

EXAM PREPARATION

Preparing for the MRCGP Examination - Membership of the Royal College of General Practitioners

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Introduction

Membership of the Royal College of General Practitioners (MRCGP) is the major postgraduate medical examination for general practitioners in the United Kingdom. Whilst still not required to be accredited as a general practitioner, most individuals take the examination to gain experience, improve their knowledge and skills and to enhance their curriculum vitae. Evidence is also slowly accumulating that general practitioners who are members of the college differ from those who are not. As far back as 1967 members have been found to have better equipped practices, offered a wider range of services and had a greater understanding of psychiatry in general practice (1). There is also some evidence that members are less likely to be reprimanded or found in breach of the NHS terms of service (2). Thus the MRCGP is seen as a marker of quality and proof to an individual doctor that they have reached the high standard necessary to be a member.

Membership can be gained by two methods; by examination and membership by assessment of performance (MAP). MAP is a new route to membership of the College. It allows experienced GPs who can show evidence of good quality practice to become members of the College through an assessment of their performance rather than by sitting the College examination. MAP is equivalent to membership by examination, but the examination may be less suitable for doctors who have been practising for several years and whose understanding of general practice derives from this experience. However, the majority of candidates still opt to gain membership by the examination route, particularly at the end of general practitioner vocational training.

The MRCGP examination consists of four modules:

- Written paper
- Multiple choice paper
- An assessment of consulting skills (video assessment for most candidates)
- Oral examination

The aim of this article is to explain briefly the background to the MRCGP examination and give some assistance to candidates considering taking it. Further information is available from The Royal College of General Practitioners Examination Department, via the RCGP website - www.rcgp.org.uk or in the book recently re-published by the Royal College of General Practitioners(2).

Background

The first membership examination took place in 1965 and became compulsory for entry into the college in 1968. Whilst the format of the examination has changed many times over the intervening years (the first paper consisted of five essay questions), it continues to test UK orientated general practice. It is set by UK general practitioners and is one of the few postgraduate exams where the examiners and the examination are rigorously assessed (3,4). With sensible preparation and reading widely most candidates can expect to pass (the pass rate is approximately 70%, see Table 1). There is no limit to the number of modules that can be taken at one time and, since May 1998, a maximum of three years is allowed from initial application to obtain a pass.

In addition, since 1 January 2001 a pass in the MRCGP video module and since 1997 a pass in the multiple choice paper have been acceptable to Post Graduate Deaneries and the Joint Committee on Postgraduate Training for General Practice (JCPTGP) as evidence of competence for summative assessment. This has considerably reduced the amount of work for candidates often during busy practice attachments. However,

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Table 1. Breakdown of MRCGP candidate results for the winter 2001 examination. Figures in brackets are percentages. (Source: RCGP Examination Department Jan 02).

	Total Candidates	Pass (%)	Merit (%)	Total Pass (%)	Fail (%)	Alpha Coefficient
Written Paper	608	322 (53)	152 (25)	474 (78)	134 (22)	0.87
MCQ Paper	669	379 (57)	161 (24)	540 (80.7)	129 (19.3)	0.87
Video	635	367 (58)	79 (12)	446 (70.2)	189 (29.8)	
Simulated Surgery	71	37 (52)	17 (24)	54 (76.1)	17 (23.9)	
Orals	562	347 (62)	130 (23)	477 (84.9)	85 (15.1)	

some still opt to take either the summative assessment video or MCQ, or sometimes both. In the event that a video is not adequate for MRCGP, the tape is referred for further assessment at summative level.

Preparing for the Examination

It is very important that candidates fully understand the various modules of the examination. The examination department publishes a helpful booklet explaining the regulations which is also available from the RCGP website. It outlines some past questions including examples of the types of MCQ question used as well as definitions of some of the common terms used. For example, “pathognomic, diagnostic, characteristic”. The booklet explains the curriculum of the examination and explains that the MRCGP sets out to test those areas

Table 2. In devising the modules which make up the examination, the Panel of Examiners is guided by the following blueprint which describes in general terms the domains of competence required of a contemporary general practitioner:

