3.25–3.45

the questions, repeated paired t-tests were performed (see Table 2). Once again, consideration of the mean marks indicates very high inter-assessor agreement. In only one case (question 1, panel 2) was the lay assessors' mean mark statistically significantly different from the medical assessors' mean mark ($t(206) = -2.51, P = 0.01$), but this amounted to a difference of only 0.11 marks. For another question (question 1, panel 1) lay assessors were on the verge of awarding statistically significantly higher marks ($t(206) = 1.94, P = 0.053$), but the difference was even smaller at 0.08 marks.

Perceived role

The survey asked whether lay and medical assessors were equally valued within the selection process. Thirty-nine respondents (85%) thought that they were equally valued and of these, 25 provided written comments. Eleven wrote about the important role lay assessors play in bringing a different perspective to the process. Typical comments included:

'We see different aspects to each question.'

'I believe that a lay person looks at potential GP from a different perspective: after all we are "the patients".'

Other responses included that the other panel members listened to their comments (three respondents); and that they felt valued because their marks were of equal value (two respondents). Seven respondents (15%) thought they were not equally valued in the selection process and of these, five provided written comments. Two commented that they felt undervalued by the medical assessors, one writing:

'There was still an element of "what are you doing here?".'

One thought that there was too great an emphasis on clinical issues in the selection process; and two suggested that lay assessors play a different role to medically qualified assessors, stressing that the latter have greater knowledge of clinical matters.

DISCUSSION

This study raises two main issues around the inclusion of lay people on interview panels: who are they, and what is the impact of their involvement? Both have a direct impact on the wider consideration of their role on the interview panel. These issues are explored in turn.

Despite the title 'lay' assessors, the findings suggest that the majority of lay people involved, whilst not medically trained, did

Table 2 Scores by question

Panel	Question	Mean lay mark (SD)	Mean lay mark 95% confidence interval	Mean medical mark (SD)	Mean medical mark 95% confidence interval	t score	Significance (P)
1	1	3.75 (0.98)	3.61–3.89	3.67 (0.93)	3.54–3.80	1.94	0.053
1	2	3.34 (1.03)	3.20–3.48	3.33 (0.91)	3.21–3.45	0.22	0.83
1	3	3.45 (1.03)	3.31–3.59	3.49 (0.95)	3.36–3.62	-0.79	0.43
1	4	3.19 (1.27)	3.01–3.37	3.11 (1.14)	2.93–3.29	1.69	0.09
2	1	3.43 (0.95)	3.29–3.57	3.54 (0.88)	3.42–3.66	-2.51	0.01
2	2	3.38 (0.98)	3.24–3.52	3.36 (0.84)	3.24–3.48	0.58	0.56
2	3	3.10 (1.13)	2.94–3.26	3.10 (1.04)	2.96–3.24	0.00	1.00
2	4	3.20 (1.17)	3.04–3.36	3.20 (0.96)	3.03–3.33	-0.10	0.92
Overall		3.357 (0.79)	3.25–3.47	3.351 (0.76)	3.25–3.45	0.27	0.79

have some relevant knowledge or experience: nearly 90% worked in professions related to medical education. This mirrors experiences elsewhere.³ In this study, the lay assessors cited their relevant experience as a major motivational factor, as they felt the selection process was of interest to them and relevant to their work. This group of lay assessors was highly motivated, with nearly half of respondents willing to offer a twice-yearly commitment. The retention of a 'pool' of experienced lay assessors from which organisers can draw may be beneficial: advantages would include increased confidence and experience. However, the relevant experience of the lay members also calls into question their 'lay' status: they do not represent a broad spectrum of society, and it cannot be assumed that they represent the 'ordinary' views of society as a whole. The difficulties of recruiting members from a broad spectrum of society have been documented, and it is recognised that lay representation will always be skewed towards certain groups, such as those with the time and inclination to participate.⁵

