

Cragg Ross Dawson

**MRCP(UK)**

**Qualitative research on  
perceptions of the exam  
among stakeholders**

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## A. SUMMARY

### 1. **Objectives and sample**

1.1 CRD were commissioned to conduct qualitative research among key stakeholders to explore their perceptions of the MRCP(UK) diploma, focusing on its overall reputation and on specific issues to do with its content, structure, timing and fees.

1.2 We conducted focus groups and depth interviews with junior doctors, clinical and educational supervisors, hospital clinical and medical directors, national clinical directors, training programme directors, postgraduate deans and professional body education directors.

### 2. **Contextual issues**

2.1 Postgraduate medical training was largely well regarded, but there were concerns that though it is now more structured and organised than it used to be, it demands specialisation earlier, and that this impacts on junior doctors' competence in general medicine.

2.2 Those in senior positions believed that as a result of this, of the effects of the European Working Time Directive, and of increased anxiety about patient safety, junior doctors lack the general skills they would have had at the same point in the past, and so are less competent, though no less bright or enthusiastic.

2.3 Junior doctors themselves were aware that they did not have the same level of experience as junior doctors in the past and put this down to changes in training and fewer opportunities to carry out procedures.

2.4 In relation to their training, junior doctors felt they received less input from educational and clinical supervisors than they wanted, particularly in relation to exams and workplace-based assessments. Some also felt their hospital trusts did not give them the support around training that they needed.

2.5 Everyone regarded exams as an essential means of measuring and monitoring junior doctors' knowledge and abilities, alongside other elements of their training.

2.6 Workplace-based assessments attracted some criticism: the idea and the intention was sound, but they were rarely done with any depth or detail and were not taken as seriously as they should be.

### 3. **MRCP(UK) overall**

3.1 The MRCP(UK) exam had a good reputation: it was seen as a reliable benchmark against which to assess junior doctors' basic competence and their fitness to go onto specialty training. It had status and prestige, and passing it gave junior doctors a strong sense of achievement.

3.3 As a whole the exam was seen as having a high academic standard: it was difficult and demanding to pass, but appropriately so. There was no appetite for it to be made easier.

3.4 The exam was believed to help increase junior doctors' knowledge and skills through providing motivation for learning. In this way, indirectly, it contributed to increased quality of patient care.

3.5 However it was seen more as an *entry* exam than an *exit* exam: passing it indicated that a junior doctor was now ready to enter specialty training but not necessarily that they were fit to practise unsupervised. This point would come only when he or she became a consultant.

3.5 There was no sense that the apparent decline in junior doctors' competence perceived by those in senior positions was related to the MRCP(UK) exam. Rather, this change was almost entirely a consequence of changes in the structure of training, and junior doctors' working hours.

3.6 In practical terms the exam was widely seen as broadly fair and consistent in the way it is assessed, well run and managed, and overall as fit for purpose.

### 4. **MRCP(UK) – specific issues**

4.1 Most stakeholders felt that the exam has largely stayed relevant and up to date, and that MRCP is proactive in making sure this happens. There were two broad qualifications to this general view.

- 4.2 Part 1 prompted complaints from junior doctors that its content is obscure, irrelevant and remote from day-to-day work now or in the future; they queried its place in the exam; some supervisors had sympathy with this. In comparison Part 2 was directly linked to clinical work and was thought valid as a test of applicable knowledge.
- 4.3 Some supervisors felt that the exam as a whole lagged behind changes in medical procedure a little, and did not address current issues facing the NHS, including the move towards integrated care. This could make it seem a little out of touch.
- 4.4 PACES was the most high profile part of the exam; it prompted more comment and debate than the other Parts and for some it defined the exam.
- 4.5 Though PACES was not thought a comprehensive test of practical abilities, it was generally believed to be as close to the real world as it is possible to make an exam that relies on real patients, and to be essential as a gauge of junior doctors' skills.
- 4.6 PACES was thought to cover a reasonable range of issues, given the limitations imposed by its format, and to be set at about the right level of difficulty.
- 4.7 It was regarded as largely fair, though some junior doctors believed it can be easier to pass in some parts of the country than others.
- 4.8 A minority of junior doctors from ethnic minorities complained that people who do not have English as a first language can be disadvantaged in PACES, because they inherently lack the communication skills of other candidates.
- 4.9 Station 5 attracted widespread comment, most of it favourable. It was welcomed for allowing junior doctors to talk to a patient, unlike the other stations, and so felt closer to the 'real' patient experience. Some saw it as a sign of MRCP(UK) moving with the times.
- 4.10 Hosting and organising PACES was seen as demanding and stressful, especially finding suitable patients available on the day.

- 4.11 Some who had been involved in hosting PACES felt MRCP(UK) does not provide enough support to hospitals and individuals in putting on the exam, given what it seems to expect from them.
- 4.12 The timing of the exam concerned some supervisors, TPDs and PG deans: they felt there is pressure on junior doctors to cram it in by the end of the 4<sup>th</sup> year. This could mean that if they failed a part they had difficulty finding a post before they completed it and could move into specialty training.
- 4.13 MRCP(UK) fees attracted strong complaints from junior doctors, echoed by some others, given the other expenditure they have to commit to the exam and given how much free help is provided by hosts and organisers.
- 4.14 MRCP(UK) was generally seen as part of the Royal College (respondents tended to refer to it as this and did not distinguish between the different Colleges), and not as a separate body with its own identity.
- 4.15 Most respondents had a vague impression that people or a department running the exam division existed among the three Colleges, but they did not distinguish this from the Colleges.
- 4.16 A better informed minority had been involved in PACES or in setting questions for one of the written papers, or had close contact with one of the Colleges and saw MRCP(UK) as distinct from the Colleges.

## B. BACKGROUND AND OBJECTIVES

### 1. **Background**

MRCP(UK) commissioned CRD to conduct research into perceptions of its diploma among junior doctors (junior doctors at ST3 level and above), clinical and educational supervisors and other in hospital trusts and national roles.

The Federation of Royal Colleges of Physicians (RCP) comprises the Royal College of Physicians of Edinburgh, the Royal College of Physicians of Glasgow and the Royal College of Physicians of London. The three Royal Colleges of Physicians share a common membership examination in general medicine: the examination for the Diploma of Membership of the Royal Colleges of Physicians of the United Kingdom. Successful candidates are eligible to apply for the award of the MRCP(UK) Diploma.

The MRCP(UK) is a postgraduate entry exam which provides valid, reliable evidence of attainment in knowledge, clinical skills and behaviour. It is a mandatory component of assessment for Core Medical Training (CMT).

The exam comprises three main parts, which MRCP recommends are taken as follows:

- Part 1 written - 1-2 years after graduation
- Part 2 written - up to 3 years after graduation
- Practical Assessment of Clinical Examination Skills (PACES) - 3 years or more after graduation, and after passing the Part 2 written exam

Typically a junior doctor can take the first part of the exam in Foundation Year 2 (FY2), and at the latest is expected to have passed this by the middle of his or her Core Medical Training. The remaining parts are normally completed by the end of CMT and before the start of specialty training at ST3 stage. This timing reflects a fairly recent change to the exam: in the past it could be done over a seven year period; it is now expected to be completed within three years.

In order to keep the exam relevant and up to date, the RCP needs to demonstrate to the General Medical Council, which regulates doctors, that the exam is capable of meeting current needs and standards that apply not only to junior doctors but also to hospitals and patients.

An e-survey was carried out among training programme directors in 2012 to examine perceptions of the MRCP(UK) exam and follow up anecdotal evidence of concerns that have been raised about aspects of it. The results suggested that there is general confidence in the exam and the standards it sets, but also showed that there are reservations about levels of competence and confidence among junior doctors.

## 2. **Research objectives**

The overall aim of the research was to explore and establish the reputation of the MRCP(UK) diploma among junior doctors and their peers. Specifically the research explored...

