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Refining the MRCGP

EVER since the first five candidates took the MRCGP examination in 1965, it has undergone a life of perpetual change.[1] Some of the developments introduced over the past few years include the introduction of the Critical Reading Paper (CRQ), the restructuring of the Modified Essay Question (MEQ), the refinement of the oral examinations, with greater emphasis on examiner training,[2] and the introduction of the consulting skills assessment.[3] This constant refinement of examination techniques and examiner training has inevitably resulted in the MRCGP becoming a source of advice to other medical colleges across many specialties, both in the United Kingdom (UK) and internationally.

More recently, the Examination Board has permitted candidates to take the Multiple Choice Question (MCQ) paper early, or to retake it without retaking the rest of the examination. Superficially, this was a simple change, primarily introduced to benefit candidates and associated with the introduction of mandatory summative assessment in the UK. Summative assessment was introduced as a professionally led assessment of all new entrants to general practice.[4,5] Using a number of assessment techniques, it is designed to ensure that general practitioner (GP) registrars have reached a minimum standard before being permitted to practise unsupervised. The MRCGP is set at an optimum rather than a minimum standard, and passing the MRCGP MCQ gave candidates exemption from the MCQ used in summative assessment. However, this simple change had a profound effect on the rest of the examination. We were no longer examining a single cohort of candidates at a time. The uncoupling of the MCQ from the other written papers meant that these required extra testing time to preserve their reliability as stand-alone papers. The statistical methods by which marks had been calculated required major changes. In addition, many candidates felt that the whole examination structure had become unnecessarily complex.

It became apparent to both the Examination Board and the Panel of Examiners that a radical solution was required. The intention was to simplify the structure, making it more logical, dealing with some of the organizational inconsistencies that had crept in, and making it genuinely easier to take but no easier to pass. It became clear that the solution, and the next natural development for the examination, was a modular structure.

As candidates will have been aware, over the past few examinations there has been a gradual blurring of some of the previous differences between some of the written papers. For instance, the CRQ has used MCQ techniques, and the MEQ has used extended matching questions. This blurring has made it even more essential that the examination is blueprinted — a technique of increasing importance in medical assessment worldwide.[6] Applied within the MRCGP initially by the former convenor of the panel, Professor Lesley Southgate, and more recently by her successor, Dr Roger Neighbour, blueprinting defines the examination's content and ensures that the appropriate test methods are used for each area.

So, while appearing revolutionary, the revised modular structure is actually a logical product of the MRCGP's evolution. From May 1998, the examination will consist of four separate stand-alone modules:

Paper 1. A three-hour written paper, derived from the pre-1998 Modified Essay Question and elements of the pre-1998 Critical Reading Question.
Paper 2. A three-hour machine-marked paper, including the pre-1998 Multiple Choice Question and elements of the Critical Reading Question.

Consulting Skills Assessment. Either an assessment of 15 videotaped consultations or (in exceptional circumstances) a 'simulated surgery'.
Orals. Two 20-minute oral examinations.

In addition to these, the requirements for cardiopulmonary resuscitation and child health surveillance remain unchanged.

For the first time, all MRCGP candidates will be examined in the orals. In the past, those with the lowest 15% of marks in the written papers were excluded. Candidates will be able to take the papers in any order and as often as they like, but all must be passed within three years of the original starting date. While there is no doubt that many candidates will continue to take all the modules in their final year of training, some may choose to spread this out. In addition, some established GPs have viewed the current examination as being too intensive and too threatening a hurdle. These doctors may feel that tackling one module every six months is an excellent form of postgraduate education and is nowhere near as daunting as taking the whole examination at once. Moreover, the arrival of compulsory summative assessment, which at present results in most GP registrars taking two separate assessments in their training year (something that can never have been intended and that in due course, it is hoped, will prove unnecessary), has made many registrars and trainers feel that their training has been disrupted by assessment. Modularization may take some of this pressure off.

The changes even extend to the marking of the examination. In each module, the top 25–30% of candidates will be awarded a pass with merit in that module. Candidates who get a merit in two modules (and pass the other two) will be awarded a pass with merit. If they gain a merit in three or four modules, they will be awarded MRCGP with distinction. This change is designed to encourage candidates to excel. Assessment should not simply be a means of assessing minimum competence. The MRCGP is far more than that. Indeed, it is becoming clear that patients and other health service professionals are expecting that GPs should have reached a high, rather than a minimal, standard of competence. There can be no logic in accepting lower standards in the medical specialty that is least supervised, hardest to do well, and easiest to do badly.

Modularization also offers the potential for other benefits. It is possible that international modules may become available in the future. There could be an overlap between the modules used in the MRCGP examination and in 'membership by assessment of performance'. Indeed, it is possible that a modular structure will develop for post-MRCGP learning. For too long, passing the MRCGP has been seen as an end in itself. In the future, passing the MRCGP should instead be the start, not the end, of real membership of a real college.

Throughout the development of the changes, the Examination Board has been keen to stress that no change is expected in what candidates should study. The MRCGP is designed to assess high-quality practice. Those who devote their training to becoming high-quality GPs will have used their time far better than those who cram or try simply to learn how to answer examination questions. The Royal College of General Practitioners (RCGP) is also keen to discuss the blueprinting of the examination with those involved in medical education. The blueprint should be of value to both teachers and learners, as well as examiners.

Throughout all these changes, the Examination Board has been keen to preserve the reputation of the MRCGP examination for competence, integrity, and excellence. As Denis Pereira Gray, then Chairman of Council, wrote in 1990: 'The MRCGP examination is a living, dynamic institution, ready to review itself, ready to respond to the policies of the RCGP as a whole, and ready to incorporate new ideas and new techniques in the light of evolving practice.'[8] It is indeed appropriate that, in line with our place as an integral cornerstone of the College, these changes have combined the *scientia* of sound academic credentials with the *caritas* of candidate-friendliness. Modularization should give the RCGP an even more exciting future.

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