

Organising an MRCP course in Pakistan

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ABSTRACT The MRCP(UK) examination enjoys a tremendous reputation internationally. Recent changes to the immigration system have made it difficult for international graduates to come to the UK for training, which has resulted in many doctors taking the MRCP examination without having worked in UK. Understandably, these doctors face difficulty in tackling the exam, especially the talking stations (2 and 4) of the Practical Assessment of Clinical Examination Skills examination (PACES). Our answer to the problem was to set up preparatory courses for the MRCP examination in our hospital. Although faced with logistical difficulties we have managed, with support from our consultant colleagues, to set up and run courses both for Part 1 and the PACES examination of Part 2. In holding the courses we have identified a huge deficiency in the training of our doctors in communication skills. We hope that similar courses will be set up across the country, and that communication skills will gain more recognition in the medical curricula at all levels.

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The format of the examination for the MRCP(UK) (Membership of the Royal Colleges of Physicians of the United Kingdom) has changed considerably over the past few years. It is now composed of two written papers and the PACES (Practical Assessment of Clinical Examination Skills) component. A great deal of work has been done over the past decade to develop PACES to render it more reliable, reproducible and as free from bias as possible.

The MRCP examination enjoys a tremendous international reputation. Traditionally, the best and the brightest young physicians training in Commonwealth countries have looked to the UK to advance their postgraduate training, and many thousands came to the UK and worked in the NHS before taking their Membership or Fellowship examinations. Following recent changes to UK immigration law and to medical training systems, however, it has become virtually impossible for physicians from our country, Pakistan, and those from other countries, to enter the UK for training. This has led to increasing numbers of candidates from Pakistan attempting to sit the MRCP(UK) examination without ever having worked in the UK.

The majority of candidates who attended our course were in this situation. Some of them had sat the examination prior to attending the course. In discussions with the candidates it emerged that they felt that a lack of familiarity with the British medical system, coupled with little or no knowledge of British culture and norms and the variety of British regional accents encountered in the examination, contributed to their failure. Many of the candidates, having saved money for up to two years

before undertaking the expensive process of going to the UK to sit the examination, are all too often disappointed, bewildered and embittered by the outcome.

A recently published survey showed a significant difference in the likelihood of passing the PACES examination between graduates from UK medical colleges (67.0%) and those who had qualified overseas (26.2%).¹ Interestingly, the difference in success rate was not significant in the first attempt at MRCP Part 1, perhaps suggesting that the core medical knowledge is broadly the same in the two groups. Similar findings were noted for the MRCPG examinations by Roberts et al. in 2000, who showed that doctors trained on the Indian subcontinent were more likely to fail the examination than graduates of UK and Irish medical colleges. They postulated that one of the possible explanations for this might be linguistic.²

Given the myriad difficulties faced by candidates from Pakistan when preparing for and sitting the MRCP examination, we decided to set up preparatory revision courses for both the MRCP Part 1 and the PACES examination at our institution, the Shaukat Khanum Cancer Hospital and Research Centre in Lahore. This hospital is a tertiary care cancer facility in Pakistan, established to provide the best possible cancer treatment to all patients regardless of their ability to pay. Each year, the hospital provides free treatment to more than 70% of its cancer patients, paid for by a combination of charitable donations and self-generated revenue.

The hospital is committed to the education and training of healthcare professionals, and educational programmes are taught in multiple medical disciplines under the umbrella of the College of Physicians and Surgeons of Pakistan (CPSP), while the Office of Postgraduate Education co-ordinates all postgraduate activities in the institution. Currently, the hospital is recognised by the CPSP to provide fellowship training in internal medicine, pathology, medical oncology, nuclear medicine, radiation oncology, anaesthetics and radiology. Each year, the hospital hosts medical students from institutions in Pakistan, the UK and other countries, for periods of elective education and training, usually in their fourth or final year of training. We are also in collaboration with the University of Bradford in the UK, with whom we offer a BSc (Hons) in Medical Imaging.

Our formal effort to initiate MRCP teaching began with a series of weekly tutorials for our own candidates, conducted by one of our consultants who had recently returned from the UK. Due to the popularity of the tutorials, it was decided to launch a full three-day course, with provision for doctors training elsewhere to attend. All our consultant staff are trained in the UK or the US, giving us a large pool of potential teachers in various subspecialties. We decided, initially, to involve only those consultants who had themselves trained in the UK, held the MRCP or FRCP and were familiar with the examination. Later, the pool of teachers was enlarged to include consultants trained in the US. It proved difficult to ensure the availability of all the tutors during the week, and so the course was designed to start on a Friday morning and run over the weekend, with a final examination followed by individualised feedback on Sunday afternoon. The hospital's education department provides logistic and administrative support.

The course is run three times a year, three weeks before each diet of the MRCP(UK) examination. Teaching is consultant-led. Each session focuses on a specific specialty in which the tutor goes through mock examination questions. An attempt is made to ensure that the most important and 'hot' topics in that specialty are covered in the session. Time is set aside for discussion on topics thought to be poorly understood. At the same time, examination technique and questioning style are also discussed. A mock examination is held at the conclusion of the course, giving candidates a chance to practise answering questions under examination conditions.

We decided at the outset to offer the course free of cost to our own trainees, but hoped to attract external candidates to help defray expenses. Costs were kept low by the consultant staff foregoing any fees for teaching on the course, and we obviously remain heavily dependent on their goodwill and support. The hospital charges the course an administrative fee to cover the costs of food, and utilities, as well as logistic and administrative support.

