UPDATE - MRCP (UK) EXAMINATION

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In the late 1960s a joint Examination Board of the Royal College of Physicians of Edinburgh, the Royal College of Physicians and Surgeons of Glasgow and the Royal College of Physicians of London was set up and a common Part I Examination introduced in 1968, with a common Part II Examination introduced in 1972. The MRCP (UK) was awarded to those successful in both parts of the Examination. This was an important action by the three Royal Colleges of Physicians (the Federation) which has been consolidated in many other areas since, e.g. the most recent being a common approach to CPD.

The MRCP (UK) is important for a number of reasons:

- It is a qualification sought by physicians and other trainees prior to entry into higher training.
- It is sought by many colleagues from overseas and is used as a yardstick by educational authorities in other countries to compare their examination with one which is internationally recognised.
- It is the first point of contact that trainees have with the Royal Colleges of Physicians.
- It binds together three institutions which have common aims.

During the life of this common diploma there has been continual audit and modification. In spite of the acknowledged high standard of the examination, the MRCP (UK) Policy Committee obtained permission in 1996 from the Federation to undertake a review. A conference was organised at which Working Groups, Members of the Policy Committee, Examining Boards, Members and Fellows of the three Colleges, along with representatives from the RCPCH, RCPI and internationally recognised experts in medical education were invited to contribute.

A comprehensive set of proposals and recommendations was made. The underlying principle guiding the review process involved a commitment to base any recommended changes on sound educational principles designed to improve the objectivity of the examination. The MRCP (UK) is recognised as a test of a candidate's knowledge at the end of general professional training and as such must be comprehensive, reliable, consistent and valid.

The changes proposed have relied on major academic work and new IT programmes. Both exercises have proved time consuming and expensive. At the same time the basic principle - that any major change to the content or format of the examination would require one year's notice to be given to candidates and examiners - has and will be kept to.

A number of changes have proven relatively easy to introduce:

- Removal of any restriction on the number of attempts at each part of the examination, subject to the proviso that any candidate unsuccessful in passing Part II within a period of seven years would be required to take and pass Part I again.
- Improved feedback to all candidates sitting Part I Examination.
- The mark of nine in Part II written does not now need compensated for, i.e. providing other criteria are met, a candidate gaining nine in the written can pass with a total mark of 25 and not 27 as previously stated.

Other changes are working their way through the system. The question format and therefore the question papers are likely to look different in the future. New format MCQs will be used in Part I Examination and replace current format Data Interpretation and Grey Case questions in the Part II written exam. These new format questions - best of five, n from many, etc. have already appeared in the Part II Examination but not in large numbers. The introduction of these new style questions will allow for computer marking of the Part II as well as the Part I paper. The problem, of course, is to generate high quality, valid questions of the type necessary to meet these needs. This is actively being tackled at present with Speciality Question Groups representing the three Colleges and drawn from Fellows and Members (including Specialist Registrars and newly appointed Consultants) meeting on a regular basis.

Recently a number of publications covering the Part I Syllabus, Part II Clinical Guidelines and PACES (Practical Assessment of Clinical Examination Skills) have been made available. The Part I Syllabus should answer many of the concerns of candidates on the areas to be covered. The Clinical Guidelines mean that candidates and examiners will be using the same text and therefore concerns regarding consistency and fairness will be answered.

The new clinical examination PACES will not be introduced before 2001(2) at earliest. This examination will replace the current long case, short case and oral examination sequence. Candidates will be exposed to more examiners, who will be using a standardised marking sheet and marking independently. In addition to the clinical stations there will be observed history taking and communication skills stations. These we see as a vital component of the examination at a time when the public are highly critical of our skills in these areas.

In an examination of high quality, reliability is essential and statistical information is available to the Boards of the Examination at the completion of each diet. VARG (Validation Audit and Research Group) has been given the task of auditing the examination, defining the aims and objectives of the examination and in the future is likely to carry out research.

The Federation of the Royal Colleges of Physicians believes that the MRCP (UK) is but the beginning of a lifelong educational process for those following a career in medicine and its sub-specialities. As such they see it as vitally important that the Examination remains relevant to modern medical practice. The examination will continue to evolve long after the current changes are in place and as medicine and educational practice dictate.