- overall attitudes to the exam among the main stakeholders
- perceptions of its strengths and weaknesses, perceived purpose, fit with postgraduate training, academic level, standards
- views of the PACES part of the exam from the point of view of junior doctors taking it and hospitals hosting it
- feelings about the timing of the exam and the number of times junior doctors are allowed to take it
- attitudes to the fees charged for the exam
- knowledge of and attitudes to MRCP(UK) as a body
- the context of junior doctors' training, and junior doctors' levels of competence and confidence

## C. METHODOLOGY AND FIELDWORK

### 1. **Methodology**

We conducted 5 focus groups, 47 individual interviews and 1 paired interview. Most of the fieldwork was conducted face to face; 6 of the interviews were conducted by telephone, where respondents who were located in the north England, Scotland or Wales were not available on days when we were in those areas.

Groups and interviews followed a structure and question format agreed with MRCP(UK) in advance and outlined in the topic guides appended to this report. As is the nature of qualitative research, they were discursive and took in issues that respondents wanted to discuss as well as those covered in the guides. Groups lasted between 60 and 90 minutes, interviews typically 50-60 minutes.

The groups and face-to-face interviews were conducted in London, Kent, Hertfordshire, Cardiff, Birmingham, Edinburgh and Falkirk. Telephone interviews were conducted with respondents in Cardiff, Durham, Newcastle and Glasgow. They took place in May, June and July 2013. The researchers were Tim Porter and Alice Bearn.

Respondents were recruited from lists provided by MRCP(UK), in some cases with the help of individuals in hospital trusts.

### 2. **Sample**

The sample was configured as follows

- Junior doctors:
  - 5 focus groups; 6 individual interviews
  - all at ST3, ST4, ST5 or ST6 level
- Clinical supervisors:
  - 12 individual interviews
  - range of specialties represented

- Educational supervisors:
  - 11 individual interviews; 1 paired interview
  - range of specialties represented
- Training programme directors: 6 individual interviews
- Hospital clinical directors: 2 individual interviews
- Hospital medical directors: 1 individual interview
- National clinical directors: 2 individual interviews
- Postgraduate deans: 4 individual interviews
- Professional body education directors: 3 individual interviews

### 3. **Notes on the research and this report**

This was qualitative research. Numbers in the sample are relatively small and the findings cannot be regarded as statistically valid. Nevertheless the consistency and patterns of findings give us confidence that they reflect opinion at the wider level.

All respondents were promised confidentiality. Attributions of verbatim quotes in the report are designed to show what perspective respondents had on the issues without identifying them.

Four of the training programme directors we interviewed had taken part in the MRCP(UK) pilot e-survey last year.

We use the term *junior doctors* in the report, though often our respondents preferred trainees. Everyone regarded them as meaning one and the same thing: postgraduates at ST3 level or above who is not (yet) a consultant.

## D. DETAILED FINDINGS

### 1. **Contextual points**

#### 1.1 The role of junior doctors

Junior doctors' role was invariably described as covering two distinct components: training and providing a service. Perceptions and experience of how these they interacted varied, but there were consistencies in the way people viewed them.

Most of those other than junior doctors themselves regarded the role as primarily one of training, which effectively had to be paid for by junior doctors providing a service. Some younger supervisors who had been through training relatively recently believed junior doctors were expected first to provide a service, and to fit in training round this. If this was the case they felt that service demands on junior doctors were too high, and interfered with training.

*"There's two roles. The most significant role is learning. Their main job is to get trained to achieve a position of competence where they can then go on to either sub specialist training or generalist training. In addition to that they clearly do important service delivery which is ingrained into that training."*

Clinical Supervisor Wales

Junior doctors themselves reflected this mix of views. Some felt they were expected primarily to work and to fit training in when they could. They felt they were doing much of the service provision in hospitals, they found it hard to make time for training and revising and they resented this. In a few instances they had encountered difficulties getting time off to take exams.

*"I feel like a service provider, not a trainee. I've not been trained. I've just had good experience."*

Junior doctor South East

*"We're service providers. And we do supervision of juniors, making sure that the ward runs smoothly, helping the bosses out in the clinics, facilitating patients' journeys by booking the tests, getting them on, following them up."*

Junior doctor London

Others thought their main role was training and that service provision was an important but subservient role. Their experience was that

hospitals were accommodating of their training needs: training was highly structured, study leave was available and was ring-fenced by the Trust for their benefit.

*“It used to have a bad reputation here but we now have a nice agreement where the clinical fellows and the research fellows will cover the services that need to be provided for the inpatients, they’ll carry the on call bleep for those days so that we can go to the training.”*

Junior doctor London

Irrespective of how the two parts of the role were prioritised, at all levels there was awareness and experience of tensions between training and service provision. Everyone knew that the balance between maintaining standards and the need to produce enough doctors to run the NHS is tricky to achieve. There was no easy solution to this: it tended to be regarded as a consequence of pressure on the NHS to meet rising needs at a time of funding cuts, and ultimately to be a political issue.

*“I think it’s a tricky balance between service and training...I think sometimes some of the junior doctors underestimate the importance of learning their job through working.”*

Junior doctor Wales

The impression was that larger and teaching hospitals were more accepting of training needs and put less pressure on them to provide a service. Teaching hospitals, by their nature, were also believed to be more geared to training and to have more of a training ethos. Experiences district of general hospitals were more mixed, but some junior doctors had been in DGHs which they felt had had a positive approach to training. Some said that differences were more closely linked to the attitude and interest of supervisors than the approach of hospitals.

## 1.2 Postgraduate training

### 1.2.1 *Mixed views on quality of training*

Perceptions of the quality of postgraduate training differed between different supervisors, between supervisors and others, and between junior doctors and supervisors, but again there were patterns in the feedback on this issue.

As with views on the role of junior doctors, perceptions were generally more positive among supervisors and those at higher levels than among junior doctors. Those with the most favourable views were postgraduate deans, TPDs and some clinical supervisors.

Positively, most believed that training is more structured than it was in the past. The impression was that deaneries help impose a framework for training and give it a degree of transparency: junior doctors have an idea of how their training will be done; and hospitals understand what training demands there will be on junior doctors.

In terms of organisation most respondents felt that there is now more formal training available, and that in most cases it is at least reasonably well organised. Those at TPD, Postgraduate Dean and clinical director level believed that junior doctors generally have access to high quality training input, from supervisors and from outside sources.

*“The process of the training may well be more effective in that programmes are planned more carefully so we place doctors where we think they need to be to get the experience so the whole programme is carefully mapped out to make sure they get this amount of experience in this post and this amount of experience in that post so they can cover the curriculum. We have much closer clinical supervision and we have educational supervision and we assess them so in that sense it is much better.”*

Postgraduate Dean

*“In the past people went through their training as an experiential type of thing. If you were a good chap and had done most of the things you'd come out with your ticket. You couldn't guarantee the ticket in Edinburgh would be the same as in Devon or Cornwall or London. We have a uniform standard of training now.”*

Postgraduate Dean

Against this, many clinical and educational supervisors expressed concerns about postgraduate training. They felt that for various reasons junior doctors have less opportunity for experiential, on-the-job training, and so miss out on important learning that they would have received in the past. This was principally because junior doctors work fewer hours now, and so spend less time on wards, but other factors also played a part (see below).

*“All this drive to reduce working hours and increase protected time off for training, it has all served not just reduce to people's experience at the coal face which does have its*

*benefits, but I think to also to drive down levels of professionalism and responsibility.”*

Educational Supervisor London

Junior doctors themselves were generally less sanguine about their training, and often expressed dissatisfaction and resentment about aspects of it. In most cases their experience was that training is inconsistent and even haphazard in its provision, and variable in quality. Some complained that their training was not always supported by trusts or by consultants/supervisors, who gave them limited support and who did not make it easy for them to get study leave. A few said they had had to miss training to meet their work responsibilities, and that if this happened they received negative feedback in their APRC.

*“I don’t think we get the support we need. You never know when you can get off to do training stuff, it’s not well organised.”*

Junior doctor London

*“Unfortunately not all of them are that keen on teaching and some of the hospitals are more concerned with service provision than satisfying training needs.”*

Junior doctor South East

*“In terms of formal teaching they [supervisors] don’t really have the time any more than we do”*

Junior doctor South East

There were also more positive experiences. In some cases they had simply accepted that they were not going to get much input from consultants and would have to be proactive in organising their training. If this were the case they would deal with it.

