Out of Hours

Hearing crackles:

why all GPs should pass PACES

CSA AND THE PACES EXAM

As a GP registrar, the MRCGP Clinical Skills Assessment (CSA) exam is currently at the forefront of my mind. Vocational Training Scheme teaching focuses on how to pass, evenings are spent revising, and my bank account, now £1700 lighter, still makes me shudder. And yet, perhaps naively, it was still a shock to me to find out that at no point in the CSA exam am I expected to accurately detect real clinical signs. Of course, the CSA assesses many other important skills, including problem-solving skills, person-centred care, and attitudinal aspects.[1] My argument is certainly not with the inclusion of these. However, given that *'The validity of the CSA resides in its realistic simulation of real-life consultations'*,[2] it seems strange that it includes no real patients, and consequently no real physical signs, both somewhat important components, I would argue, of many real-life consultations.

By contrast, the clinical component of Membership of the Royal College of Physicians (MRCP), the PACES exam (Practical Assessment of Clinical Examination Skills),[3] involves real patients with a given condition. Candidates undertake a respiratory, abdominal, cardiovascular, and neurological exam, as well as a history station, communication and ethics station, and two brief clinical consultations. In these, candidates are given 8 minutes with a patient to take a focused history, carry out a relevant examination, respond to the patient's concerns, and explain a management plan.

This PACES exam is robust, and considered a rite of passage for medical trainees, who often require multiple attempts to pass. To a GP trainee it often seems unattainably tough. When colleagues pass, we congratulate them, but we also breathe a sigh of relief that we don't have to go through the same arduous process, and, in doing so, we perhaps elevate our colleagues above ourselves.

I would argue that this is wrong on many levels. This veneration of MRCP gives the impression that our exit exams are 'easier', or that we couldn't pass a more robust exam should we need to. As a GP trainee who decided to undertake my MRCP exam, I would argue this is far from the truth.

BUT WHY ARE YOU BOTHERING TO DO THE EXAM?!

When I first started revising for the exam, I was met with a mix of attitudes. Confusion from many other trainees (why on earth would I put myself through such an arduous process when I didn't have to); despair from my husband (yet another set of costly exams and weekends revising); and downright derision from my programme directors, who actively discouraged me from taking the exam as it would be a *'distraction'* from *'becoming a good GP'*. But having been through the process, I can argue sincerely that I have little doubt I am a much better GP as a result.

"This veneration of MRCP gives the impression that our exit exams are 'easier', or that we couldn't pass a more robust exam should we need to."

WHAT THE EXAM ENTAILED

Revision involved seeing and examining vast numbers of patients, and I now have much greater confidence in my ability to detect signs and synthesise clinical findings appropriately, quickly, and under pressure. The two brief clinical encounters are pretty much as close to a real-life GP consultation as you can get, and preparing for these was directly relevant to my day-to-day work in general practice. The sophisticated communication skills training I have received as a GP trainee was invaluable for the history and communication stations. The feedback I regularly receive from my GP trainers was far more meaningful and insightful than that given at expensive revision courses run by an eminent hospital consultant, and this regular feedback is something I truly value as a result.

Attending revision courses and practising with colleagues really made me appreciate the art of consulting that we, as GPs, spend much time and effort honing, particularly as I watched others tying themselves up in knots over ethical dilemmas and breaking bad news scenarios that would be bread and butter to a GP trainee.

IT'S DANGEROUS TO PLACE SECONDARY MEDICAL COLLEAGUES ON A PEDESTAL

But more than just the relevance of the exam and the associated learning, gaining my MRCP has taught me so much more. It was a hard, but an eminently passable, exam.

Although it is tempting to put medical colleagues who have passed on a pedestal, this is dangerous, and risks exacerbating the disconnect between primary and secondary care. As GPs we are more than capable of passing this exam. I spend my days seeing undifferentiated patients, who present with a symptom (or seven!) rather than a diagnosis. Hence, 'examine this patient with shortness of breath' didn't frighten me. I rarely have the results of bloods, imaging, or other diagnostic tests on hand to confirm a diagnosis. Therefore, detecting and interpreting a patient's heart murmur without the luxury of an echo wasn't anything new. Seeing a wide variety of patients in quick succession under considerable time pressure is 'just another day in the office' to me. As GPs we have important skills we should recognise and be proud of.

LACK OF UNDERSTANDING

Furthermore, the revision process made

"... when he found out I was a GP trainee, he exclaimed: 'What a waste! Why does a GP need to know anything about pulmonary fibrosis? You just hear the crackles and refer.'"

