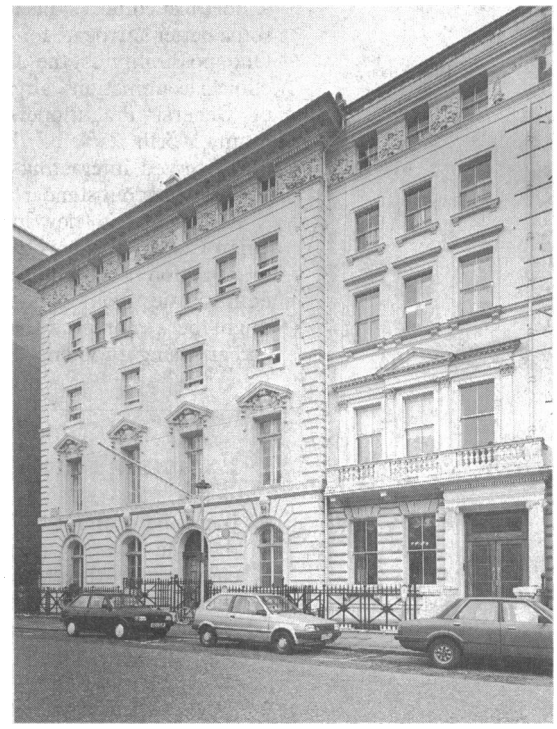
MRCGP: examining the exam

Fiona Godlee

Medical colleges have a reputation for being elitist, exclusive, and closed to scrutiny. Not so the Royal College of General Practitioners. Recently I went at the college's invitation to observe the proceedings of its membership oral exam. Having taken the membership exam of the Royal College of Physicians and watched while friends were made miserable by the cramming, grilling, and failing, I was intrigued to see how general practitioners—examiners and examinees—would behave under exam conditions.

I was due to sit in on some vivas but started the day by joining the examiners at their briefing session. A video of a previous oral exam was being shown to calibrate the examiners with each other. By a show of hands they registered their opinions of the candidate's performance. Most judged it "satisfactory" but there was a broad range from "very good" to unsatisfactory." The convener of the oral exam, Peter Tate, a GP in Oxfordshire, greeted me at the end of the meeting. "We want to be perfectly open," he said. "We don't want to hide anything from you." And no, he wasn't worried by the range of opinion we had just witnessed. He saw it as a potent reminder of the potential for subjective judgments.



Not elitist, exclusive, or closed to scrutiny: the Royal College of General Practitioners, London

Exam content and reliability

Peter Tate explained that it was to reduce the potential for subjectivity that the college first set up the exam. In its early days the college selected its members by recommendation and interview. Now GPs have to pass a multiple choice paper testing factual knowledge, a modified essay paper testing ability to define and solve problems, and a critical reading paper before being allowed to sit the vivas.

First set up in 1965, when all five candidates passed, the exam has changed remarkably little despite constant scrutiny from college examiners and outside advisers. Its design was the result of advice sought mainly from the Royal College of Physicians with input from American psychometric experts. The examiners seem pleased with the result. "It has the advantage of having been thought out from scratch," said Mike Ruscoe, an examiner I met later in the day, implying that other colleges' exams, lumbered with years of traditionalism, do not.

There have, however, been changes. Two thousand candidates now take the exam each year, and the pass rate has fallen from that first all time high to an almost constant 75%. The traditional essay paper has been scrapped—"It was poor at discriminating and difficult to mark," said Mike Ruscoe—and replaced by the critical reading paper. In this the candidates must show their grasp of basic statistics and study design. It includes a scientific article for criticism, a question about recent coverage of a clinical problem in the academic press, and a circular, such as a letter from the chief medical officer, which candidates must evaluate in terms of its impact on their practice.

"The new paper is easier to mark and has large standard deviations, which means that it's good at separating the sheep from the goats," said Mike Ruscoe. "We found that candidates were not well read, but already the critical reading paper seems to be changing behaviour. The standard of reading is going up."

Standard deviation and statistical reliability are buzz words among RCGP examiners, and they make no secret of their own ratings. The reliability of an exam reflects the statistical likelihood of the same candidates achieving the same results if they were to sit the exam again. Calculated from the standard error, the α coefficient of reliability should be around 0·8 for a test to be acceptable. The RCGP's α coefficient has been 0·81 for the past two years. The RCGP is the only medical college in Britain to make such figures publicly available.

