Life & Times

The MRCGP Recorded Consultation Assessment:

a perspective from three inner-city trainees

Scanning each day's appointment list, we think: 'How many will be suitable for the Recorded Consultation Assessment (RCA)?'; 'How many presentations are sufficiently complex, but manageable in 12 minutes?'; and 'Will these allow us to demonstrate all of the assessed skills?'

Half of the booked appointments are follow-ups; some are patients requesting a female doctor for intimate examinations; many require interpreters; none of these are suitable for the exam. We've asked receptionists to avoid booking these 'types' of consults with us, but it is difficult when patients might face a longer wait or ask to see a familiar face. Some patients decline recording. We record two consultations: one is unusable because of a poor phone signal; in the other, the patient goes 'off-piste' to ask about old blood tests. Patients do not always disclose 'hidden agendas'; many are not accustomed to sharing their expectations. We are reminded that these are real patients and not actors. We resort to seeing extra patients during academic time or our own time. Some of us pay for extra childcare to do so.

This is a snapshot of our experience of the MRCGP RCA. It highlights some key issues that we hope the Royal College of General Practitioners (RCGP) will consider in the future iteration of the MRCGP assessment.

THE REALITY (OR LACK THEREOF)

It is well established that assessment shapes learning.[1] Listening to our recordings with our trainers provided helpful reflections on our consultation skills. However, the consultation approach required for the RCA excludes many of the consultation skills we use daily. Follow-up consultations are deemed less likely to demonstrate competence, yet these help us develop invaluable skills such as providing continuity of care, managing uncertainty in patients with normal test results or where treatment has not helped. Continuity of care is a cornerstone of general practice and impacts patient outcomes,[2] but this is not incorporated into the assessment.

In our opinion, the exam necessitates a consultation style best suited to an affluent, health-literate population with specific expectations of health care. Most simulated patients we encountered in the Fourteen Fish RCA revision package, created by an MRCGP examiner, are White, male, and able to clearly articulate their problems and expectations. Candidates working in areas with greater deprivation and diversity may struggle to find patients 'appropriate' for the RCA: a high proportion need interpreters; many have multiple needs and require more time; and low health literacy impacts on patients' ability to articulate expectations or engage in shared decision making.[3] Margaret Ikpoh, in discussing the future of general practice during a House of Commons Health and Social Care Committee meeting in June 2022,[4] stated that International Medical Graduate trainees, who make up 47% of GP trainees, often work in deprived areas. Is this contributing to differential attainment?[5,6]

We must also consider the impact on practices and patients. Practices are under immense pressure. It can be difficult to allow trainees extra time to record. Additionally, asking colleagues to see our follow-up patients feels unfair to both colleagues and to patients, when we know the importance of continuity of care.

PRIORITIES FOR A FUTURE ASSESSMENT

We argue that the RCA has a significant impact on trainee wellbeing that is unique from the Clinical Skills Assessment. We felt that the exam consumed each day, reducing our enjoyment of work. It also impacted our training, by narrowing the type of consultations we sought out. We feel that there is significant variation in support from trainers and practices, despite RCGP guidance. The RCA was created during a crisis and a new assessment is under development. The College states this will be *'robust, reliable and reflect the realities of modern general practice'*, and *'delivered in a way which is equitable for all trainees'*.[7] We welcome this ambition and suggest that the RCGP should prioritise the following:

1. Action to address differential attainment: invite experts in this area to propose feasible, evidence-based solutions.
2. Acknowledgement of diversity in approaches to consulting: ensure that the assessment is representative of the range of clinical encounters, and rewards inclusion of complexity, continuity, and cultural competence.
3. Involvement of stakeholders in development and piloting of the new assessment, including patients, trainees, and trainers who reflect the diversity of the UK's population.

There is an awareness that GPs need to function as *'expert medical generalists'*, who are *'fit for the future'* of UK general practice.[8] The MRCGP examination must be designed to reflect this.

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