The nMRCGP Handbook
2nd edition

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By

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About the author

Dr Bob Mortimer qualified from the Welsh National School of Medicine, Cardiff, in 1983. He passed the MRCGP in 1992, and became a Fellow of the Royal College of General Practitioners in 2005. He has been a GP trainer since 1995. In 1994 he set up the Swansea MRCGP Course and became an examiner in 1996, obtaining the Diploma in Medical Education (Cardiff) in 1998. Dr Mortimer was Associate Director for the Welsh Deanery until 2005.

Dr Mortimer is a full time GP and is an assessor for the Clinical Skills Assessment (CSA), and in addition to being a trainer for assessors he is also one of the senior marshals involved in the actual running of the CSA. He also runs the Swansea MRCGP Course.

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I would like to thank the Panel of Examiners for the MRCGP Examination, who have been the most inspiring group of people I have ever had the privilege to work with.

Foreword to the second edition

I am retired now and I still dream of failing finals. I also dream of the little man knocking at my door and saying: '*Found you out, you are a fake aren't you*'. That is the trouble with exams, they are both memorable and important. I still remember my viva for the MRCGP in 1974 because it was searching, relevant and it found me out — not quite enough to fail, but enough to tell me that my learning was nowhere near done.

The MRCGP exam became part of my own life, and after 25 years as an examiner I retired as Convenor just as the old exam metamorphosed into the new. The nMRCGP exam, unlike the old MRCGP, is a licensing exam. This means that it is not an optional extra but an essential requirement to be a primary care doctor. It marks the end of your initial training.

General practice remains one of the hardest of all medical disciplines to do well: it requires a complex synthesis of knowledge, curiosity, tenacity and humanity. Over the last 60 years general practitioners have often been derided by more specialised colleagues as academically slightly below par; in some cases this was true, but for most patients it is the skill of the generalist that is needed by the specialist as much as the other way round. These arguments have become less heated and less relevant, but such attitudes are still around in hospitals and medical schools.

This book is about the academic underpinning of the discipline you have chosen. You owe it to your patients and to yourself to practise general medicine to the best of your knowledge and ability. This of course means not just passing the nMRCGP, but also learning how to learn and keep learning. This book will enable you to catch a glimpse of the thinking of the generations of general practitioners who have contributed to the development of the examination.

Bob Mortimer has produced a straightforward, easy-to-read book that gives you all the information to help you surmount this hurdle in your life without too much difficulty. The exam is modern, very wide ranging, searching and stimulating — yes, stimulating! This wonderful little book tells you all you need to know about the examination, its ethos and its methods. It is written by a good friend who is an examiner of many years standing and a working GP. I am able to hear Bob's voice as I read the text. You will find it full of good advice, spot-on up-to-date information, technical tips, and inside knowledge, but to me the best of all is the humanity, wisdom and experience of the author that illuminates the whole. This is not just a book about how to pass an exam, but is a manual to help you learn for a whole career.

Dr Peter Tate MBE FRCGP
Retired Convenor MRCGP Examination

Foreword to the first edition

I never enjoyed taking exams. Who does? But several decades ago, when I was coming to the end of my vocational training as a fledgling GP, I took the Membership of the Royal College of General Practitioners (MRCGP) Examination. I have never been a good judge of how I was doing during exams, and my pessimism was often justified. On this occasion I thought I was floundering. None of the questions had seemed straightforward, and my doubts and insecurity were increasing by the minute. And so, when the examiner asked me how I would deal with a patient who had been bitten by a dog shortly before boarding a plane in India the previous day, I just shrugged. '*I'm sorry*', I said despairingly, '*I just don't know anything at all about rabies. I'd look it u*p'.

But instead of groaning, both examiners grinned. One said: '*I've been asking this question for five days. You're the first one to give me the right answer*'.

And he was not joking. For a UK family doctor to treat possible rabies from memory would indeed be unsafe and unwise. Ultimately my result was better than I had ever dreamt of, and I decided this was a 'real-world' organisation that I could do business with. All too many examinations in the past seemed to have been built on theory alone. The Royal College of General Practitioners (RCGP) seemed to me to focus on the uncertain and unpredictable world that real GPs face with real patients, and over many years working with the RCGP, including 15 years as an examiner, my view has not changed.

That was then. This is now. The arrival of the Postgraduate Medical Education Training Board has led to the introduction of new curricula across every medical specialty, providing common standards, clarity and transparency to training, as well as promoting the continuous development of doctors' skills in order to meet patient need. General Practice, at long last, has now been recognised as a medical specialty equivalent to every other, and new assessment methodologies have been developed to match.

