SOME PERSONAL REFLECTIONS ON EXAMINING IN PACES

I read Drs Hafeez and Yusuf's paper 'Organising an MRCP course in Pakistan' (*J R Coll Physicians Edinb* 2008; 38:302–4) with interest and wish to add some thoughts of my own specifically limited to PACES. There is no doubt that the MRCP examination is an important function of the College.[1] I have been an MRCP examiner for 22 years and hosted the clinical section (PACES since 2001) for most of that time. The examination was mostly held on general wards because dedicated examination facilities were rarely available.

To my mind there are three 'problems' with PACES. Firstly, MRCP(UK) is an entrance exam for Higher Medical Training, but a worry is that in some countries MRCP is often taken to mean that successful candidates are partially trained.

Secondly, MRCP(UK) is reductionistic and does not assess abilities to cope with complex situations, although history-taking stations may to a limited extent assess abilities to deal with complex situations. The history station, logically enough, focuses on history-taking ability. When writing scenarios I tried to make history taking more usefully discriminatory. One scenario I wrote featured a young woman who had been seen several days previously in A&E because of a diazepam overdose and slashed wrists, and who was referred four days later because she had developed jaundice, monumentally high ALT levels but negative serology for hepatitis viruses. Only half the candidates realised the obvious diagnosis (covert paracetamol overdose at first presentation), although most had otherwise taken a good history. Pass or Fail?

In the examination-based stations, in which ten examiners make 14 assessments, candidates cannot be assessed on one patient with two problems. For example, in the CNS station I once put in an elderly patient with a hemiparesis who had an obvious facial rodent ulcer that only a few candidates noted, but sadly assessment had to be restricted to CNS aspects.

Thirdly, acute conditions are not assessed because PACES are mostly staged in designated areas. One consequence of using such areas is that patients usually have to be outpatients who are basically well and who have stable long-term conditions. I advise intending candidates that the conditions used are thereby limited and candidates should be well acquainted with 'the usual suspects'.

Cardiovascular system stations often feature heart valve abnormalities that are usually congenital or degenerative now that those with rheumatic heart valve disease have died off (degenerative aortic incompetence or stenosis/sclerosis regularly feature in my experience). Respiratory stations tend to have stable COPD or cryptogenic fibrosing alveolitis with clubbing and crepitations. Nervous system stations often have hemiparesis, multiple sclerosis, paraplegia from Spina bifida, Parkinsonism or (diabetic) peripheral neuropathy. Abdominal stations often have a liver and or a spleen or polycystic kidneys (often misdiagnosed as hepatosplenomegaly, despite evidence of haemodialysis and presence of a transplanted kidney). I used to include patients with chronic urinary retention (it is amazing how often candidates do not feel for enlarged midline organs such as the bladder or uterus). Eye stations are likely to have optic atrophy (and if nystagmus coexists the diagnosis is multiple sclerosis), diabetic retinopathy, retinitis pigmentosa or choroidoretinitis.

Often discussion is poor. Few candidates realise that 'pure' retinitis disrupts the retinal blood vessels, whereas 'pure' choroiditis does not. When asked to test visual acuity about half of candidates do not ask the patient to close one eye. One nervous candidate started to test visual acuity by asking the patient to close both eyes! If patients with both eyes open report impaired visual acuity, few candidates realise there must be visual impairment in both eyes.

Endocrine patients are difficult to find with the exception of patients with goitres with or without eye signs (who will hardly ever be clinically hypo- or hyperthyroid as they will have been treated), acromegaly or patients with steroid facies. Locomotor stations almost invariably include a patient with rheumatoid hands. Other choices include psoriatric arthropathy, osteoarthritic hips and ankylosing spondylitis (I once had a patient with ankylosing spondylitis who had ankle involvement – a case of spondylosing ankylitis then?). Skin stations will have psoriasis, scleroderma, occasionally cellulitis imported from the ward with an antibiotic infusion to help the diagnostically destitute or eczema.

Communication skills and ethics stations tend to focus on explanation of disease processes or breaking bad news. As noted by Hafeez and Yusuf, candidates are often deficient in talking skills, and in particular communication skills (the two are not the same). The only extra comment I would make is that we hardly ever assess or teach how good news should be imparted – not 'There has been a car crash involving your daughter and she has no major injuries' but rather 'The first thing is that you daughter is fine and there is nothing to worry about. She has been involved in a car crash…'

Marking is made as consistent as possible to ensure that assessments are standardised. I wish I were allowed a little subjectivity (I am human after all). My criteria for a pass is that I would allow the candidate to treat fellow examiners, and my criteria for a clear pass is that I would be happy to allow the candidate to treat me!

J R Coll Physicians Edinb 2009; 39:90–4

The exam is fair. One paper studying outcomes for UK graduates reveals that the exam marking is free from bias.[2] White candidates perform better overall than non-white candidates, and women perform better than men. 'It seems possible that in any postgraduate medical examination, female candidates will perform better at assessments involving consultation and communication.'[2]

Finally, mention has to be made of Mrs L Tedford, known to everyone as Lindy, who administrates the Edinburgh exam. She could organise examiners for PACES during a tsunami following an earthquake in a war zone. I have a personal belief that she has a computer-assisted telephone attachment for contacting potential examiners such that she can be perceived simultaneously to be a combination of assertive, about to burst into tears and under intolerable stress that only you can relieve by agreeing to examine.

Philip D Welsby
Retired consultant physician, Edinburgh

References

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2 Dewhurst NG, McManus C, Mollon J et al. Performance in the MRCP(UK) examination 2003–4: analysis of pass rates of UK graduates in relation to self-declared ethnicity and gender. *BMC Med* 2007; 5:8.