Letters

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MRCGP Recorded Consultation Assessment — the hidden fourth construct

Chris Williams rightly identifies case selection as a fourth factor in the assessment of Recorded Consultation Assessment (RCA) candidates,[1] in addition to data gathering, clinical management, and interpersonal skills. He questions whether the ability to submit suitable cases is *'really a prerequisite for safe, independent general practice'*, and implies that this requirement is underhand and unfair. It is neither.

The exam regulations make it clear that the onus is on candidates to submit evidence that they are competent to manage the whole range of problems they may face in unsupervised practice. As a patient, I would have no confidence in a process that could certify a doctor's competence on the basis that they could satisfactorily manage a straightforward case of otitis media. It may well be that some candidates are disadvantaged by their background or by the demographics of their training practices. But which is more important — to overlook doctors' weaknesses or to keep patients safe? I don't want to be treated by someone who thinks otitis media is a difficult challenge.

Dr Williams asks, *'can* [the] *"level of challenge" of a GP consultation even be judged reliably?'* Certainly it can. The assessment of any complex skill where competence cannot be reduced to a checklist of objective 'yes–no' items, such as general practice, ultimately relies on carefully selected, well-trained, and rigorously monitored judges exercising their judgement. MRCGP examiners meet these criteria in spades. If they conclude that, on the evidence submitted, a would-be GP has not convinced them that they are ready to practise unsupervised in most circumstances, I and the British public can believe them; and we are the safer for it.

Dr Williams suggests some future hybrid of the RCA and Clinical Skills Assessment (CSA), and I am sure the College, with an eye both to fairness and practicalities, will be considering this and other options. But the examiners should be congratulated on the speed and efficiency with which they have devised and implemented an assessment methodology that maintains pre-COVID standards of competence with minimal disruption to the careers of the unfortunate trainees caught in the crisis.

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Prostate-specific antigen testing and opportunistic prostate cancer screening — CAP intervention

Clift *et al*[1] aimed to estimate prostate-specific antigen (PSA) contamination in the control arm of the CAP prostate cancer screening trial, concluding that there is *'limited plausibility of deriving clear conclusions from trials of PSA screening'*. However, their conclusion failed to acknowledge that the CAP intervention significantly increased prostate cancer detection: during the first 18 months following recruitment (the screening phase) there was a 5-fold increase in rate of prostate cancer detection — 10.42 per 1000 person-years in the intervention group versus 2.18 per 1000 person-years in the control group ($P<0.001$).[2] Such a difference would be expected to lead to mortality benefits over long-term follow-up, but there was little evidence of any subsequent mortality reduction from earlier detection. Relying on how urinary symptoms are coded may overestimate opportunistic PSA screening.

In our analysis of 558 UK general practices,[3] 28% of men received a PSA test, but a raised PSA (≥3 ng/ml) was rarely followed with a prostate biopsy (6% of tests) or prostate cancer diagnosis (15%), as would be clinically expected for screening. In our trial, the corresponding figures were 85% undergoing biopsies and 34% diagnosed with prostate cancer. The CAP trial excluded London, the South East, and West Midlands. In the Clift *et al* paper, 21% of men were from London and PSA screening was 34% higher in London than the East Midlands; 46% higher in the South East; and 20% higher in the West Midlands. The CAP trial was overseen by independent, international Trial Steering and Data Monitoring Committees to ensure robust inference.

We believe the CAP trial conclusions remain important: single PSA screening detected significantly more prostate cancers compared with *ad hoc* testing but had no significant effect on prostate cancer mortality after 10-years' follow-up.

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