FAQ for Candidates – Changes to PACES

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GENERAL

What is the purpose of PACES?

The assessment system for Core Medical Training in the UK is comprised of Workplace Based Assessment and the MRCP(UK) examination, of which PACES forms one part. The purpose of the MRCP(UK) is to allow trainees in medicine to demonstrate attainment of the knowledge, skills, behaviours and attitudes necessary for the practice of General Internal Medicine as described in the new curricula for medicine. The purpose of PACES is to assess the trainee's ability to take and interpret a clinical history, to perform a clinical examination, to apply problem solving skills to information gathered from history and examination, and to communicate sensitively and effectively with patients, carers and colleagues.

Why change PACES?

The PACES assessment format has proven to be popular, reliable and easily deliverable around the world since its introduction in 2001. The Clinical Examining Board wish to minimise change to the basic format, and only one of the five Stations changes in 2009.
The changes have been driven by internal quality review processes in MRCP(UK), and as a response to the changing training environment for medicine in the UK, in particular the introduction of new medical curricula, workplace assessments and PMETB standards for postgraduate assessments. The new changes improve the utility of Station 5, the method of assessment and the means by which a pass:fail standard is set, and ensure that the examination maps clearly to the new curricula, is complementary to workplace assessments and meets PMETB standards.

What are the aims of the changes?

There are three key aims. Firstly, to redefine the clinical skills assessed in the examination and focus examiners and candidates on the assessment and demonstration of these skills. Secondly, to relate what is assessed in PACES explicitly to the new curricula and ensure that the information regarding trainees that PACES provides is complementary to that provided by workplace assessments. Thirdly, to further enhance the fairness of the method by which candidates are assessed and the pass standard set.

When are the changes being introduced?

The format of the examination changes in the third diet of 2009 (2009/3) with the introduction of the new mark sheets and the restructured Station 5. The pass:fail standard setting methodology will change in a staged manner, described in a later section.

Does this effect the positioning of the PACES examination in training?

The changes to PACES have no direct effect on the positioning of the examination in UK postgraduate training or on the rules regarding eligibility to sit, which can be found on the MRCP(UK) website.

What doesn't change in the examination?

Many elements of the examination do not change. Examiners continue to work in pairs, calibrating in detail before assessing candidates and marking each candidate independently. The content of Stations 1, 2, 3 and 4 is unaltered, as is the overall duration of the examination (125 minutes). Assessment continues to be based on observation of the candidate-patient interaction, followed by a discussion of methods, findings, diagnoses and management. Importantly, the overall standard of the examination does not change – examiners will not change the overall level at which they pitch their assessment of candidates.

What differences will candidates notice?

The only visible difference to candidates who have sat the examination previously is in the structure of Station 5. They will need to ensure that they are familiar with the new format and a substantial amount of explanatory material, including a new candidates' video is available for them.

After the examination failing candidates will notice that feedback on their performance is provided in a different and more detailed manner.

STATION 5

What happens in the new Station 5?

In the new Station, which is called Integrated Clinical Assessment, there will be two encounters, each known as a Brief Clinical Consultation, and each lasting ten minutes. These two encounters replace the current station five format of four five-minute encounters.

What is expected in these encounters?

For the first time in PACES candidates are asked to show how they integrate history taking and examination to solve a clinical problem.

What kinds of clinical problems will be set in these encounters?

The problems could relate to in-patients or out-patients and cover a wide range of symptoms and systems. For example – you are asked to see a 55 year old man with a community acquired pneumonia on day three of his admission because he has developed diarrhoea. What questions would you ask? What parts of the examination would be important?

Candidates should refer to the “Top Twenty” symptoms in the new curricula (see JRCPTB website - http://www.jrcptb.org.uk/Specialty/Documents/2009%20GIM%20curriculum.PDF) as some of these symptoms will form the basis of the encounter.

A key factor for all encounters is that they will pose problems that will be possible for a competent candidate to undertake in 8 minutes - the time available with the patient.

How will the new Station 5 work?

When you arrive outside Station 5 you will be given two scenarios to read in the five minutes available. When the bell rings the examiners will take you to the case represented in the first scenario. You then have eight minutes with this patient, followed by two minutes discussing the case with one examiner. You will then be taken to the second case, where identical timings will apply, and the other examiner will take the lead.

Do I have to undertake history and examination in any particular order?

No. You can do history and examination in either order, or at the same time if you wish.

Do I need to complete a full history and examination in the time available?

No! It wouldn't be possible for anyone to do that in the available time. The examiners want you to show that you can think of - and ask - the most important questions to solve the problem that has been posed by the case, and think of -and undertake - the most important elements of the examination.