- A Factual knowledge
- B Evolving knowledge: uncertainty, ‘hot topics’, qualitative research
- C The evidence base of practice: knowledge of literature, quantitative research
- D Critical appraisal skills: interpretation of literature, principles of statistics
- E Application of knowledge: justification, prioritising, audit
- F Problem-solving: general applications
- G Problem-solving: case-specific, clinical management
- H Personal care: matching principles to individual patients
- I Written communication
- J Verbal communication: the consultation process
- K The practice context: ‘team’ issues, practice management, business skills
- L Regulatory framework of practice
- M The wider context: medico-political, legal and societal issues
- N Ethnic and trans-cultural issues
- O Values and attitudes: ethics, integrity, consistency, caritas
- P Self-awareness: insight, reflective learning, ‘the doctor as person’
- Q Commitment to maintaining standards: personal and professional growth, continuing medical education

Testing of the domains is shared as follows between the examination’s modules. The allocations shown represent differences in emphasis, and should not be taken as inflexible.

Module

Domains

Written Paper 1
A, B, C, D, E, F, G, H, I, J, K, M, N, P

Written Paper 2. Multiple Choice Paper
A, B, C, D, G, L, N

Consulting Skills
G, H, J, O

Oral
D, E, F, G, H, J, K, M, N, O, P, Q

of professional knowledge, skill and value, which reflect the consensus view of what comprises good general practice. Table 2 outlines the “blueprint” of the examination within the “domains of competence” required together with how the domains are shared between the various examination modules.

Each candidate must have certificates of proficiency in cardiopulmonary resuscitation (CPR) and child health surveillance (CHS). CPR can be tested within an Accident and Emergency Department, by an ambulance-training officer or by a Forces doctor with specific skills and experience. There are various exemptions, for example possession of the Advanced Life Support (ALS), Pre-Hospital Emergency Care (PHEC) certificates, or the Diploma in Immediate Medical Care.

Child Health Surveillance (CHS) competence can be certified by a general practice principal on the Health Authority or Health Board list for CHS, a consultant paediatrician, an NHS clinical medical officer active in CHS, or an Army GP principal who regularly does CHS. A certificate by a health visitor alone is not acceptable, but can be countersigned by a suitably qualified doctor. The CHS certificate examines competences in three age groups; 6–8 weeks, 6–9 months and 36–48 months with the aim that the candidate can provide evidence of their competence in the practical aspects of CHS. Other elements of the examination test knowledge, skills and attitudes appropriate to CHS.

A candidate may apply to take any part of the examination at any time during vocational training, but cannot use the letters MRCGP until The Joint Committee on Postgraduate Training grants a certificate of prescribed or equivalent experience for General Practice and the individual has paid the appropriate subscription to the College.

It is extremely useful to go on an MRCGP preparation course. The ‘Millbank Course’ currently held at the Royal Defence Medical College (RDMC) in Gosport is very suitable. In addition, for doctors employed by the Ministry of Defence, the RDMC can arrange an attachment to an NHS practice between the course and the examination. It provides exposure to patients and some issues that are infrequent in military general practice and thus is essential preparation. As an example, of the last seven registrars completing both the MRCGP course and an NHS attachment to the Horndean practice near Portsmouth all have passed with a merit in one or more papers.

Too many registrars approach the MRCGP like an undergraduate exam. There is little to be gained from reading hospital orientated textbooks. This is an examination on UK general practice. One of the major textbooks on preparing for the MRCGP

should be either borrowed or bought. Most candidates have found "MRCGP: Approaching the New Modular Exam" by Saunders (5), "The MRCGP Examination: A Guide for Candidates and Teachers" (2) by Moore or "Notes for the MRCGP" by Palmer (6) to be helpful although there are others now available. Revision should be broad based and include other textbooks (see later), academic general practice orientated journals as well as GP journals that provide an overview or summary on a subject (for example UPDATE, Practitioner, Pulse or GP magazines).

The Written Paper Background

This paper is a combination of the old Modified Essay Question Paper (MEQ) and the Critical Reading Paper. The split is roughly 3 or 4 Critical Reading Questions (CRQs) and the rest MEQ. This is a hand marked examination so legible writing is essential. The examination lasts for three hours, however, extra reading time (often 30 minutes) may be given depending on the amount of reading material.

There are multiple centres for sitting the written papers, these are listed in the examination handbook and are conveniently located for most candidates (7).