*“I’ve been quite satisfied with my training. There have been times when I’ve been anxious about parts of it but...then it’s down to you to try and sort it out. You have to be motivated to help yourself, whereas I think there’s a lot of ‘Well the system let me down...’.”*

Junior doctor Scotland

Nevertheless junior doctors detected an ambivalence in the system towards training. Their impression was that though it is regarded as essential in helping the NHS and the country produce enough able doctors, and is vital in equipping doctors with necessary skills, it is largely left to junior doctors themselves to organise and see it through.

Junior doctors often compared their training with that of peers and friends in other professions, who they believed received much fuller

support and encouragement. Their perception and experience was very different: they had to be proactive and self sufficient with their training in a way that was not evident in other fields.

### 1.2.2 EWTD and loss of teams

The European Working Time Directive (EWTD) was regarded as a major factor in junior doctors' training, as a direct consequence of its limiting the hours they could work. Many supervisors and others felt that postgraduate training had suffered because the EWTD meant junior doctors now worked fewer hours.

Though the reasons behind this were well understood, and though the general feeling was that in principle it has been good to get away from the extremely long hours worked by junior doctors in the past, it was undeniable that it reduced the time they had for training. Specifically it resulted in junior doctors having less time to fulfil their joint training and service provision roles.

This in turn meant that junior doctors' time for experiential learning was reduced. Their rotas were shorter, they had less patient contact than in the past and they rarely had time to see a patient through from admission to hospital to treatment and then to discharge. This gave them less experience of the patient pathway and so made their training less complete.

*"Us older people remember the days when we worked 110 hours a week. If you had to ask me 'Would you go back and do all of that again?' the answer is 'yes'. It's bloody hard work when you're doing it but you gain so much clinical experience but working all those hours that I'd feel much less secure as a good physician if I was doing the training now than when I trained however many years ago."*

TPD

*"I'm sure you've heard lots of consultants moan about the hours spent at the clinical coalface which has gone down in the last twenty years because of the impact of the European Working Time Directive. Inescapably, the more clinical experience and exposure you have the better you are. So clearly in year X as a registrar today, compared to twenty years ago, people have less clinical experience."*

National Clinical Director

Another feature of reduced time for junior doctors was that teams on wards are less tight-knit than in the past because their members

(consultants, junior doctors at different levels) spend less time together. A consequence of this was that consultants have less chance to observe junior doctors at work and so are less able to get a sense of how good they are. At the same time they are less able to give junior doctors input.

*“Compared to the training that I received a few years ago the continuity in training has been lost because of the fragmentation, because of the European Working Time Directives. Our team based approach has been lost for a ward based approach.”*

Educational Supervisor Wales

*“In the old days we used to have something called firms. When you were a junior doctor and got a job you'd be attached to a consultant and you'd work with that consultant and his registrar and the houseman and you'd always be together and when you did the on-call, you always did the on-call as your team. Now doctors work much more in shifts so you could be put on a shift where you work with a consultant, you have a registrar from another – there is a sense of dislocation, not belonging any more.”*

Postgraduate Dean

Some supervisors saw a benefit of reduced hours for junior doctors: hours on were more intense and junior doctors did more, so they learned more and got more out of training.

### 1.2.3 Concerns about patient safety

Many respondents also raised the issue of patient safety and its impact on the type of training junior doctors are able to do, particularly the breadth of experience they can acquire. Hospital management, driven by political need, expected consultants to carry out many procedures, in order to minimise the risk of anything going wrong.

In the past junior doctors had been able to build up their experience effectively by practising procedures on patients. There was much less opportunity to this if many procedures were expected to be done by consultants. It also meant that consultants had less chance to see junior doctors trying the procedures. Procedures mentioned in this context were putting in central lines, lumbar punctures and chest drains.

*“I think they are probably not as competent doing procedures as they used to be but I think that has probably been deliberate in terms of the governance structure of the NHS*

*that says that the idea that you'll be a bit of a jack of all trades is perhaps much less acceptable now."*

Educational Supervisor Wales

*"In the past a lot of junior doctors would be able to insert a sort of central venous line by the time they're sort of registrar equivalent or ST3 or 4 equivalent, but that's now much more the role of critical care. Until they do their critical care attachment they don't have those skills. So some of the skills are lacking and they have a reduced opportunity to do some of those skills because of the increasing sort of sub specialisation that's occurring."*

Educational supervisor Scotland

Another issue came up in this context among a few junior doctors: they said that they are no longer allowed to visit other hospitals as part of their training, for reasons to do with patient safety. This reduced the opportunity for broadening their experience of conditions they did not encounter in their own hospitals.

#### 1.2.4 *Shift from general to specialty training earlier*

At all levels above junior doctor, concerns were raised about the current structure and format of postgraduate medical training. There was a widespread impression that a structural change had taken place which had resulted in a move to specialty training earlier in a junior doctor's career, with a consequent loss of emphasis on general medicine training.

The reasons for this were perceived as closely tied up with changes in the NHS, and particularly the need for more specialist consultants, driven by demand for specialist service provision. They were also believed to be driven by bigger hospitals with a wide range of specialist departments which could handle any specialist need and did not require much generalist capability.

*"In the early 1990s you could sit in general roles, general medicine with a bit of diabetes and gastro and cardiology for a year. Even at registrar level you could sample different specialities before committing to your decision. Now you almost have to decide immediately and just get on and do it whereas there was the opportunity to sit back, even at registrar level."*

National Clinical Director

*"Now there are some hospitals, particularly the bigger London hospitals and places like Oxford and Cambridge, they feel that their junior doctors do not need to have*

*experience of doing all these procedures because they're all done by other departments within their hospital."*

TPD

Though this change was understood, for many at senior levels it has not been a good thing for postgraduate training, for several reasons. It has meant that junior doctors have less time for general medicine training and so have less all-round experience than they would have had in the past. It has come to mean that generalist skills are not sufficiently valued: the goal as communicated to junior doctors is to prioritise specialisation. Some junior doctors echoed this concern and felt unsure of the expectations on them in relation to specialising.

*"The whole restructuring of the training was originally driven by government. They wanted to try and get junior doctors through the system quicker so they could expand the consultant body. The downside of that is you end up with a load of consultants who are very much less experienced than people were ten years ago."*

TPD

*"I think we need more people in the workplace doing the general medicine."*

National Clinical Director

*"I think people want to get specialists out of the sausage grinder in order to provide a service and you wonder whether the aim of the training is to create specialists who can provide a service or to create consultants."*

Junior doctors London

At a more specific level it has meant that junior doctors are not encouraged to think around subjects in their training; if they encounter a patient whose condition is not immediately clear to them they seek a specialist diagnosis and treatment rather than consider it from a general point of view. Also it meant that procedures needed in specialties were now not always covered in general training: instead they were left until junior doctors did specialist training, later on, and had fewer opportunities to do and to practice common medical procedures during core medical training.

The consequence of this was that junior doctors had less experience of carrying out procedures, were less able to do them without supervision and so relied more on consultants. This resulted in consultants feeling under pressure either to carry out procedures themselves or supervise junior doctors doing them.

### 1.2.5 *Differences between hospitals and regions*

Two differences between hospitals in terms of their need for specialist and general staff were apparent, but we did not visit enough hospitals for these to be regarded as definitive, or as indicative of a general pattern.

There was some feeling among supervisors and TPDs that district general hospitals can suffer through having fewer specialty staff than teaching and specialist hospitals. If DGHs have fewer specialists they need general physicians to be more competent in more things because they cannot assume there is a specialist on hand to help out. This was not universal: certain DGHs were known to have good training in all fields, and to be committed to training.

*“The teaching hospitals have often been able to provide more exposure to the rarer sides of speciality work. That is what they can provide that district general hospitals don’t.”*

National Clinical Director

Several supervisors, TPDs and junior doctors believed that postgraduate teaching in Scotland is better organised and more rigorously done than in England. This was an opinion, and cannot be seen as fact, but given that it came up, often unprompted, from a number of people in different hospitals, it is worth noting.

We also had the impression that junior doctors in part of the South East of England received less training input, and were noticeably less happy with their training, than those elsewhere. They were more concerned about the demands on their time for service provision, and about the attitude of Trusts towards them doing training, than junior doctors in other parts of the country.