But change is always rather confusing, and it certainly feels threatening for learners as well as their trainers. At this time of great change in the MRCGP Examination, this book offers real insight and real support. Quite rightly, it stresses that the best way of passing the exam is by becoming a good GP. Exam technique, and understanding how exams work is important, but nothing counts for as much as being a caring, learning, and listening GP.

The nMRCGP is now a licensing exam. Every new GP in the UK will have to pass it. This is exactly how it should be — after all, being a GP is one of the

most complex and skilled jobs in medicine, and it has always seemed insulting that lower mandatory standards were acceptable in our specialty. But now they are not. You have to pass, and the nation's patients deserve nothing less.

Reading this beautifully written, informative and supportive book will demystify many of the changes in the nMRCGP exam, and allows the reader to focus on what really matters — the patients and the care we can offer. High quality General Practice is of vital importance to patients everywhere. After all, good GPs really do make a difference.

Professor David Haslam CBE, FRCP, FFPH, PRCGP
President of the Royal College of General Practitioners

CHAPTER 1

Why do we need exams?

The aim of this book is to help you prepare for and pass the new membership exam for the Royal College of General Practitioners — the *n*MRCGP. This introduction will explain why the exam is there and how it came about. It might not seem terribly relevant to you right now, but the key to passing any examination is to get to know as much about it as you can.

This book will describe the elements of the exam in some detail, with information on what each part is designed to assess and the methods used to assess you. There will be lots of practical advice on how you should prepare for the exam and how to ensure your best performance on the day.

There are no easy shortcuts to passing the *n*MRCGP, it is a highly rigorous assessment of your knowledge, clinical and communication skills and your ability to solve problems in general practice. Making sure you understand the exam will however mean that you can make efficient use of your time preparing for it. Much of your learning for the exam can be within your day-to-day experiences in your work, and this book will, wherever possible, advise you on how to maximise the benefit you gain from these experiences and minimise the amount of the more traditional, and often less interesting, methods of preparing for an exam such as reading textbooks and journals. You will of course need to do some reading for the exam, but this book will help you to target the right material and use it efficiently.

Reasons for exams generally

By the time you get to sit the *n*MRCGP you will be quite an exam expert. You will have taken GCSEs at age 16 (or their equivalent where you were educated), A-levels or equivalent at age 18, followed by the various hurdles set in your way throughout medical school. Generally speaking the degree of difficulty rises as you progress through your career. There are several reasons for exams existing:

- To ensure suitability or ability to pursue a particular course of study — for example the assessment used for entry into training for general practice
- To check that you have learned what you were supposed to in your coursework

- To discriminate between applicants for a job or a place in a school or college
- To ensure you have the knowledge and skills required to do a particular job
- As a mark of status, or to demonstrate a level of excellence.

When you sit an exam it is important to have a clear idea of why you are taking it and what it is there to test. The previous MRCGP examination was mainly aimed at the last of the above bullet points — a pass demonstrated that you had achieved a level of excellence. It was also to some extent used to discriminate, for example practices appointing a new partner or salaried doctor would usually prefer someone who had passed the MRCGP exam and it was generally required if you wanted to become a GP trainer.

The new assessment however is a *licensing* examination and its main purpose is to ensure that you are fit to practice as an independent, unsupervised GP in the UK.

Over the last few decades general practice in the UK has undergone dramatic change. It is just as demanding a career as any other in medicine and is no longer, if indeed it ever was, a 'soft option' compared to the medical and surgical specialties. A GP requires a working knowledge of all areas of medicine, surgery, paediatrics, gynaecology, etc. and needs advanced communication and clinical skills to apply this knowledge. GPs must be able to work in complex multi-disciplinary teams, often in a lead role, and have significant responsibilities in managing access to secondary care. Once you are qualified as a GP you have to do all this independently and without supervision, although most of us are fortunate enough to work in supportive practice environments.

Another issue is the effect a rigorous entrance examination has on the perception of a profession by others — setting a meaningful minimum standard for general practice can only enhance its standing both with the general public and with our peers in other specialties. This then has a knock-on effect on morale within the profession leading to enhanced self-esteem among GPs along with improved recruitment.

Exams can test various things:

- Recall of facts you are supposed to have learned
- Ability to reason and solve problems
- Practical skills
- Checking some of your values and attitudes.

There are many different types of exams, and each type of exam will be more or less effective at assessing each of these attributes. The modules of the *n*MRCGP are designed to ensure that they rigorously assess all of the above and we will explore which module assesses which attributes throughout this book.