Written Paper – The Former "Modified Essay" Type of Question

These questions test the ability to integrate and apply theoretical knowledge and professional values in primary care. All the questions should be read carefully. Ten minutes should be spent on each question, although there is more time. Experience shows that few marks are gained in the last few minutes, but missing out a whole question significantly reduces the overall scoring potential. Answers should be in short note format as they score better (and can be marked more easily). Think laterally about the question and about as many aspects that can reasonably be considered. List the main issues or themes of the question on the left hand side of the answer sheet, leaving room to expand each issue in note form. In most questions there will be between three and five issues or themes. Remember that the questions are planned so that there is no overlap between the issues in each individual question. Think as broadly as possible. For example, a 46-year-old patient with a history of alcoholism, who is unemployed presents to you for an HGV medical. What issues does this raise? The themes could be for doctor, patient and family, medico-legal, society, the practice or employment law or DVLA. Consider each in turn, as described, above.

It is essential to practice past papers. The College web site offers marking schedules for questions in the last examination and there

are lists of the types of themes in most preparation books and in many GP magazines.

Written Paper – The Former "Critical Reading" Type of Question

To answer the "CRQ type" section, it is essential that candidates understand the principles of critical appraisal and can apply them. Preparation should begin with reading 'How to Read a Paper' by Trisha Greenhalgh, (8) as it provides an excellent overview. Other books which have been found to be helpful during preparation have included "Evidence Based Practice in Primary Care" by Ridsdale (9) and "Critical Reading Questions for the MRCGP" by Stacey and Toud (10).

As with other parts of the examination, it is frequently helpful to collaborate with others to make up a "critical reading group". Traditionally this has been by done by arranging to meet to discuss papers, but more recently electronic mail has been used. Papers should be chosen from the major UK journals, but especially the British Medical Journal and the British Journal of General Practice. It is essential that candidates get used to commenting on the bad and good features of a paper; it is easy to be critical, but remember that every paper has some good points.

Two types of questions are frequently set; questions that test the ability to evaluate and interpret written material (such as part of a study or an audit) and questions that are designed to test knowledge and the interpretation of general practice literature. The CRQ part examines GP critical reading, not statistics. It will often be necessary to state the obvious. For example this paper looks at common GP problems; qualitative research is subjective; this paper may not be applicable as it was done in Holland; it is rare to change practice as a result of one paper; more research is required. Each of the main points of the paper should be discussed in turn, assessing its good and bad points. There is no negative marking. If in doubt write it down.

It is important to be aware of the hierarchy of evidence for example, a randomised control trial is considered better than advice from a local expert. A number of points are frequently worth making:

- GP practice is a difficult environment for the performance of valid research because conditions, treatments, GPs, outcomes and a host of other factors are heterogeneous. For example researching something as simple as 'cough'. This is made up a number of variable causes such as COPD, URTI, asthma, and hay fever. It is treated differently depending on the underlying cause and often assessment of the outcome is subjective.
- GPs rarely change their practice after one

paper. If asked how a paper would affect general practice, state this and in most cases suggest that more research is required.

The following questions may also be relevant:

- How would it have been done better?
- Is it realistic in General Practice?

The CRQ element of the written paper also includes question(s) that test knowledge and interpretation of general practice literature. Recent examples have been on musculoskeletal problems, drug abuse or heart failure. Candidates were asked to comment on the problem, giving evidence in the form of references to support their views. Whilst knowing references is useful, and gains some additional marks, the majority are given for showing an understanding of current or topical issues and outlining any particular arguments or controversies.

The Multiple Choice Question Paper

The Multiple Choice Question Paper (MCQ) is characterised by having a paper that can be marked by machine (as opposed to by a human examiner). It is designed to test knowledge and the deeper understanding and application of knowledge. From October 2001 the MCQ has comprised 150 items of the extended matching, single best answer, multiple best answer, summary completion and algorithm formats; and 100 multiple true false items.

The number of multiple true false items has been steadily reduced over recent years and, with effect from May 2002, the format will eventually be abolished, and at the same time the maximum number of items reduced from the current 350 to 250. There is an intention to increase the number of images (including fundi, skins, ECGs etc) used in the MCQ during the next year.

In preparing for the exam, it is important to start reading the British Medical Journal and British Journal of General Practice for the year previous to which the examination is to be taken as the examination is set during this period. Only those articles with relevance to UK General Practice or that address important current GP issues, (for example, "Heartsink" patients, clinical governance, antibiotics, and depression) should be studied.