What else do I do apart from take a history and examination?

You must ensure that you explain your plan for any investigations and treatment to the patient and answer any questions that the patient asks you.

How long do I have with the examiners at Station 5.

You will have two minutes. You have the full eight minutes with the patient to ask what you want, examine what you want, explain things to the patient and answer their questions.

What will the examiners ask me?

They will focus on the assessment of two skills (see below) – differential diagnosis and identifying physical signs.

Has this been piloted?

Yes - there were four pilots of the new Station 5. Candidates generally liked the encounters and felt that they were more “real life” than current Station 5 encounters.

Will Station 5 continue to include just rheumatology, dermatology, endocrinology and ophthalmology?

No. The system content of Station 5 is not now limited to these four specialties.
You could see a patient with a problem related to another specialty such as elderly medicine or haematology or a problem that crosses specialty divides. You could also see a patient with a problem relating to one of the Station 1 or 3 specialties.

So I don’t need to practice opthalmoscopy anymore?

We would strongly recommend that all candidates still come prepared to use their ophthalmoscope. Although they will not always have to use one, when they do, it will be part of a more detailed assessment of a patient. The station will also be worth more marks than is currently the case. It will therefore be harder to get through the examination if you are incompetent in fundoscopy in the new examination than is currently the case.

What happens if the patient at the new Station 5 doesn’t speak English?

There will be an English speaking surrogate standing next to the bed. Regard this surrogate as if they are a relative or friend of the patient. They will know everything you need to know about the patient’s history and will also ask you the questions the patient would have asked if they could speak English. They will not be acting as translators between you and the patient, but simply interacting with you directly, so no time will be lost.

What if I want to check the blood pressure?

Say that to the examiners and they will either tell you the value or show you the chart.

If the encounter was with a real life in-patient I would be able to see the drug cardex or observation charts. Will they be available?

If your Station 5 encounter is set in an in-patient setting and you feel that a drug chart or observation chart review would help, then ask to see them. If they are available the examiners will show you them, if they are not, they will give you credit for asking.

Will all the patients at new Station 5 have abnormal physical signs?

No. Just as in real life consultations, there may be no abnormal physical signs to find. If you find no abnormal signs say so!

PASSING THE EXAMINATION

The new format of the examination also includes changes to the way examiners assess candidates and the way that the pass mark is set.

How will the examiners assess me?

The examiners will be looking at your performance in seven “core clinical skills”. These skills are described below and are very similar to the skills traditionally assessed in PACES – take time to familiarise yourself with them.

Seven Clinical Skills in the PACES examination		
	Clinical Skill	Skill Descriptor
A	**Physical Examination**	Demonstrate correct, thorough, systematic, (or focused in Station 5 encounters), appropriate, fluent, and professional technique of physical examination.
B	**Identifying Physical Signs**	Identify physical signs correctly, and not find physical signs that are not present.
C	**Clinical Communication**	Elicit a clinical history relevant to the patient's complaints, in a systematic, thorough (or focussed in Station 5 encounters), fluent and professional manner. Explain relevant clinical information in an accurate, clear, structured, comprehensive, fluent and professional manner.
D	**Differential Diagnosis**	Create a sensible differential diagnosis for a patient that the candidate has personally clinically assessed.
E	**Clinical Judgement**	Select or negotiate a sensible and appropriate management plan for a patient, relative or clinical situation. Select appropriate investigations or treatments for a patient that the candidate has personally clinically assessed. Apply clinical knowledge, including knowledge of law and ethics, to the case.
F	**Managing Patients' Concerns**	Seek, detect, acknowledge and address patients' or relatives' concerns. Listen to a patient or relative, confirm their understanding of the matter under discussion and demonstrate empathy.
G	**Maintaining Patient Welfare**	Treat a patient or relative respectfully and sensitively and in a manner that ensures their comfort, safety and dignity.

Are all seven skills assessed at every encounter?

No. Different numbers and combinations of the skills are assessed at each encounter – again familiarise yourself with the skills assessed at each encounter from the table on the website.

Station	Encounter	Skills assessed
1	Respiratory	A:B:D:E:G
1	Abdominal	A:B:D:E:G
2	History Taking	C:D:E:F:G
3	Cardiovascular	A:B:D:E:G
3	Nervous System	A:B:D:E:G
4	Communication Skills	C:E:F:G
5	Brief Clinical Consultation 1	All seven
5	Brief Clinical Consultation 2	All seven

The mark sheets also summarise what is assessed at each encounter – again you can see these on the website (at http://www.mrcpuk.org/PACES/Pages/PacesMarkSheets.aspx) and you will have them with you as you go around the PACES carousel. You can check before you go into each Station the skills you are expected to demonstrate.