### 1.2.6 *The role of supervisors in training: limited*

Educational and clinical supervisors varied widely in their approach to postgraduate training. Some were enthusiastic and involved, and appeared to give it plenty of time and attention. They set aside time for formal and informal training and tried to make themselves available to provide help when needed. This extended to offering guidance specifically on the MRCP(UK) exam, and particularly on PACES. Typically they were younger and had become consultants within the

last five years. Partly as a consequence of their younger years they were sometimes better informed about the exam than others and better able to advise on it.

Other supervisors seemed less involved in junior doctors' training and generally more distant in their dealings with them. Some appeared not to know much about the specifics of the exam, nor able to give much in the way of tailored guidance on it. Impressionistically these were older consultants who had taken the exam at least ten years ago, often longer, and acknowledged that it had changed substantially since their day.

*"Teaching is not designed for the exam, more for clinical practice. But we know they have to take the exam, we encourage them to take it."*

Educational Supervisor Scotland

*"I would only be supporting that (the MRCP) insofar as providing teaching which I did quite a lot of, generally when I'm actually on the ward...but beyond that no."*

Educational Supervisor South East

Junior doctors themselves largely reflected this division. They felt that the quality of training they received varied significantly depending on the consultants they were working with. In their experience a few were willing to put in extra work to help them, by giving them advice on topics that might come up or, in a few cases, holding out of hours PACES preparation sessions. Against this, many junior doctors felt that their supervisors had little interest in teaching and did not give it much time or attention. Some said their supervisors knew little about the MRCP(UK) exam, particularly if they were older and had taken it a long time in the past.

*"I think they knew I was taking the exam but because of lack of interest or whatever it didn't happen. But there are some consultants who are former PACES examiners, who are very keen to teach."*

Junior doctor South East

*"How many people can say that that there's somebody who knows me well and knows my flaws as well as my positives and can tell me where I can develop? It's a really hard thing for junior doctors to find somebody who knows them like that."*

Junior doctor Scotland

Junior doctors were aware in broad terms of the changes in training structure and the increased demands being made of consultants. They knew that many consultants had more to do, as a consequence of changes in their contracts, and that trust management expects them to take on additional work for little or no reward. Not only did this impact on the time they had available for training, it made some of them resentful about the demands on their time and less willing to put themselves out.

A few junior doctors gave the impression that there was a direct link between these changes and consultants' diminishing willingness to put time into non-core work such as training and giving guidance on the MRCP(UK) exam. They believed that consultants' goodwill has been undermined by the growing demands placed on them by the government, the NHS and trust management and that they are now less happy to help in areas that are not central to their consultant role.

*"It'll be very interesting in the next few years to see how it all pans out because all of these incentives are sort of being eroded and you just wonder how long people will keep giving up their time to examine, to train and to organise when actually those incentives are largely gone.*

Junior doctor Scotland

Few supervisors acknowledged this openly, but some clearly felt that they had more responsibilities on them than in the past. And a few said they had taken on their supervisor role by default, effectively inheriting it from predecessors. Since they had not chosen it they did not feel committed to it.

*"(On teaching) It's quite a high priority for me and I do try and adhere to it but it's going to be the first thing to go under any kind of pressure because it is fundamentally in the short term dispensable."*

Educational Supervisor South East

One other factor was raised in relation to supervisors' input into training: the need to complete workplace-based assessments for their junior doctors. Workplace-based assessments attracted much criticism (see below). In addition to specific concerns about them there were complaints that they took up too much of consultants' time, and they made consultants less inclined to put time into bedside teaching and out of hours teaching than in the past.

### 1.3 Exams: essential component of training

Everyone regarded exams as an essential component of learning and training for junior doctors. Junior doctors, perhaps predictably, were less enthusiastic about them than others, but they accepted that exams play a significant part in their training.

In principle exams were seen as having value in two ways. They were important as indicators of knowledge and ability: they provided a fairly reliable, transparent gauge of what junior doctors knew. Given that postgraduate junior doctors have already taken numerous exams to get to where they are, and should by now be used to taking them, the feeling was that exams should work to show how knowledgeable junior doctors are.

Exams were also thought to provide motivation to learn. Since junior doctors needed to pass the relevant exams to progress in their careers, inevitably they had to learn as much as was required to achieve this. Preparation through revision helped instil the knowledge they needed.

*"I guess revising for any exam does improve knowledge. If you have to revise for any exam it somehow comes together so I think it does improve that ground knowledge. Not sure how much sticks and for how long but it does mean they've done the work."*

Clinical supervisor London

Everyone accepted that exams have limitations: they are a narrow test of knowledge, on the day, and do not necessarily indicate a candidate's all-round abilities. Related to this, some junior doctors and a few supervisors believed that exams do not account for and cannot test qualities such as interpersonal and communications skills, which are essential elements of being a good doctor.

*"The examination process is unrealistic – you are never going to see a patient without talking to them in real life and you will never see a patient in only four minutes"*

Junior doctor Birmingham

Some supervisors and junior doctors said they knew junior doctors who were good doctors at a particular level, and would be good enough to go on and become consultants, but were not good at exams and had trouble getting through MRCP(UK). They thought these junior doctors

would be a loss to the NHS if they did not complete training because they did not pass the exam.

#### 1.4 Workplace-based assessments: not well regarded

Almost everyone acknowledged that other inputs into training are important. Two stood out: experiential (on the job) training, discussed above, and workplace-based assessments.

Perceptions of workplace-based assessments were mixed but overall not highly favourable. The general view appeared to be that they were a sound idea in theory, and had been introduced with good intentions, but did not work well in practice.

Some of those at senior level regarded workplace-based assessments as an important means of gauging junior doctors' practical capabilities, alongside learning through exams. The assessments formalised the input they got from consultants. *If* consultants assessed and gave feedback on junior doctors' work in detail they could get a strong sense of how well junior doctors could perform specific tasks, and provide guidance where necessary.

This was a big *if*, and most junior doctors felt that their supervisors did not give them the detailed input they needed on their assessments. Instead supervisors seemed to pay them little attention and did not use them to tell junior doctors how they really performed. They characterised workplace-based assessments as box-ticking done by consultants who had no real interest in their training, and as open to manipulation by junior doctors.

*"I think the buy into them has not been sort of complete, yet they're compulsory and so everyone knows to a certain extent they're a bit of a game. They've become a bit of a box-ticking exercise."*

Junior doctor Scotland

*"Work based assessments aren't going to improve someone who is generally good and does generally well in their job. I think it might isolate people who are totally cack handed or totally inappropriate, but even then I know people who if you're half intelligent you're going to work the system. You'll only ask someone to do a work based assessment on you if you think that they are going to give you a reasonable response. So it's open to gaming."*

Junior doctor London

Some supervisors and others, particularly TPDs and Postgraduate Deans, echoed this view, though usually in less strong terms. They felt that too little time was available for proper implementation and use of workplace-based assessments, and that for all their good intentions, they did not fulfil their purpose.

*“The workplace based assessments are not delivering what we want them to. They are seen as burdensome, bureaucratic and ineffective at discriminating the average poor junior doctor from the average good Junior doctor... That's why, in a way, having MRCP as this high stakes examination to progress is very very important because the other assessments are not working.”*

Postgraduate Dean

### 1.5 Perceptions of junior doctors' competence: generally positive

We asked all respondents how they perceived the standard of current junior doctors' competence and confidence in clinical roles.

There was no real sense of a tangible drop in levels of junior doctors' overall ability in recent years. Many at Postgraduate Dean, clinical director and medical director level, and some TPDs and supervisors, said that their junior doctors (and their undergraduates) are still of exceptionally high calibre, and are confident and able.

*“I would say the majority of them are as good as you used to see before the system changed over the last fifteen or twenty years.”*

Postgraduate Dean

Where there were reservations these tended to be about junior doctors' competence in carrying out procedures *because they had had less experience* than they would have in the past, for the reasons described above, and did not reflect concerns about their about underlying ability.

Competence and confidence were seen as going hand in hand: the more competent a junior doctor felt, the more confident they were in their work; the more confident they were the better they did their job. On this point, exams played an important part: passing an exam, particularly MRCP(UK), gave a junior doctor a significant boost in confidence which rubbed off on his or her competence.

## 2. Overall perceptions of the MRCP(UK) exam

### 2.1 Overall impressions largely very positive

Almost all respondents felt that MRCP(UK) has a generally good or very good reputation, though many had a few reservations about it.