"Reliability is terribly important," said Philip Tombleson, the examination convener and a GP in Sussex, over coffee. But he sees problems with becoming too rigidly tied to it. "In America reliability became so paramount that candidates started taking examiners to court if the figures weren't good enough. The colleges reacted by dropping all forms of clinical assessment, relying entirely on MCQs. MCQs are very reliable, good at testing factual knowledge in a repeatable way. Testing clinical ability is more of a problem."

Testing clinical skills

It is a problem with which the RCGP is still grappling, so far with only limited success. Unlike

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other medical colleges, in its exam there is no direct clinical assessment. The organisers plead mitigating circumstances. "The cornerstone of general practice is the consultation. More than anything else GPs must be good at communicating with their patients," said one examiner. "This is not easily tested in an exam. It's certainly not tested in the membership." I thought back to my membership exam. She was right. We were repeatedly reminded not to hurt the patient, especially if the examiner was looking. But I could remember nothing that might have tested my skills at breaking bad news or counselling difficult patients.

Philip Tombleson believes that the RCGP's oral exam—two half hour vivas with two pairs of examiners—does test clinical skills indirectly. But he agreed that some better surrogate for bedside manner was needed. One possibility is the OSCE (objective structured clinical examination), already used by the Irish College of General Practitioners. In this section of the exam, worth 25% of the total marks, candidates are observed interacting with volunteer role players trained to act out standardised scenarios.

The Irish exam now includes 13 OSCE "stations." Brian Coffey, former chairman of the Irish college's examination subcommittee and an RCGP examiner, is enthusiastic about the results. "A typical roleplay might be a mother whose child has scabies. It's an embarrassing problem. She's angry. The candidate must deal with her anger and give her advice." OSCEs are good at showing up bad candidates, but they are difficult to judge objectively. Data from the ICGP's last three years' experience are due to be published soon.

"The Royal College has a number of objections to OSCEs," said Brian Coffey, a large, gently spoken man who, according to his college colleagues, none the less knows how to put a candidate on the spot. "But the main one is the logistical problem. The Irish college is much smaller. Lining up enough patients or volunteers for 2000 candidates would be quite some undertaking." The OSCE is also thought by some in the college to fragment the consultation, making it unrealistic for an established GP who is used to dealing with the whole patient.

A development of the OSCE is the idea of simulated surgeries, currently being researched by another RCGP examiner, Elizabeth Bingham, who practises in Berkshire. Her enthusiasm for the idea was evident. Instead of following the candidate around, she explained, the examiner would enter and leave the room with the patient or volunteer. The candidate would remain in one place, seeing a number of patient/examiner pairs and being interrupted by simulated phone calls from health visitors and hospital laboratories. It all sounded great fun, but wouldn't it be simpler just to go and inspect GPs in their own

Examining the examiners

It may be a comfort to GPs planning to sit this exam that the scrutiny they will be under is nothing compared to the critical analysis endured by their examiners. After lunch I sat in on an examiners' debriefing session. Seven of us—four examiners, Peter Tate, Richard Wakeford (the Cambridge psychologist who advises the examination board on psychometric and statistical matters), and me—squeezed into a small attic room already crowded with television screens and video recorders. (Earlier, as part of his warm up act to put the first batch of candidates at their ease, Peter Tate had joked that without video cameras it wouldn't be the MRCGP.)

Peter and Richard led the discussion. In the video of the first viva one of the examiners had been, they thought, irritated with the candidate. Her body language had given her away. She agreed. She had felt bad at the time about not being able to hide her annoyance. But the candidate had kept skirting the issue and waffling. The discussion turned from overcoming a personal reaction to a candidate to the need to pin candidates down and come back to things they have managed to avoid answering.

These sessions—a combination of peer assessment, psychotherapy, and group bonding—are a regular feature of life for the college's 125 examiners. But to have reached this stage they must already have leapt through several hoops. Potential examiners are put forward by their local college faculty. They must have been in general practice for at least five years and must resit the written exam, achieving not less than one standard deviation below the mean. My obvious surprise at this low level of requirement seemed to amuse Richard Wakeford. "Examiners don't need to be brilliant," he said. "But they must be able to make critical judgments about other people." To test this they are asked to mark and rank order sample written papers, with the assessors on the lookout for aberrant judgments.