A further consideration is the level of acceptance of the lay panel member. Studies of lay involvement on other healthcare decision-making panels have shown that the lay members do not have a strong voice on the panel, their role is peripheral, and that there is potential for coercion or subversion of their views.⁶⁻⁸ In contrast, this study suggests that lay members felt accepted on the panel, with 85% of survey respondents stating that they felt equally valued within the selection process. It may be that the lay members' relevant experience contributed to their greater acceptance on the interview panel. Whilst this cannot be confirmed from the current data available, one hypothesis is that the doctors on the panel could recognise the expertise of a practice manager, for example, and therefore accept and welcome their contribution. It may be that over time lay members from a wider range of backgrounds could be recruited, as the involvement of lay members becomes accepted as the norm. In this way, the current situation

in the West Midlands could be viewed as a 'stepping stone' towards wider lay involvement. However, consideration would need to be given to the recruitment, motivation and training of those wider groups. At present, lay members are mainly recruited through direct contact by the selection organisers, are largely motivated by the relevance of the selection process to their work, and are trained alongside medical assessors. The involvement of wider groups of lay people may require different recruitment and training mechanisms.

Central to this discussion is the role of the lay member. Lay people have been defined as having the 'ordinary' values and perspectives of society, in comparison with the perspectives of health professionals.^{3,4} The role of the lay assessor in GP selection may therefore be seen as providing an alternative perspective on the interview panel. Many lay assessors felt they did play this role: nearly half of survey respondents (47%) said they marked differently to the medical assessors, with written comments suggesting that they focused more on non-clinical skills. However, score analysis revealed no significant difference between the overall mean scores awarded by lay and medical assessors, and the inter-assessor correlations were high.

More detailed analysis revealed even further the similarities between lay and medical scores. The difference in performance by candidates from different countries of qualification has been reported elsewhere, with candidates who qualified in Asia scoring less well than their UK trained counterparts.¹² The findings presented here show that this difference in marks was almost identical for the lay and medical assessors. When individual questions were analysed separately, there was a significant difference between the lay and medical assessors' marks on one question, and close to significant difference on another. These differences may simply be by chance, partly caused by the inflation of type I error rates caused by performing multiple t-tests. However, it is possible that the differences are genuine and due to the medical and lay assessors responding differently

to candidates' answers to these specific questions. If this is the case, then it is important to consider the magnitude of the differences. The largest (and only significant) difference between lay and medical assessors was 0.11 marks. This 0.11 mark difference only applied to one question, whereas the 1.1 mark difference between marks awarded to candidates who qualified in UK and Asia applied to all eight questions. Therefore, it is reasonable to conclude that any differences that may exist between lay and medical assessors' marks are small when compared with differences due to attributes of the candidates themselves.

There are a number of possible explanations for this high level of agreement between lay and medical assessors. All assessors attend the same training day, which includes discussion of scoring using videos of role-played candidates. Whilst panel members are encouraged to write their marks down separately, there may be within-panel discussion leading to similar views. It may be that there is high correlation between a doctor's clinical and non-clinical attributes, so that a good candidate performs well in the eyes of both lay and medical assessor. Alternatively, it may be that the relevant knowledge and experience the lay people in this selection process possess mean that they are not sufficiently removed from the field of medicine to provide a truly alternative view.

CONCLUSION

Whether the lay assessors in this study provided an alternative perspective on the panel or not, their involvement should not be considered worthless. The high correlation between lay and medical scores may reflect a shared agreement on the 'best' candidates, those with both clinical and non-clinical attributes. Ongoing research into the long-term training outcomes of candidates will shed more light on the accuracy of this shared view. UK government policy calls for greater involvement of lay people in

health service decision-making processes. The inclusion of lay people in the selection of GP registrars in the West Midlands is clearly compatible with that policy, and has proved acceptable to both the candidates and lay members involved.¹¹ Advantages include increased openness and transparency within the selection process, and a reduction in doctors' hours spent in recruitment. For these reasons, consideration should be given to lay involvement in a wider range of selection and assessment processes nationwide.

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