The MRCP(UK) exam: an examiner's view

There are in the world few surviving postgraduate medical examinations with a serious practical clinical component covering general medicine and its main specialties. The MRCP(UK) and the Colombo MD are the only ones I know of and have examined in. I am not sure why the others have vanished; perhaps it is because they are hard to standardise and infuriating to organise.

Certainly the latter point will be agreed by any past host examiner or organising registrar or, especially, departmental secretary [1]. It takes a month out of everyone's life. It involves dealing with patients, managers, nurses, colleagues, taxi drivers, catering staff and porters, to give an incomplete list. I will not say which is the most difficult group, but it is not the patients. Odd things go wrong. We arrived one morning at the start of Final MB to find that management had removed all beds and other furniture from the ward that management had specially reopened and re-equipped for the examination. Ophthalmoscopes talk to each other: if one goes on the blink, so do all the others.

On balance, Final MB in traditional style (examined in everything all at once) is more hectic and emotional than the MRCP examination. There are more candidates, they move round faster to more places, and there is a larger sense of potential doom. This may be transferred to the MRCP when no one can enter a recognised training post without it.

We know what the candidates get from the examination. Do the organisers or examiners benefit? The answer is mostly yes. For the registrar the experience is worth any number of day release courses in management. For the examiners it is a welcome and regular postgraduate revision course, since we learn from the patients, our coexaminers and, as usual, the registrar. Some conditions are never seen in real life, only in MRCP short cases (eg pseudo-clubbing). Besides, I always enjoy watching neurologists examining the chest, just as, I expect, they barely conceal their amusement as I elicit the Babinski response which I feel will be appropriate to the diagnosis that I had already made (or was told by the registrar). The departmental secretary presses on regardless. There is no benefit for her, I fear.

Is the clinical examination appropriate? It should, I suppose, be aimed at outpatient practice, since a clinical test of this type on acutely ill patients is ethically and practically impossible. Thus, in the long case, seeing a patient without notes or X-rays closely approximates real life in an outpatient clinic provided with a heavily managed medical records service. For total realism, notes and X-rays should be given to the candidate just after the viva, ie too late to be any use. I am told that the allowed time of 45 minutes was originally determined to coincide with that of a standard consultation in Harley Street. This is clearly far too long for the modern practitioner who has a list of five new and 12 follow-up cases to see within three hours, failing which there will be meaningful looks from clinic staff who have to get to the shops before closing time on the way home, and a reminder from management about the Patient's Charter. Twenty minutes for the long case would be more like it. In addition there should be a telephone which rings at least twice during that time, once with a wrong number and once with some other message, say from the pharmacy wondering if the candidate is serious about the dose of frusomycin just prescribed for Mrs Smith and, since they do not stock frusomycin, only erythromide, asking if that is all right. A pseudo-SHO (perhaps a resting actor) could be employed to pop in now and again with a chest X-ray showing something rather rum in the bottom left-hand corner, requesting the candidate's opinion about it, and asking if a bronchoscopy should be done tomorrow. The possibilities for added realism are endless.

All this need not be taken entirely seriously. In a practical clinical examination, what is required from the candidate is evidence of a practised technique. On stepping into the passenger seat of a car, one knows in a short time whether one is happy with the driver's skill. The same is true of a clinical examination at any level. Misinterpretation of physical signs will not automatically fail the candidate. It is not always possible to tell where a systolic murmur comes from. A palpable kidney is sometimes shown by ultrasound to be a spleen, and vice versa. What is important is that physical signs should be correctly and systematically explored. Some physical signs are almost totally useless (palpation of the trachea in the suprasternal notch is a good example) but still required. Why? Because in one sense the MRCP is a game. It is, of course, much more than a game, but playing it as a game scores results. Technique counts. Back to the playing fields.

Reference

1 Friedman EP, Gray J. Organising the MRCP exam—a guide for registrars. *J R Coll Physicians Lond* 1994;**28**:264–9.

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