Across the sample the exam was believed to be well regarded. It commanded respect, and passing it lent a junior doctor kudos and a degree of status that he or she did not have before. Irrespective of the direction a junior doctor took later, having MRCP(UK) would always stand him or her in good stead. It was significant that many supervisors and others we spoke to seemed almost as pleased and proud to have passed the exam as junior doctors, even if this was ten years ago or more.

*"I know if someone has got the MRCP that they have gone through a certain rigour, a certain process and achieved a certain level of standard. Having done the MRCP myself I know the amount of effort you have to put in to get through the exam. Looking at the quality of the doctors who got through the exam you know that it is of a high standard so it gives you a lot of confidence."*

Clinical Supervisor Wales

*"I think it's regarded as an essential part of growing up to be a physician. It's still a very well respected exam."*

TPD

*"To my mind there is no noise around the MRCP. There is noise around some of the other Royal College exams but none about the MRCP. Everyone recognises it as a valid or well tested waypoint. Nobody challenges the legitimacy of it. Everyone accepts they need to go through it and is proud to have it as a qualification."*

Postgraduate dean

*"I think it's still a currency, a standard. People acknowledge you as someone who has passed the MRCP and it gives you a certain degree of kudos. Say you're a GP or someone who didn't have to do MRCP then you look on their name and they've got MRCP and that makes you think about them in a slightly different way."*

Junior doctor Scotland

*"You feel great when you've passed it. You feel you can do it."*

Junior doctor London

A number of junior doctors, supervisors, TPDs and others who had worked abroad or dealt with colleagues from other countries, or who

simply had travelled abroad, said that MRCP(UK) is highly regarded overseas. They felt that this enhanced its standing in the UK, and reinforced their own satisfaction at having passed it and at being involved in helping people prepare for it.

*"It's internationally respected. You meet a taxi driver in a foreign country and 'Oh you're a doctor. My daughter is training, she is going to do the MRCP.' That might be in any old place. You feel proud to be able to attach the label to your medical qualifications."*

Junior doctor London

*"It's very well regarded. Of all the college exams it is one of the ones that carry both UK and international reputations."*

Postgraduate Dean

Many supervisors and TPDs mentioned the short period a few years ago when MRCP(UK) was not required for entry to specialist training (run-through), and invariably saw this as a mistake. They felt that passing it demonstrated at least a basic knowledge which was essential in preparing for further training.

The impression was that anyone who has taken and passed the exam, and/or works with junior doctors who have, perceived it as having a clear trajectory through the three parts, from knowledge to practice. They saw Part 1 as strongly focused on theory and background knowledge (though there were reservations about this); Part 2 as much more about clinical practice orientated to day to day dealings with patients, but addressed in a written paper; and Part 3 (PACES) as the wholly practical component. This was seen as broadly logical.

Supervisors and above believed that MRCP(UK) has changed in recent years, largely for the better. Older respondents thought the changes were significant. Two features of the exam stood out. It was now known for being more mainstream in the conditions it covered: in the past it had been known for testing junior doctors on unusual, esoteric conditions and problems, which had generated some concerns and resentment.

*"Before the change 10-15 years ago you might be a good doctor but in fact had a bad day and got given three awful cases."*

Educational Supervisor SE

This tended to be seen as an outdated view, but a handful of people in senior posts had a lingering impression that it was still the case.

More generally the exam was seen as now more consistent and, implicitly, fairer. Some gave the impression that in the past getting through the exam had been at least partly based on 'a nod' from someone in the right place, and not necessarily related to merit. These days it was rigorously and impartially assessed.

*"I think with the change in the membership examination several years ago I think that was a good thing. It took some of the luck, the chance out of doing the examination, for the candidates. It formalised a procedure by which you evened out difficult cases, you evened out the difficult examiners."*

Educational supervisor Scotland

*"It's fairly structured marking. It's not like it was in the old days when if you had the right club tie on and you were able to give the right chat then you'd be OK. It's not like that any more."*

TPD

One clinical director wondered what NHS Trust management believe about MRCP(UK). In particular he was not sure, on the basis of conversations with managers, that they believe that doctors who have passed it are necessarily any better placed to improve the patient experience than those who have not. He had the impression that some managers believe the exam is too knowledge-based and not enough about practice.

Occasional comments were made that the exam as a whole leans towards the academic and theoretical, and away from the practical. Again it may well have been that this was a perception that lagged behind reality. Most respondents seemed to regard it as well balanced between the two.

## 2.2 It is perceived as an entry exam, not an exit exam

MRCP(UK) was typically characterised as either a gateway to further training and/or a hurdle to progress in a medical career. Perspectives on it varied according to experience of it but also by views of postgraduate medical training more generally.

*"It's definitely a hurdle. Gateway sounds welcoming."*

Junior doctor Scotland

*"It's an absolute necessity for further training."  
 "If you don't have it it's just a barrier to you progressing.  
 Without it you'd never move on."*

Junior doctor Scotland

Many supervisors and others at higher levels characterised and described MRCP(UK) as a gateway, but it was clearly more of a gateway *into* something than out of it. They saw it as an *entry exam and not an exit exam* (their words). They meant by this that it does not mark the end of a period of training on a particular topic or topics, nor confirm competence in specific areas, but that passing it allows entry to further (specialty) training.

*"MRCP, in my mind, was always the hurdle you have to jump over just to be allowed to train to be a specialist. Not to come out the other end."*

National Clinical Director

*"I think it's a basic test of knowledge. I don't think it's anything more than that. I couldn't look at it and say 'There's a really mature doctor who's ready to take on bigger roles.' It's just a test of knowledge. It allows you to apply for specialist training".*

Professional body

*"Its role is to prepare you for higher training. It is a waypoint in your journey through medical training to say that you can run a medical take. You have sufficient knowledge and skills to be able to build on that to become a better physician."*

Postgraduate Dean

*"I see it as the passport to higher training, very much so. You've gone through the early part of your training and this is the hurdle that then puts you into your speciality. It's not to make sure that somebody is capable of performing at level x y or z because I don't think it necessarily does that... It's to say 'OK you've got through your 11 plus now you can head towards your A levels'."*

Educational supervisor Scotland

In this way they regarded it as unlike specialty membership exams, which are, in their view, clearly exit exams. More specifically some believed that as a measure of competence it is a little less rigid than some exams in its standards, because it was not a marker of defined, specific abilities.

*"You don't have to be quite as strict as if it was an exit exam, from which you're letting people loose on the world, as it were."*

Professional body

Junior doctors invariably thought of passing MRCP(UK) as an essential stage in their career. It was a significant preoccupation during their training years, and passing it was an important milestone. Invariably they regarded passing with real satisfaction: they felt genuinely proud.

Some echoed the supervisor view that passing MRCP(UK) allowed entry to further training; in any case they were more interested in specialties than general medicine.

But many believed that passing the exam has a role in providing quality assurance. It demonstrated not only to their peers but also to the wider world – other health professionals and patients – that they have a certain standard of ability. For some it went further than this. They felt that passing MRCP allows them to practise as a registrar, that registrar is a highly important and responsible role in a hospital, with a distinct place in the hierarchy, which carries considerable status. In this way passing MRCP means achieving something significant in terms of competence to practise.

*“It's a seal of respect. Consultants, even medical consultants, if you pass any of your exams in MRCP that's good, they know it's not easy. I know the standard has been maintained and it is an asset to have”*

Junior doctor South East

*“It's sort of shaping our entire existence to becoming that medical registrar, to being the person who keeps a hospital together in the middle of the night. You have the kudos and responsibility. I think being a medical registrar is something that as a junior doctor you're terrified of the prospect and you really admire them.”*

Junior doctor London

### 2.3 The exam's role in relation to clinical competence and training

Directly related to the way MRCP(UK) was perceived more as an entry than an exit exam, it tended to be seen as indicative of a certain level of clinical competence, but not a high level.

At the most positive, there was some impression of a correlation between overall ability and passing the exam: junior doctors who struggled with the exam were probably below par more generally, and those who passed were good.