The history of the MRCGP examination

The MRCGP has always been the examination to gain *membership* of the Royal College of General Practitioners (RCGP). Until 1968 a GP could join the College by simply paying a fee. Then along came the Membership exam and this became the only route to College membership. You did not *need* to become a member of the RCGP, and historically only just over half of trainee GPs took the exam and became members.

Those who did take the exam did so for various reasons — some because they felt it was important to be a member of the College, but these were probably in the minority. Some took the exam as a personal challenge and as an affirmation that they had attained a certain level of achievement following their vocational training. Some did it out of peer pressure or because their course organiser or trainer expected them to do it. Probably the largest group was those who did it because they thought it might improve their chances in job applications.

Initially the MRCGP comprised a multiple choice question paper (MCQ), a modified essay question paper (MEQ), a practice topic question paper (PTQ) and two oral examinations. Over the years these were gradually refined, often as a result of analysis and advice from the College's psychometric advisers. For example, over time the MCQ stopped using negative marking as this discriminated against more timid candidates who were afraid to guess, and the true/false question format developed into extended matching questions and other question formats as this increased its ability to accurately discriminate between strong and weak candidates. Many of the lessons learned from this development have been incorporated into the new assessment and the College continues to work with psychometric experts to ensure its robustness.

About the *n*MRCGP examination

Until 2007, GP registrars in the UK had to satisfy the requirements of the Joint Committee on Postgraduate Training for General Practice (JCPTGP) by passing Summative Assessment. Some of the elements of Summative Assessment could be exempted by passing the appropriate modules of the MRCGP examination. At this time the Government replaced the JCPTGP with a new body called the Postgraduate Medical Education and Training Board (PMETB, generally pronounced *pee-met-bee*). While the JCPTGP oversaw only training for general practice, the PMETB has responsibility for all the medical specialties. The JCPTGP was called the Joint Committee as it was made up of representatives from both the Royal College of GPs and the General Practitioners Committee of the British Medical Association (BMA) (i.e. from the profession's academic body as well as from its 'trade union'). The vast majority of its members were GPs.

The PMETB is entirely different, with its members appointed by government and with 17 medical members (four of whom have a background in general practice) and eight lay members. It was decided that there was to be a new licensing examination for each medical specialty, and that this would be approved and overseen by the PMETB (Department of Health [DH], 2001).

The RCGP followed these political developments closely and from an early stage started planning the new assessment. It was clear that any new assessment would need to be specifically designed to assess GP registrars at the end of training, and that simply presenting the existing exam would not be acceptable. The College has developed its curriculum for general practice and this formed the basis for the new assessment which was designed to ensure that it tested all areas within the curriculum. For each area of the curriculum it was considered what form of test would be most fit for purpose. The RCGP curriculum will be covered in the next chapter.

The key challenges to the new examination were developing an assessment that was rigorous and robust enough to stand up to legal challenge; that had more emphasis than previous assessments on doctors' practical skills in consulting with and examining patients, and that assessed their progress through their training in a more structured and rigorous way. It also had to be able to assess the 3,000 or so doctors completing GP training each year.

There was a lot of discussion about the actual standard that was to be set — the MRCGP had previously had an overall pass rate of just over 70% while only a handful of doctors failed Summative Assessment each year. On the one hand it was felt that a pass rate of 98–99% was inappropriately high and would be allowing through doctors who almost certainly had not achieved a high enough level of competence, and it was also accepted that the implications of preventing almost 30% of registrars from entering general practice immediately after training were significant. Therefore it was important from the outset that the new assessment must be *criterion referenced*, meaning that it made an objective assessment of a doctor without comparison to everyone else taking the assessment. This makes standard setting even more important since it means that theoretically the assessment could fail everyone who took it if the standard were set too high, or conversely pass everyone if it were too low.

The development of the new assessment has been led by various working groups comprised of members from both the College and the Deaneries across the UK, as well as having extensive input from lay representatives. The final product has three components:

- An applied knowledge test (AKT), which is a multiple choice type test
- The clinical skills assessment (CSA), which is a series of consultations with simulated patients.
- The workplace based assessment (WPBA), which is a structured assessment of the registrar's work in their training practice.

The responsibility for the AKT and the CSA is largely held by the RCGP, with the Deaneries largely responsible for the WPBA, The *e*Portfolio is run by the College.

A registrar will not 'qualify' as a GP until they have satisfactorily completed all three components (AKT, CSA, and WPBA). The workplace based assessment is continuous throughout the three years of training (see Chapter 4). The applied knowledge test can be taken at any time during training but will usually take place during the last year of training, and the clinical skills assessment will need to be taken during the last year in general practice training.