It is important to obtain an up to date British National Formulary and to read and learn the written text of each chapter. Practising large numbers of GP orientated MCQs is also important. A current sample MCQ paper is available from the RCGP Sales Department or books of suitable papers are published (11). For clinical matters the Oxford Handbooks (12,13) can be used as an easily accessible resource. To understand the structure of the consultation,

a reference book such as Pendleton *et al* (14) or Neighbour (15) is recommended together with a reference on practice management and finance (16,17).

During preparation for the exam, some candidates have found that answering the sample MCQs using negative marking is useful. Remember that this does **not** happen in the exam but it can help in preparation. If you score 3 out of 5, or more, on a question move on. If you score less, pencil an asterix next to that question and review the subject area. The question should then be repeated. It is important not to move on until a score of 5 is achieved. Once the book is completed all the questions with a pencil asterix should be done again. The same principle should be applied if the score is still less than 3. If more than three is scored, the asterix can be erased. This will demonstrate weak areas. It is not necessary to practice areas of strength.

All the questions should be answered. If an answer is not known, a guess is appropriate, bearing in mind that a 'true' answer in a question is more common than 'false'. However, care needs to be taken in those questions with multiple true/false answers. Hunches should be backed and in general, too much deliberation is best avoided, as first thoughts are often best. When filling in the computer answer sheet, blank spaces should not be left with the intention of coming back to them. This may not be possible due to time constraints and often confuses the candidate themselves

The Test of Consulting Skills - The Video

The video assessment of consultation skills and is used by the majority of candidates. The RCGP also arrange a simulated surgery as a test of consulting skills, but it is limited to candidates who have insuperable difficulty in submitting a video tape for assessment of their consulting skills. It will not be discussed further in this article but details are available from the RCGP website.

The video assessment of consulting skills component requires seven consultations, each of which is to be less than 15 minutes in duration. There should be one consultation with a child (aged less than 10 years) and one with a significant psychosocial problem. The assessment criteria used were originally based upon the "Pendleton *et al*" model of the consultation (14). This together with the examination criteria should be studied to ensure that they are understood. An appropriate analogy to the video component is the driving test: on an empty road, few people use their indicators; in the driving test it is essential to demonstrate the correct use of the indicators and position on the road. In the video component the examiners must see that the criteria have been fulfilled to award

marks. Whilst all the performance criteria are important, the commonest reason for failure is not demonstrating patient centred behaviour. General practitioners find this approach difficult to implement but recent research has shown improved patient outcome (18).

The three areas candidates find most difficult are:

- The doctor responds to cues. During consultation patients generally give verbal and non-verbal cues showing underlying anxiety, concerns or a specific health belief. An example would be a child with mild periumbilical pain and no sinister features. His mother may say “His grandad died of bowel cancer” this should be addressed, even though it is apparent that the child does not have bowel cancer. A non-verbal cue may be somebody looking tired who on questioning turns out to be working on permanent night duty, or looking after an elderly relative. This may be very relevant to their health seeking behaviour and should be followed up by further questioning.
- The doctor elicits appropriate details in order to place the complaint in a social or psychological context. “How does this condition affect your work?”, “Who is at home with you?”; “Has this caused you to take him off school?”; would be common questions used.
- The doctor shares management options with the patient. This is a two-way discussion involving the patient and the doctor. It is important not to assume that one party automatically knows what is best. The patient should be asked what they would like. For example, a patient

with a simple painful knee, no sinister history and only mechanical pain on examination may be told: “I can find no serious damage to the knee, but it is obviously painful”. The options are to do nothing as it will probably settle by itself, to take analgesia or to undertake further investigations (for example X-ray) or even to refer for physiotherapy.

Whilst, under some circumstances, it is correct for the doctor to give a clear view on what the doctor’s recommendation on further management is, almost every illness can result in 3 options: doing nothing, treatment from or at the surgery and referral for hospital care or treatment outside the practice. Ultimately, however it should be for the patient to decide with help from the doctor.

It is a good idea to try and get all the performance criteria in all of the seven consultations, but each PC should feature on at least 4 of the 7 consultations. If possible the tape should also be viewed by someone experienced in video assessment as often some difficulties do not become apparent until seen by an outsider.