*“The people who have difficulty in the workplace and in assessments...are the same people generally as the people*

*struggling with the exam. It seems as though the exam is measuring something which is relevant and valid to be measuring."*

Postgraduate Dean

*"The people who struggle are the people who are not up to the mark, I think. Certainly the junior doctors we've had who passed the MRCP have all been very good physicians."*

TPD

*"It sets standards and gives the junior doctors something to measure themselves against. If you can't pass it then I think the assumption is that you're probably not going to make consultant level."*

Clinical supervisor London

*"Say a new patient comes through the doors of A&E that I am seeing on an intra-take ward round or a post take ward round. Someone who has been through membership, there's attention to detail in the history and examination relevant to the differential diagnosis that you're working towards. People who haven't had the membership experience I've always tended to find don't give as full a differential diagnosis, haven't necessarily examined as thoroughly bringing in all of the relevant aspects to that differential diagnosis. So my perception is that the membership still works well in that regard. It seems to skill people up in the relevant areas and help to make them competent."*

National Clinical Director

However most respondents thought passing MRCP(UK) said a junior doctor was capable of moving onto further/specialised training, but that it could not be regarded as a benchmark of ability *without reference to other aspects of training*. The fact that in comparison with the past junior doctors generally have less clinical experience at the point at which they can complete MRCP(UK) – often three to four years after graduating – was thought a more accurate indicator of competence to practise.

*"Possessing MRCP is good for your career progression, good for your confidence, but doesn't make you a better doctor."*

Junior doctors Birmingham

*"I'm not sure it's the exam alone, it's the fact that people have been through a training programme which exposes them to a body of knowledge and then are tested on that, that probably improves the quality of patient care."*

*"It isn't the be all and end all. You've still to perform in the workplace to show your mettle."*

Postgraduate Dean

*“From my perspective as a trainer it gives me a fair modicum of security that these people can indeed do the job that you’re anticipating they will be able to do as a medical registrar. I say a fair modicum. It’s not 100%.”*

Educational supervisor Scotland

Irrespective of opinions on this, there was some feeling that preparing for the exam, particularly Part 2 and PACES, prompted junior doctors to think more carefully about their work, often including the way they interact with patients. These parts were not so much about knowledge alone but more concerned with practising and implementing it. Alongside this, some supervisors thought that passing MRCP(UK) gave junior doctors a greater degree of *confidence* about their knowledge, so they were more confident in their service provision role, which in turn could enhance their *competence*.

*“At that point of finishing MRCP I knew more general medicine than I have ever known. It’s a worthwhile slog. You’re not just doing it as a tick box, it does impart knowledge that is required.”*

Junior doctor Scotland

*“I think you feel more confident as a doctor [after passing the exam]. I genuinely felt more confident and hopefully people felt more confident in me.”*

Junior doctor Scotland

*“Generally, thinking of the junior doctors who come through, the more experienced ones who have the PACES exam, so have the MRCP(UK), I see them as much more competent doctors. I see evidence of that in their patient management.”*

Educational supervisor London

An issue here was that junior doctors’ apparent lack of experience in certain procedures, which some supervisors and others translated into general uncertainty about competence, ran alongside MRCP(UK). Whereas in the past junior doctors had acquired this experience and ability at the same time as achieving their MRCP(UK) pass, and the two had almost been seen as tied together, now they could pass the exam without necessarily getting the parallel experience. Indirectly this could rub off, unhelpfully, on MRCP(UK).

*“I’m not sure that the MRCP exam has changed much but I think the general experience of junior doctors now that come into specialist training is much less than it used to be, simply because the period of doing general internal medicine was longer. So if you shorten it and make it less flexible then you’re going to end up with less experienced doctors.”*

TPD

*“The MRCP is a really good exam for what it does. It's well constructed, it's very fair, it's excellent, but it's not a particularly sophisticated exam because of where it is in training.”*

Professional body

## 2.4 Widely regarded as fair

The question of whether the exam is fair did not come up unprompted. This in itself suggested that there were no concerns about it on this score.

When asked about how fair it is very few respondents expressed any reservations. On the contrary it had a strong sense of integrity about it. This was perhaps attached to its provenance: the Royal Colleges were highly regarded. But it was also linked to the changes made over the years, and particularly the effort to give it greater consistency.

*“I think it probably is fair. It's reasonably broad in its content and while the method of testing may not suit most people I think it's fairly rigorous in the way the questions are written”*

Educational Supervisor Scotland

*“Years ago it was very hit and miss. You could get some hawkish consultant examining you who made it very difficult to pass a thing. But nowadays I think the way it's structured, the controls they've got in, the checks and balances, means that it is a fair examination.”*

TPD

*“If it is unfair it's consistently unfair and I think it's appropriate because if you try and make it any more standardised it becomes impossible to actually have any judgement.”*

Clinical Supervisor London

This general perception was echoed by the views of some of the supervisors, TPDs, postgraduate deans and others we interviewed, some of whom had been examiners. They said firmly that the exam is unquestionably fair, and that it is more so now since there has been greater standardisation of questions in PACES.

*“I would have to say the MRCP is probably one of the best administered college exams around. It's a big exam and they do a lot of research associated with it and they have a lot of safeguards in their processes.”*

Professional body

Several senior level people said pass rates varied widely between UK and overseas junior doctors, and between medical schools, but did not

perceive lack of fairness in this. Rather, they believed that it simply reflected differential inherent abilities between the candidates.

*“What the MRCP have done is fairly extensive research to show that there isn't any gender or ethnic bias, as far as they can see, in the exam and process. So they've looked at the ethnicity of examiners and candidates... to see if there was a difference in that.”*

Professional body

## 2.5 A high academic level

The exam was unanimously believed to be set at a high but realistic academic level. Across the sample the feeling was that the exam is unquestionably difficult to pass but that passing is achievable.

*“It's meant to be a difficult exam, there is a kudos attached to it. Currently I don't see that standards are slipping necessarily. I've not met anybody recently who I feel has passed the exam without deserving to do so.”*

Junior doctor Wales

A few supervisors felt that the standard is a little too high and that it is perhaps too academic: too much about knowledge and not enough about practical abilities. But for most it was set at the right level: it was hard enough to generate respect and status for those who pass but not too hard. There was no appetite for the exam to be made any easier. If this were to happen it would lose some of its status and all those who had passed it would feel that their achievement had been diminished.

*“It is pitched at the right level. You've got to stretch people at that stage. I know it comes into criticism for the failure rate in PACES and the failure rate overall. But given the spread of people that sit it, it is an appropriate test.”*

Postgraduate Dean

*“[The academic level is] high but appropriately high.”  
“You wouldn't like to feel that it dropped any. If there was a feeling that it had become easier for some reason I think that would devalue the standing it's held in.”*

Junior doctor Scotland

*“It's fair in a tough way. It's not meant to be easy.”*

Educational supervisor London

*It should be noted that our sample contained a few junior doctors and supervisors who had not passed all three parts of the exam first time, but none who were still to pass it and get their diploma. It may be that people in this position have a different view on how difficult it is.*

We asked respondents whether they felt the exam is a gauge of competence or excellence. The general belief was that though excellence is of course an admirable aspiration, the exam should aim to establish competence, given the need to help prepare large numbers of junior doctors for further training and ultimately a career as a consultant. If it tried to achieve excellence this would mean raising the bar too high and excluding many very good people, with a consequent effect on the number of qualified consultants.

*"I don't think the exam is geared towards marking excellence. I think the exam is geared towards 'is this doctor competent, can he or she pick out the clinical signs.'"*

Clinical supervisor Wales

*"I think it's designed to promote competence. And that's right, it has to. We're not trying to train the medical Einsteins or whatever of the future. We're trying to provide people who are prepared to know where their limits are, know where the gaps in knowledge are, know how to apply the knowledge they do have to provide care across medical environments."*

Educational supervisor Scotland

Those who positioned MRCP(UK) as a gateway exam felt that in any case excellence is not appropriate for a gateway exam: it would screen out and deter too many who were capable of going on to specialty training. It was also said that excellence could only be achieved by covering individual topics at higher levels than the exam currently goes. Aiming for excellence would mean making major changes to the exam's content and level.

*"This is a middle level exam. I'm not particularly interested in the excellence bit of that."*

Professional body

A minority of supervisors and TPDs disagreed with this view. They believed the aim should be excellence simply as a matter of principle, and that competence signalled a lack of concern for standards. This may have been in part a comment on the language. As one high level individual said, *competence* can sound low level even though it is a mark of high ability.