Would be examiners then undergo mock vivas and further direct assessment by senior examiners. They are then approved or not (about one in eight are not) and embark on an 18 month probationary period. During this time they are always paired with an experienced examiner and receive regular debriefing sessions. GPs are not ideal examiner material, according to Richard Wakeford. "Sometimes they are just too nice," he said. "They are trained to be reactive and facilitative. They have to coax information out of patients. To be an examiner you have to learn to be more adversarial."

The college's wholehearted commitment to psychometric method reflects the influence over the years of the Oxford Group, Michael Balint, and the psychologists David Pendleton and David Swanson. Richard Wakeford is the current interpreter of the sacred texts, lacing his pithy contributions to the various meetings throughout the day with statistics from validated research. The need for such reassurance is obvious. The examiners are, after all, attempting the impossible—the creation of a standardised, entirely subjective assessment of human beings who are intrinsically unstandardised by human beings who are intrinsically not objective. How, for example, should one arrive at a final mark for a candidate who has performed inconsistently in various parts of the exam? Here, after much debate, the only answer seemed to be to resort to that old fashioned, all human criterion, gut feeling. Or, as the psychometrician would have it, "a gut mediated, weighted summary."

In an individual such relentless self analysis might be thought of as verging on the obsessive. Indeed the RCGP has often been criticised for too much contemplating of its navel. I doubt, though, that such comments greatly disturb Richard Wakeford or the college's examiners. They can at least claim, with good justification, to be trying to find the best way forward. And they remain above all their own most radical critics.

surgeries? Philip Tombleson thinks not. "A real surgery may be just a lot of colds and sore throats," he said. "Simulation allows you to explore different aspects of competence."

But some examiners would still like to see the real thing. Peter Tate is looking into the possibility of candidates submitting videos showing actual consultations. Getting consent from the patients and the practicalities of making the video are not, he thinks, insurmountable obstacles.

The viva

The format of the vivas is another area of controversy. At present they contain factual questions as well as questions that test more general competence. Examiners have in front of them a grid on which the subject discussed is set against various areas of competence. These include such things as management, prevention, practice organisation, and communication. The examiner might say, for example, "Tell me about how you deal with diabetes, and I'm interested particularly in the area of practice organisation." Another subject, say hypertension, might be discussed as it related to methods of communication. In this way the examiner aims to obtain an overview of the candidate.

A recent report, however, commissioned from the Centre for Medical Education in Dundee, concluded that the viva should contain no factual questions. Factual knowledge should be entirely the preserve of the written papers, leaving the oral exam to test personal interactional skills. The Dundee report was just being absorbed when I was at the college, and there were some dissenting voices. "The danger of taking the facts out of the viva," said one examiner, as we sat in the bar at the end of the first session of vivas, "is that a social worker could get a distinction in our oral exam."

The examiners are asked to spend not longer than five minutes on each subject, allowing coverage of at least 12 subjects in total. The aim is to sample widely across a range of subjects, looking for gaps in the candidate's knowledge rather than attempting to generalise from more in depth testing on one or two areas. The college is well aware that the exam may achieve breadth at the expense of depth. But, as Peter Tate says, "skilled examiners can go very deep very quickly."

Provided the candidate is equally skilled, or schooled, all goes smoothly. I witnessed a particularly competent performance from an army GP practising near Salisbury Plain. Phrases like psychotherapeutic dialogue (rarely if ever heard in the colleges of physicians and surgeons) were rewarded by a nod of recognition from the examiners. Consultation models rolled off the well coached examinee's tongue—Roger Neighbour, Stott and Davies, Bendick's therapeutic dialogue, transactional analysis. "They are all the thing at the moment," said the candidate when we talked on the terrace afterwards. "You have to know them backwards."