"Most underestimated just how passionately we believe in the crucial role that GPs play, the enormous difference we can make to patient care, and the excellence we can strive to achieve as true generalists."

me realise that some of our medical colleagues have an almost laughable lack of understanding of what we do, and what we face, day in, day out, in primary care.

While revising with a hospital colleague, I completed a particularly gruelling viva on pulmonary fibrosis. He was impressed with my answers (helped by a recent respiratory job), but, when he found out I was a GP trainee, he exclaimed:

'What a waste! Why does a GP need to know anything about pulmonary fibrosis? You just hear the crackles and refer.'

My jaw dropped with disbelief, and, had it not been so sincere, it might have been funny. He didn't understand that GPs play a fundamental role managing patients with complex medical needs.

Needless to say I took some pleasure in pointing this out to him, while silently sobbing inside. Who suspects the initial diagnoses, and filters it out from all the others? Who supports the patient and their family through the diagnostic pathway, the treatment, and the inevitable decline? Who is there for anything and everything between their 3-monthly respiratory clinic appointments? Who keeps the patient out of hospital wherever possible, but negotiates an admission when needed? Who coordinates the vast array of healthcare professionals involved in a patient's care? Of course, their GP.

Yes, GPs value communication skills and holistic care, but we also provide very real medical care too. With foundation exposure to general practice remaining disappointingly low, we really do have a duty to address these disappointingly common misconceptions about what GPs do and the challenges we face.

MEETING GP PREJUDICE

Finally, and more controversially, I was met in some cases with a prejudice that I, as a GP trainee, wouldn't be up to the rigorous exam process in a way that my secondary care colleagues were. The sad truth, which most aren't willing to acknowledge, is that some secondary care colleagues still presume that people become GPs because they can't get in to anything else. Several I spoke to were shocked that I had turned down a core medical job to undertake GP training. Most underestimated just how passionately we believe in the crucial role that GPs play, the enormous difference we can make to patient care, and the excellence we can strive to achieve as true generalists. It surprised many that I could be bothered to learn for an exam that wasn't compulsory — a far cry from the reality of my cohort of GP trainees who have voluntarily undertaken (and paid for) many extra qualifications to further their knowledge and expertise. It gave me some pleasure when- these types saw me perform well on a particular station, but that pleasure was far outweighed by the disappointment that this arrogance and lack of respect can still persist within our profession.

However, I believe it is just as much our job to get out there and change these attitudes and to prove our worth, as it is for our hospital colleagues to start recognising and respecting our skills.

We still work in a hierarchical system of long-held beliefs and prejudices. Until MRCGP is looked on with the same reverence as MRCP, we have work to do. I refuse to be looked down on by colleagues and our exit exam, which seemingly places little emphasis on detecting clinical signs, may actually play into many prejudices about the profession, as a touchy-feely world where failed medics go to see out their days trying to persuade patients with viral URTIs they really don't need antibiotics and managing mild depression.

CRACKLES AND BEYOND

So I would argue, perhaps only a little tongue in cheek, that we all should be taking PACES. I think back to my revision course colleague and his belief that, as GPs, we 'hear crackles and refer'. Passing this exam means, yes, I hear the crackles and have confidence in my ability to do just that.

But, perhaps most importantly of all, just one or two more of my hospital colleagues might also now recognise and value us GPs as the robust, efficient, and highly skilled clinical workforce we are, who do so much more than 'just hear crackles and refer'.

ADDRESS FOR CORRESPONDENCE

Rachel Brettell
Nuffield Department of Primary Care Health Sciences, University of Oxford, Gibson Building, 1st Floor, Radcliffe Observatory Quarter, Woodstock Road, Oxford, OX2 6GG, UK

E-mail: rachel.brettell@gmail.com

Rachel Brettell,
GP, Academic Clinical Fellow, Nuffield Department of Primary Care Health Sciences, University of Oxford, Oxford.

DOI: 10.3399/bjgp16X686857

REFERENCES

1. Royal College of General Practitioners. *MRCGP: Clinical Skills Assessment (CSA).* http://www.rcgp.org.uk/training-exams/mrcgp-exams-overview/mrcgp-clinical-skills-assessment-csa.aspx (accessed 8 Aug 2016).
2. Royal College of General Practitioners. *Quality management of GP training.* http://www.rcgp.org.uk/training-exams/quality-management-of-gp-training.aspx (accessed 8 Aug 2016).
3. Membership of the Royal Colleges of Physicians of the United Kingdom. PACES. https://www.mrcpuk.org/mrcpuk-examinations/paces (accessed 8 Aug 2016).