We also asked about the link between passing the exam and improved standards of patient care. Initial reactions to this were often uncertain; people did not make a direct connection between the two. On consideration there was a general acknowledgement that passing

MRCP(UK) could improve patient care, since training and preparing for the exam results in greater knowledge and understanding, which will help raise standards generally and in patient care specifically.

*"I'm not sure I see a link between the two. I suppose you could say that if it increases their knowledge it means they'll do a better job, so it could increase care standards."*

Educational supervisor London

Junior doctors perceived a more direct link between the exam and improved patient care. They felt that Part 2 and PACES tied in with and complemented their day to day work. Both parts helped them in their clinical work by informing them about aspects of certain conditions, giving them clues on diagnosis and tips on treatment. This meant they were smarter in their work.

*"When I started studying for PACES I then again got back into the habit of examining patients properly and that was very useful for me."*

Junior doctor South East

Some of those at senior levels believed that other aspects of training contribute more to better patient care than the exam. In particular they perceived a more direct connection between patient care and experiential learning and work-based placements.

## 2.6 Generally relevant and up to date; some exceptions

The general feeling was that the exam is up to date and broadly reflects what junior doctors need to know to provide a service and do well in further training. As noted, some older supervisors and those in senior roles also said it had moved on and no longer used questions relating to more unusual conditions of the type that had been used in the past.

*"I think there has been some criticism in the past, and I think they have responded to that criticism, that some of the things within the exam are a bit esoteric. I think to some extent they have responded to that."*

Professional body

In two respects there were questions about how up to date the exam is. One concern, especially among older supervisors, those at clinical director and medical director level and education directors of professional bodies, was that the exam as a whole is not sufficiently

relevant to current needs in the NHS, nor to current approaches to healthcare. These people felt that the questions do not always chime with current ways of responding to patient needs: they can be too medical-based and do not account for the totality of a patient's circumstances. This differed from the more recent approach of integrated care which hospitals now aim to provide.

There was also a belief that the range of topics covered is narrow and specialised. A few believed that it should be broader and should take in non-clinical issues, particularly ethics in more detail, and aspects of NHS management, commissioning services, and finances. When we put this to other respondents they tended to disagree, some quite strongly, on the grounds that these were topics for other training and exams, and that MRCP(UK) should concentrate firmly on clinical matters.

*"Potentially we might have become a bit more sophisticated with how we appreciate what a good doctor is. So traditional models of encyclopaedic knowledge are less valued and diagnostic accuracy, empathy, compassion, clinical skills have become more important, which should be encouraged."*

Educational Supervisor South East

*"I think it would be more appropriate if there were more questions on things like ethics, broader knowledge of the environment in which we are operating. I mean when do they learn things about commissioning for example, and the impact that has on their service?"*

Clinical Supervisor London

*"If the question is should the MRCP have Part 4 to ensure that people are competent at procedures I don't have firm views on that but I've never really considered the MRCP as a means of ensuring people are trained to do a central line or lumbar puncture."*

National Clinical Director

Discussion of how up to date the exam is prompted some to defend it. Junior doctors, younger supervisors and those who had been involved with it in some way (helping host it, providing questions) believed that it has stayed up to date successfully. They pointed to Station 5 of PACES as an example of MRCP making an effort to keep it current.

The other major reservation, expressed by most junior doctors and some consultants, was that Part 1 is not relevant to junior doctors' current work, nor is likely to be in the future. Some junior doctors felt

strongly about this. They complained that the content of Part 1 is entirely unrelated to any work they do as junior doctors, or to the remainder of the exam. At worst they described it as A level biology, or rehashed undergraduate learning, which they might not understand but might get through using guesswork or even pattern recognition.

*"I remember remembering stuff from Part 1 but nothing I'm going to use ever again. You pass the exam and then you never use it ever again."*

Junior doctor Scotland

*"There were definitely times in the Part 1 when I was thinking 'I'm struggling to see the relevance of this'. Compared with when you get to the PACES where it's all relevant and you're kind of happy with the relevance of the exam. Maybe you have to feel that's a foundation of knowledge until you get to the clinical part."*

Junior doctor Scotland

*"I'm just never ever going to use that knowledge. Ever."*

Junior doctor Scotland

*"The first exam is a pile of ... It's impossible and clinically it's completely unrelated to anything. Very scientific and quite abstract."*

*"A lot of getting it right is guesswork."*

Junior doctor London

Two respondents said their Part 1 paper had contained a question that was factually wrong: it assumed treatment of a condition with drugs, whereas nowadays a procedure would be used.

*"In Part 1 there are some bits that are not actually accurate. I came across a question where the obvious answer for responding to a heart attack was giving drugs whereas nowadays you'd use a certain procedure, you wouldn't give those drugs."*

Junior doctor Scotland

*"As for trying to work out the actual answer that the college are looking for is it very much depends on your experience. There's nothing that they provide for you to learn from. You're not actually sure what the answers are."*

Junior doctor Wales

Some of those at more senior level took a different view of this. They acknowledged that not all the Part 1 content was knowledge that would be used, but they felt that the discipline of acquiring it was useful for junior doctors.

*"Some of it may seem esoteric, particularly Part 1 – you do tend to learn quite a lot of stuff you may never use in your*

*career. But it is a reasonable thing to expect people to have a broad knowledge at a particular stage in their career so they can build on that as they progress through their careers.”*

Postgraduate Dean

In contrast, Part 2 was regarded as very much up to date, and linked directly to day to day work. The only complaint about it was that it was in three parts, which meant it went onto a second day, and became a long and gruelling experience.

*“I think Part 2 was more clinically relevant and therefore more interesting and easier to revise for. You could think about clinical scenarios to help you work out the answers to questions, and that's how a clinical exam should be.”*

Junior doctor London

*“Coming back for that second day is just soul destroying. It's three hours in the morning, three hours in the afternoon and you come back the following day.”*

Junior doctor London

## 2.7 Other aspects of the exam's content

Apart from the issues mentioned above, MRCP(UK) was believed to be fairly comprehensive in the content it covers. Most supervisors and some others would have liked to see more questions related to their own particular specialty or interest, but conceded that it was impossible to cover everything.

One more general point on the exam's content that came up from a number of supervisors was that it does not cover much acute medicine or emergency medicine. In PACES this was inevitable, given the limitations on the types of patients that can be used, but there was a case for more questions in these areas in Part 2.

*“It's already recognised that they needed to change it a wee bit and PACES is changing but I still think it needs to change further to try and challenge people in their acute management because that is one of the things that the service does demand that people are able to do and I don't think we test it adequately at the moment.”*

Educational supervisor Scotland

### 3. PACES

#### 3.1 Generally well regarded

PACES dominated perceptions of MRCP(UK) for some. It was the most high profile part of the exam: it was the most worrying for junior doctors and hosting it was a major piece of work for trusts and the individual consultants and other staff involved.

Nevertheless the overall impression of PACES was positive. Everyone felt that in principle it is essential to have a test of junior doctors' practical skills in relation to examining patients, taking histories, making diagnoses, and ability to communicate to patients and to colleagues. Though it was not possible to replicate fully the real world of the patient experience, the general impression was that for hospital doctors PACES is probably as good as it is possible to make an exam of this type. Alongside this, the preparation for it taught junior doctors a lot.

*"PACES is the best bit. PACES is why we're doctors. It's a practical exam in what we do every day. It's a proper confirmation that you are adequate, you can do your job, make a good clinical assessment. I think it's a good affirmation, a good exam"*

Junior doctor London

*"Doing the PACES exam itself is neither one thing or the other, the process of preparing for that exam is what makes you a good doctor. So for that reason it's good...What is relevant is all the training you put in in order to get in the position to be able to do the exam."*

Junior doctor London

*"I feel that when you get your PACES you feel you've arrived."*

Junior doctor London

*"With PACES in the bag you walk around thinking 'I can deal with stuff.' So I think the process of getting PACES, although you end up studying minutiae it does give you a sense of confidence and gives you a broad based general education which I think is helpful. It's not everything but I think it's a helpful part of the training jigsaw."*

Junior doctor London

*"It's a really impressive style of examining and to me, having listened to young doctors talk about their preparation for it, it reassured me as a sort of potential patient that that sort of examining rigour makes me feel that they really do know their stuff."*

Professional body

The only comparable exam was the MRCGP Clinical Skills Assessment. Some supervisors and others regarded this as a more realistic representation of the clinical experience, but they acknowledged that PACES was addressing a different patient environment, the hospital.