Learning to pass

So after all the MRCGP exam is not so different from the MRCP or FRCS exams. In place of the stylised examination and presentation of findings, rehearsed on longsuffering friends, partners, pillows, and repeated even in sleep, here are equally stylised demonstrations of problem solving behaviour and emotional interaction. The examiner picks an annotated card from a card index and conjures the scene: a man with a knife in his bag demanding pethidine. What are your options? What are the implications of each option? Which would you choose? What are the advantages and disadvantages of that choice? The mnemonic OICAD, meaningless but memorable, reminds successive candidates: options, implications, choice, advantages, disadvantages.

As with any exam some candidates will pass because they have learnt how to pass the exam rather than because they are good doctors. The concern of the examiners must be to distinguish those who will do what they say they would do from those who are merely good at saying they would do it. At the midday meeting the examiners discussed this difference between "stated and actual behaviour." They agreed that the important thing was not simply to accept a correct answer but to make candidates justify the actions they say they would take. There was much talk of "nailing" the candidate, not letting him or her off the hook when things became uncomfortable.

Watching the vivas it was clear to me that these examiners knew how to nail a candidate if the need arose. And I felt again the sickening discomfort of my own membership viva. I remember resorting to "I'm afraid I don't know, sir," more than a few times as the examiners' questions breached the limits of my knowledge. Such candid admission of ignorance left them little choice but to change the subject.

And yet I enjoyed every bit of my membership exam—yes, even the viva. Whether due to nostalgia and the thrill of passing, or the enduring confidence boost of having those letters after your name, or the feeling—far less enduring—that you were, in some ways, as learned in medicine as you would ever be, the whole exercise seemed, and still seems, worth while. I was certainly a better doctor after the exam than before it. Friends and colleagues have less rosy memories. Some remain cynical about the whole process of professional exams, especially exams which come after long years of training, when failing would require a complete change of course.

But since the days of the barber surgeons profes-

Only half of Britain's 31 000 GPs currently belong to the college. The proportion is, however, likely to increase as about 80% of vocational trainees sit the exam each year. Because it relates exclusively and without apology to British general practice it attracts few overseas candidates, unlike the more exportable MRCP and FRCS exams.

I wondered what the long term aim of the college was; whether it planned to push for all GPs to take the exam or to leave it as it stands—a voluntary form of self assessment with no limit on the number of times a candidate can sit it. Philip Tombleson thinks it could easily be adapted to become an exit exam for vocational training, especially since the introduction of the GMC's indicative register for all specialties. At present, to have the initials GP after your medical degree requires no specialist exam.

There could, however, be resistance to the idea of compulsory membership from GPs who are not members of the college and who see it as a source of unwelcome controversy and "aggro." A less politically controversial role for the exam, of which Philip Tombleson strongly approves, is as a stimulus for continued academic progress. The college even offers members the chance to take the exam again free of charge. Apparently some have done so. He also welcomes the formal assessment, recently introduced, for fellowship of the college. In the past fellows were proposed and voted in after a number of years as a member.

sionalisation has been all about certification and exclusion. An exam should exist to improve standards, but because it must also acknowledge achievement of a required standard some people must always fail. If everyone passed where would be the point? As the registrar of the Royal College of Physicians says in his speech to new members, "The MRCP is not an easy exam. Nor, now that you have passed it, would you wish it to be."

The question, then, is not whether to examine doctors' competence, but how to. And it is a question that should be openly debated. I have been assured by physicians and surgeons who examine for the membership and fellowship exams that selection and training of examiners is rigorous and that both exams undergo intense internal audit. But secrecy fuels speculation and might even justify cynicism. The confidence with which the RCGP opens its doors to outside scrutiny sends an unmistakable challenge to other colleges to do the same.