Consent to undertake the video consultation is essential and is only valid for one year. Consent forms must be signed both before the consultation and afterwards to ensure that the consent is still valid. Thereafter the video should be treated as a set of records. Also the technical aspects of the recording must be of a high quality, most especially the sound. If the sound and picture quality are all clear, the tape should be copied and submitted. Table 3 gives an overview on the types of consultation to submit.

Table 3. Top Tips on the MRCGP video component.

Choose consultations between approximately 8 and 15 minutes. Consultations less than 8 minutes are unlikely to be of sufficient challenge and those over 15 minutes take too long to analyse (and time over 15 minutes will be ignored)	Keep to standard general practice. Rare conditions may be interesting but the assessor may have particular knowledge about a condition. There is therefore a risk that the candidate will get the management wrong and be marked down!
First appointments for a condition are normally the best. Follow up consultations may be appropriate, but only if a full assessment of the problem is made.	Avoid consultations simply for repeat prescriptions, sick notes, Med 3/5 etc.
Vary the conditions and types of patients seen. When the assessors view the tapes they want to see a broad spectrum of patient types and conditions. One consultation should be of a child and one with a significant psychosocial problem.	Avoid ethical problems particular to the military such as matters that may be discussed with a Commanding Officer. Most civilian doctors do not understand military general practice.
Summative Assessment requires a two hour tape, whereas MRCGP will look at the first Seven consultations only. Ensure that the best consultations are the first seven if there is just one tape.	The commonest reason for failing the MRCGP video is lack of evidence of “sharing management options with the patient”.
Remember that for MRCGP, involving the patient in the decision making and being patient centred in approach are necessary to gain merit marks.	The second commonest reason for failing MRCGP is lack of showing “doctor responds to cues” (either verbal or non-verbal) by the patient.
Audibility of speech is essential. Have an active microphone on the desk between the doctor and patient.	Get the finished tape and workbook reviewed by an experienced person familiar with the marking schedule.
Keep a copy of the tape so that if the submitted tape is lost or broken it can easily be replaced. The second tape should be destroyed as soon as not required and kept locked away.	

The Oral Examination Background

The oral examinations are held in Edinburgh and London. In London the orals are held at the RCGP at Princes Gate but the venue sometimes changes in Edinburgh. To assist candidates the oral development group, in conjunction with Radcliffe Medical Press, has made a video giving examples of the types of questions asked and how to answer them (19). It is strongly recommended to assist in preparation, however, for most candidates it should be borrowed from a library.

There are two orals of twenty minutes. It is essential to arrive early and to dress and behave as if attending an interview. This part of the examination is specifically aimed at testing attitudes, decision-making skills and the ability to justify those decisions. There are no rigid "College" answers, personal views that are structured, sensible and flexible should be offered. What the examiners are looking for is the way the candidate answers the question, not necessarily a right or wrong answer.

Each oral is conducted by two examiners who work in parallel with another pair. Questions for the two orals are planned in advance between the total of four examiners, who meet at the end of an individual candidate's two orals to confirm the overall mark. In most cases there is a 5 minute break between the two oral examinations.

Oral Questions

The oral questions cover four areas of competence:

1. Communication.
2. Professional values.
3. Personal and professional growth.

Each competence is looked at in four contexts:

1. Care of patients.
2. Working with colleagues.
3. Society as a whole.
4. Taking personal responsibility (for care, decisions and outcomes).

An example of communication in care of patients would be how a GP can effectively break bad news. An example of communication working with colleagues might be communicating to a partner, practice manager or practice nurse that they are performing poorly. Examples of each question type and acceptable answers will be given on courses and in the texts previously mentioned. When revising, it is most effective to work in groups and to practice. Candidates worry most about face to face contact, however this part of the examination has the highest pass rate. Further examples of questions can be gained on an examination course or from a recent article published by Dr Julia Oxenbury (20).

Some candidates find that psychological preparation is important. It should begin the day before the examination in order to ensure an appropriate frame of mind and anything that causes additional stress should be avoided.

Conclusion

The MRCGP examination is a test of quality in a doctor. It is challenging and to pass requires suitable preparation and planning, but is strongly recommended to practitioners entering general practice. The examination continues to be rigorously tested and adjusted to meet the needs of modern general practice, as shown by the adjustments to its format over recent years, to accommodate the requirements of Summative Assessment. Whilst Membership by assessment of performance (MAP) is an alternative and equally challenging route to membership of the Royal College, the majority of candidates continue to take the examination.

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