How will examiners assess each skill?

Examiners will help you to show what you can do and what you know, but the onus is on the candidate to demonstrate each of the skills at each encounter.

As an example consider Stations 1 and 3. The examiners have to assess you on five skills:

A Physical Examination
B Identifying Physical Signs
D Differential Diagnosis
E Clinical Judgement
G Maintaining Patient Welfare

10 minutes are available at the Station 1 and 3 encounters, a maximum of six with the patient and a minimum of four with the examiners. The examiner will assess A and G when you are examining the patient. They will assess B and D from what you present to them – they may have to clarify what signs you have found and what your differential diagnosis is by asking some questions. They will also need time to assess how you would investigate and manage the patient (Skill E). If you are slow or unclear in your presentation of signs and differential then this limits the time available to do this. If you run out of time and don't get asked questions on management you will not score any marks for that skill. Practice presenting findings before the examination itself – this will allow you to be able to progress to a discussion of management and gain marks from the examiners in that domain.

How do examiners grade my performance on each skill?

Examiners use a simple three point scale and each marks you independently, without discussion with their co-examiner. They can decide your performance in a skill was Satisfactory (worth 2 marks), Borderline (worth 1 mark) or Unsatisfactory (worth 0 marks). If you don't demonstrate a skill at all, that counts as Unsatisfactory.

How do examiners set the standard for each case?

Examiners set the standard in a process called calibration. Before each cycle of PACES starts, each examiner pair personally assesses the patient or surrogate. They agree what physical signs can be found, and what important aspects of communication, investigation and treatment would be. Examiners record their agreed criteria for each skill on calibration sheets, and use them to judge each candidate they subsequently assess.

How do I pass the examination?

To pass a candidate must accumulate enough marks from the various skill judgements that are made in the eight encounters that make up the PACES carousel. A total of 86 judgements are made by the examiners about each candidate in these eight encounters. The total number of marks available will be 172,and the range of possible scores 0 to 172. The pass mark will be in a range proportionate to the current PACES pass mark of 41/56.

Can any other issues lead to a fail?

Yes. In the current examination a candidate can be failed if they are judged by two examiners to have caused a patient physical or emotional discomfort. This has been known as "roughness". Very few candidates fail because of this rule. In the new marking system, "roughness" is assessed in Skill G – Maintaining Patient Welfare. If two examiners score Unsatisfactory for that skill (meaning that the mark for the Skill will be 28 out of 32 or less) then it is likely that the candidate will fail the examination overall, irrespective of their total test score.

Is this marking system likely to change?

One aim of the changes to the examination is to ensure that candidates who pass, achieve an acceptable standard in all the seven skills that are assessed.

When the examination is introduced in October 2009 candidates who achieve a total score over the pass mark will pass, provided they also score more than 28 for Skill G as described above. In late 2010, MRCP(UK) will announce the minimum scores that must be attained in each of the other skills in order to pass.

What is the standard required of candidates?

Examiners will pitch the level of their assessment of each skill at the standard required of a trainee who is ready to exit from core medical training and enter higher specialty training. Examiners will ask themselves "Is this candidate demonstrating this skill at the level required to be Receiving Medical Officer for the Acute Medical take?"

Will the new form of the examination be any easier or harder to pass?

There is no intention to make the examination any harder or easier. As noted above, examiners will still pitch their assessment at the same level as is currently the case. The Station 5 changes broaden the cases that can be encountered, but allows assessment in a model that is more like real life practice than is currently the case.

OTHER ISSUES

Are there any differences in the structure of the examination in overseas centres?

It is important that the examination is set at the same standard and has the same structure at all centres in the world. Visiting teams of examiners from the UK help to ensure that this is the case. Local patients will continue to be recruited to reflect the local prevalence of disease in each overseas centre and English speaking surrogates will be used at Station 5 if the patient cannot speak English.

Are there any advantages to candidates as a result of these changes?

Yes. We hope that the new marking system, based clearly on seven skills, allows candidates to understand exactly what they are being assessed on, and exactly what they must do to pass the examination. In addition, feedback to candidates who do not pass will be enhanced, as candidates will now find it easy to see not just how they performed at each Station, but also how they performed in each of the seven clinical skills. This should help candidates to improve performance for their next sitting.

Where is ethical knowledge assessed?

Ethical knowledge is one component of clinical knowledge, and a candidate's ability to apply clinical knowledge to a particular case is assessed in Skill E – Clinical Judgement.

Skill F – Managing Patient Concerns – may also require the candidate to apply ethical principles if a satisfactory outcome is to be achieved in the clinical scenario posed.