The Royal College of Psychiatrists, 150 years on

Henry Rollin

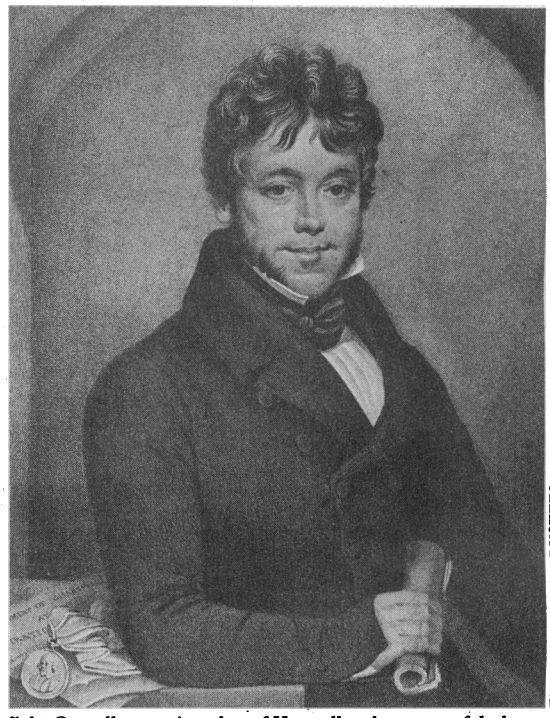
On 27 July the Royal College of Psychiatrists will celebrate its 150th birthday. With a century and a half under its belt the college can legitimately claim to be the oldest association of psychiatrists in the world.

The original association was the brainchild of Dr Samuel Hitch, resident superintendent of the Gloucestershire General Lunatic Asylum. In a circular letter dated 19 June 1841 and addressed to 83 visiting physicians and resident superintendents of 26 asylums and hospitals in England, seven in Scotland, and 11 in Ireland he suggested that such an association be formed. His opening paragraph is well worth quoting from because in essence the aims and objects of what he proposed are, with some additions and modifications, the same as those of today's college. It reads: "It having been long felt desirable that medical gentlemen connected with lunatic Asylums should be better known to each other. . . shall communicate more freely the results of their individual experience. . . should co-operate in collecting statistical information relating to insanity—and, above all, should assist each other in improving the treatment of the insane. . . ."

Of the gentlemen approached only 47 replied but, of these, 44 were in favour and three against. It was a reasonably encouraging response, sufficient for Hitch to press ahead and to organise a preliminary meeting at his hospital on 27 July 1841. There it was decided that an association on the lines suggested in Hitch's letter be established and be known as the Association of Medical Officers of Asylums and Hospitals for the Insane.

The fledgling association got off to a pretty poor start. It was described by one of its founder members, Mr John Thurnam, in 1845 as "this little society"—a sad description, but apt. The attendance at irregularly held meetings was meagre; rarely did it reach double figures. But included among those who did attend, or perhaps more exactly, were able to overcome the difficulties so that they could attend, were stalwarts who have become known as heroes of British psychiatry: John Conolly (Hanwell), Samuel Hitch (Gloucester), Samuel Gaskell (Lancaster), John Thurnam (The Retreat, York) and John Bucknill (Exeter). In 1851, however, under the great John Conolly a renaissance took place. A meeting at the Freemasons' Tavern in London drew an attendance of 26 and was followed by an even more successful meeting a year later in Oxford. Since then the sequence of meetings has been unbroken to this day.

Three important and far reaching events occurred in mid-century. Firstly, at the York meeting in 1844 it was decided to publish a journal, although the *Asylum Journal*—the forerunner of today's *British Journal of Psychiatry*—did not appear until November 1853, under the spirited editorship of Dr (later Sir) John Bucknill. The journal, once established, became for so many members marooned in their institutions the sole means of communication; indeed, the "glue" that bound the association together. Secondly, at the London meeting in 1854 a permanent parliamentary committee was formed, the first positive step designed to influence legislation affecting the control of asylums and the welfare of the patients committed to them. The third event was the institution of the presidency of the college. In 1854 Dr A J Sutherland of St Luke's Hospital, London, was the first to be elected, to be followed by a continuous line of presidents all, without exception, acknowledged leaders of British psychiatry.



THE WELLCOME TRUSTEES

John Connolly, superintendent of Hanwell asylum—one of the heroes of British psychiatry

With the building of new county asylums under the provisions of the two acts of parliament of 1845 (8 and 9 Victoria, C100 and C126) the membership of the association rose to 250 in 1864 and to 523 in 1894. It was decided in 1883—as an index of an increased interest in the affairs of the association and possibly as an attempt at decentralisation—that, in addition to annual meetings, quarterly meetings be held in Scotland and Ireland. These were the forerunners of divisional meetings (the college now has 10 divisions), which have continued to be an important feature of the organisation of the college.

In 1865, allegedly at the suggestion of Henry

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