The applied knowledge test

From the outset the applied knowledge test has been closely based on the 'old' MRCGP multiple choice question paper and the new test was developed by the same group of examiners. There is little dispute that the multiple choice question format is best suited to reliably test factual knowledge, and there were ample statistics to demonstrate that the MRCGP multiple choice questionnaire paper could do this reliably. Reliability in this context means that a candidate's mark could be regarded as a true reflection of his or her ability, without being adversely influenced by the different question formats or by the wording within individual questions. It also means that each separate sitting of the exam can be demonstrated to be of comparable difficulty so that candidates of similar ability at different sittings of the exam could be expected to achieve similar scores.

The clinical skills assessment

The clinical skills assessment was devised to assess the practical skills that GPs need, such as clinical examinations and communication.

Some envisaged this component as a form of objective structured clinical examinations (OSCE) in which candidates would visit stations at which they would be expected to demonstrate a specific skill, as commonly used in undergraduate medical exams. This, however, was felt to be too simplistic — it was felt that it was important to test integrative skills, meaning the ability to combine communication skills with clinical skills to gather information and then to use medical knowledge and decision making skills to formulate a management plan. From an early stage it was considered that the best way to do this was using simulated patients. The MRCGP already had a simulated surgery module based on a series of consultations with simulated patients, but this was not felt to be a suitable model for the clinical skills assessment and a working group set about planning the new assessment from scratch.

What they have finally come up with does look remarkably similar to the

previous simulated surgery — which is not exactly surprising given that both assessments were designed for the same purpose.

The workplace based assessment

While examinations are a good way of testing knowledge and practical skills, some of the practical skills required are difficult to test in a formal examination setting and are more appropriately assessed in the workplace. It is also difficult to assess attitudinal aspects and professional values in an exam. To get a more holistic assessment of a registrar's competence it was felt that some form of in-training assessment was necessary. This has been present previously with the record of in-training assessment (RITA) during hospital training and the trainer's report in general practice. Although the trainer's report was quite comprehensive and well structured, the workplace based assessment is more rigorous with elements of external assessment and incorporates an objective assessment of consulting skills based on the criteria for the video module of the previous exam.

For the workplace based assessment the GP trainer collects evidence relating to the registrar's performance throughout their training. Much of this will be recorded by the trainer, directly observing and recording the registrar's performance and progress, but there are several specific tools used to record and evaluate this:

- Case-based discussion (CBD), which is a semi-structured interview based on cases
- The consultation observation tool (COT), which is an objective assessment of consulting skills using a video of consultations
- Multi-source feedback (MSF) via questionnaires from colleagues
- Patient satisfaction questionnaires (PSQ)

Progress throughout the workplace based assesment is recorded in the *e*Portfolio, which is an electronic learning log used both as an educational tool and to record successful completion of the main elements (See chapter 4 for more information on the *e*Portfolio).

What happens if I fail?

First of all it is important to say that there is no reason you should fail! To get into training for general practice in the first place you have gone through a fairly rigorous assessment which in fact looks at much the same competencies as *n*MRCGP. The standard of training in general practice is also very high so

provided you make the most of your training and prepare yourself well for the assessment you should not have too much difficulty.

The problem facing trainees is that if they have not successfully completed all the modules by the time they finish their training and they have nowhere to go. They cannot enter General Practice as they are not qualified and it is no longer easy to return to hospital for the odd six month job as a stop-gap while they retake modules they have failed. Any trainee who has not passed all the modules will be considered by a Deanery Annual Review of Competency Progression Panel. As long as the Panel considers that the trainee has a good chance of passing with further training it will generally allow an extended period of training, subject to funding being available. To date Deaneries have been able to provide this for the vast majority of trainees.

Most trainees are likely to attempt the applied knowledge test relatively early in speciality trainee level (ST3) or even in speciality trainee level 2 (ST2) so that there are opportunities to attempt it again. There are some arguments against sitting it during speciality training 2, and these will be discussed in Chapter 3.

The clinical skills assessment is more problematic as there are less opportunities to sit this, and sitting it early may significantly increase the risk of failing. Again the reasons for this will be discussed in the relevant chapter.

The workplace based assessment is probably seen as the module least likely to be failed, although it will undoubtedly cause some trainees difficulty. The nature of the workplace based assessment however should mean that difficulties can be identified early and addressed with the trainer.

Ultimately however any additional training period is likely to be limited to six months in general — the old days when doctors could carry on in limbo doing hospital jobs until they passed their exams are gone. If you have not passed all the modules by the end of extended training it is unlikely you will be able to continue on to a career in general practice. Therefore, prepare yourself well and do not waste opportunities.

DH (2001) *Postgraduate Medical Education and Training*. Department of Health, London