For the external candidates, we have managed to keep costs low, given that most trainee doctors in Pakistan are rather poorly paid and have to pay their own course and exam fees. The first course had four external and three internal candidates. The second had five external and four internal candidates and numbers have continued to grow, albeit slowly.

Emboldened by our success, we decided to attempt a much more challenging Part 2 course, focusing in particular on stations 2 and 4 of the PACES carousel. This was based mainly on our view that it was the 'talking' stations that our candidates fared especially badly at during the actual examination. The course has been planned to run over two days. On the first day, we cover, in a semi-didactic manner, important ethical issues in accordance with current UK laws, such as DNR (Do Not Resuscitate) decisions, obtaining consent for post mortems, advising physicians found to be hepatitis B positive, and so on. Issues such as these tend to be especially difficult for our candidates to deal with in the examination situation, since they involve not only 'medical' knowledge but also knowledge of UK law as it relates to the practice of medicine as well as considerable linguistic and empathic attributes. We also hold practice or 'mock' scenarios, where the tutor acts as the patient or relative (the patient or surrogate role) and the candidates are encouraged to take turns in dealing with the scenario in front of the other candidates, so that they can all learn from each others' performance.

On the second day, a mock examination is held. We are fortunate to have a number of British, Irish, Australian and other expatriate staff, as well as a number of British citizens of Pakistani origin, all of whom volunteer for no fee to play the role of the patient/surrogate. In this way, we attempt to familiarise the candidates with the 'British' accent and to try to replicate, as far as possible, true examination conditions. Examiners use marking sheets similar to those used in the actual examination. At the end of the second day, individualised feedback is given to candidates to highlight areas of weakness.

We currently charge the equivalent of about £50 for the full three-day course. This has resulted in a surplus of £500 in our account after payment of all expenses. As the popularity of the course grows and the number of paying candidates increases, we hope to be able to offer honoraria to the course tutors.

All participants appear to have enjoyed the courses thoroughly, and feedback has been almost uniformly positive, not to say complimentary, with candidates often thanking the course organisers for having arranged the first course of this kind in Pakistan. Analysis of the anonymised feedback forms has shown that 93% of the candidates thought the course was very beneficial. All respondents said they would recommend the course to

colleagues and that the mock examination with individualised feedback from the examiners was the best part of the course.

In general, the tutors feel that most candidates have a good theoretical knowledge of medicine, but often fall down in the application of their knowledge. In particular, poor spoken English often results in poor performance in the clinical section of the examination. Analysis of the result sheets used by the examiners shows that the spoken English of the 67% of candidates who failed the mock examination was graded as poor. Even for those who passed, the examiners thought that spoken English needed improvement in 15% of candidates. The examiners also felt that the candidates were uncomfortable discussing personal issues such as sexual history, use of recreational drugs and alcohol. They commented on the candidates' inability to 'control' the interview and the lack of proper summarisation of the discussion towards the end of the interview. Interestingly, Tim Hall's book, *PACES for the MRCP*, mentions this as a common fault in history-taking.³ Course tutors noted that some of our candidates were not mindful of the patient's dignity, an issue raised both by Hall and the Royal College of Physicians of London.⁴

We have not, so far, attempted to gather data on the pass rates of candidates attending our course in the actual examination. We plan to do this henceforth in order to identify gaps in our teaching and improve the course further.

The lack of formal training in communication skills at the undergraduate level in Pakistan is all too evident. Candidates are unfamiliar with, and often uncomfortable, discussing issues such as DNR decisions, switching off ventilatory support, breaking bad news to family members and other situations familiar to physicians in training in the West. All too often in Pakistan, such discussions are consultant-led, with trainees largely uninvolved, other than as observers. In the light of our experience with the

physicians attending our course, we are now holding weekly tutorials on history-taking and communication skills in house for our trainees. As Hall states, communication skills training is a core component of medical education, and there is good evidence that such skills can be acquired.³

The next challenge is to expand the course to cover the clinical stations. Other than the usual difficulties associated with this, which centre around the logistics of finding, and maintaining lists of, suitable patients willing to attend on a regular basis, a particular problem that we anticipate is that many of our patients do not speak English. Additionally, many patients attending our tertiary care cancer hospital are from far-flung areas, making transport costs another important issue.

It would seem that we have identified a genuine gap in the market. Candidates feel that they benefited greatly from the didactic, targeted teaching for the examination, while candidates on both courses rated the mock examination as the most useful aspect in advancing their training. Most of the candidates on the PACES course commented on the fact that, prior to attending the course, they had received virtually no training on communication skills in their entire clinical careers.

We feel that holding preparatory courses for the MRCP has highlighted a significant deficiency in both undergraduate and postgraduate training in Pakistan. It has certainly helped us to improve the standard of our own teaching and we feel that we have identified a need among the wider medical community. Ours may be a small step in trying to bridge this gap, but we hope it will be a significant one and will lead others to step forward and set up similar courses across the country. Ultimately, we hope that those in charge of medical education in Pakistan will respond to the urgent need to update and modernise medical education curricula, with the goal of improving healthcare for all the citizens of our country.

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The 2009 dates of this course have yet to be confirmed, but please contact c.gray@rcpe.ac.uk and details will be sent to you when they are available.