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. 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; 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), 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.

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.

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.

LACK OF UNDERSTANDING
Furthermore, the revision process made...
MEETING GP PREJUDICE

Finally, and more controversially, I was met 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 refer.

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 much more than ‘just hear crackles and refer’.

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

DOI: 10.3399/bjgp16X686857

REFERENCES