A few features of PACES generated concern, but none attracted widespread or strong criticism.

### 3.2 PACES: key features work well

The use of real patients in PACES was widely considered essential. Real patients lent the exam a sense of life in the hospital, and helped candidates feel closer to the patient experience. Several supervisors had experience of actors in practical exams and felt that this was less effective.

Some concerns were raised about using real patients. Clearly it was only practically possible to patients with chronic conditions, not those with acute conditions, which introduced limitations on the scope of what could be covered, and meant junior doctors could not be assessed on certain conditions. A few said that patients used for Station 5 cannot always articulate their symptoms clearly and this made it more difficult for candidates.

*“The problem with that is that the only patients you can get to come up to exams are the fairly chronically ill rather than the acutely ill. So you might be testing a proportion of the practice rather than the whole practice.”*

Professional body

*“It’s a sort of perfect situation testing, it’s not testing it in real life where you’re often busy and stressed. It’s very sort of like a lab test...”*

Clinical supervisor London

These were relatively minor problems, and the general view was that there is no obvious alternative to using real patients. The alternative of using actors was generally considered far less satisfactory.

Station 5 attracted much unprompted comment, mostly positive. There was a general welcome for Station 5 it since it had been introduced. Junior doctors felt it better reflected the current approach to dealing with patients because it allowed interaction with the patient and

discussion of symptoms, rather than examination alone. There was some feeling that Station 5 signalled MRCP moving with the times and keeping the exam up to date.

*"In the last ten years the biggest thing that has changed has been the change to station 5 of PACES. That's changed considerably. That was the first attempt to try and increase the relevance to the acuity of medicine so that's an appropriate thing to do."*

Educational supervisor Scotland

### 3.3 PACES: minority reservations

A small number of clinical and educational supervisors felt that PACES is formulaic and too standardised. In their view it did not allow for enough variation or the introduction of topics out of the run-of-the-mill, and so was not as good a test of 'physicianly' skills as it could be.

*"I think there are six stations and they are very formulaic and reliable in that there will be a respiratory and/or heart problem or something at each station. I think there's a fairly limited repertoire."*

Clinical supervisor London

This concern seemed almost to be expressive of a desire to revert to the days when PACES had included rare and obscure conditions, which most people felt was best left behind.

A few supervisors and one TPD who had examined PACES thought Station 5 was difficult to examine fairly because some of the output from it was dependent on the patient's comments and specifically on his or her contribution to the candidate's understanding of their condition.

*"It's not easy to examine. It makes me nervous having to test people on the conversations they have."*

TPD

*"I think we've still got to get station 5 right. That still fluctuates a bit"*

Postgraduate Dean

The same TPD did not like the current marking scheme for PACES as a whole, which he felt was not sufficiently graded (ie only satisfactory or unsatisfactory).

### 3.4 The fairness of PACES

Overall PACES was regarded as fair, but discussion of this issue prompted some debate.

The use of multiple examiners, two for each station, was believed to be significant in making it fair. Consultants and others felt that using two examiners at each station, and the practice of marking before the examiners discussed the candidate and their answers, made the marking system objective. Older respondents believed that it has been standardised in a way that has made marking more consistent than it used to be.

*"I think there are fourteen different examiners or something so if you can impress fourteen different people to say that you're OK, that seems pretty fair."*

Junior doctor Scotland

*"I think these days that with PACES they are trying to go for the more standard type diseases and much less of the very rare sort of neurological conditions."*

Clinical supervisor Scotland

*"I can remember one of my co-registrars when he was organising the exam for his bosses deliberately going down the list of really interesting patients with very esoteric diagnoses. That's how it was. A lot more depended on luck rather than quality of the cases."*

Postgraduate Dean

Junior doctors believed that there is a significant degree of luck in passing PACES. They felt that much depended on what conditions came up, though of course this could be said about almost any exam. They also believed that the conditions featured in the exam varied between parts of the country, simply because some are more common in certain areas than others. One junior doctor said that PACES is easier to pass in Edinburgh than in other parts of the country. She had no proof of this but regarded it as well established hearsay among junior doctors.

*"The further up North you go, the more likely you are to pass PACES."*

Junior doctor Birmingham

*"I suppose the only thing is people do talk about different places where they've got their favourite patients or something. In one part of the country you may get very*

*standard conditions. And in one part you may get very esoteric things."*

Junior doctors Scotland

Two junior doctors said that one of their PACES examiners had been difficult to deal with and had treated them unfairly. It is hard to know whether their feedback was more perception or more reality, but clearly it had left them with bad tastes in their mouths about PACES.

*"It wasn't just my experience because at that particular station we talked about it after the exam, all of us who were in that station together and it was the same for every single candidate. Everyone kept saying "What was wrong with that examiner? Why is she being so horrible?" And that was the station that I performed most poorly on."*

Junior doctor South East

When asked, supervisors and TPDs did not see any differences between the conditions covered in PACES, or the questions asked, between different parts of the country. A few who had been examiners felt strongly that PACES is fair and consistent irrespective of where it takes place.

One other concern about fairness came up. A minority of junior doctors from ethnic minorities, in one focus group, said that in their experience, and those of people they knew, examiners do not always make full allowance for accents among candidates who did not have English as a first language, and that this could count against them. Their point was that when they described conditions in their examinations, or answered examiners' questions examiners occasionally queried them because they did not immediately understand what had been said. This could be off-putting, in a situation was already stressful.

*It is important to note that this complaint was not concerned in any way with discrimination on grounds of race or nationality, it was specifically an issue of language and understanding.*

### 3.5 Other issues

A few older supervisors believed that PACES does not cover all the communications issues it could. They believed that it should include writing a discharge note for a patient, writing to a GP about a patient's condition, and giving a patient bad news. All these were important

aspects of communication for a hospital doctor and all were areas in which they believed standards need to be examined and maintained.

One clinical director felt that PACES is formulaic and not close enough to the real world of diagnosis and treatment. He accepted that it would be difficult to make it much closer, but was less positive than others about how well it really tests junior doctors.

### 3.6 Hosting and organising PACES: difficult and stressful

The job of organising and hosting PACES exams was seen as effectively the role of the hospital Trusts where it was run and the individual(s) who agreed, or were deputed, to do it. A number of experienced supervisors, TPDs, Postgraduate Deans and clinical directors had been involved in organising PACES and some were still involved. A few junior doctors and younger supervisors said they had been asked to help run PACES in the past.

The expectation, based on experience, was that apart from providing the examiners MRCP(UK) would not be directly involved in PACES, either on the day or in preparing for it.

All those who worked to help organise and host PACES felt it put a heavy burden on Trusts, hospitals and individuals. Most others had an impression of what would be involved and assumed it was a demanding task.

*“Oh it's a lot of work organising it. You've got to find all the patients”*

*“It's a military operation.”*

Junior doctor Scotland

*“It's a huge task. You have to start preparing for it months in advance, and on the day there's a lot of anxiety about everyone being in the right place at the right time.”*

Educational supervisor London

A few in Edinburgh and elsewhere said that Edinburgh has a well organised system for hosting PACES, including running PACES in one centre, and using a patient bank, both of which help make it run smoothly. Some of those who knew it believed Scotland's ability to handle PACES well relied to a large extent on one individual, who went to considerable lengths to ensure it ran smoothly.

*"I think Edinburgh got it right. There are other models across the country saying OK there are hospitals that have education centres, we'll have one centre for Edinburgh with lots of examiners playing in from across the Lothian region, across different hospitals. So you'll never find the exam being performed in Edinburgh Royal Infirmary or St Johns hospital, and many other hospitals just don't host the exam where you have a centre and lots of physicians contribute."*

Educational supervisor Scotland

*"I'm not sure what's going to happen when she retires!"*

Junior doctor Scotland

No comments were made specifically about the organising and running of PACES in other parts of the country, or by the RCP of London or RCP of Glasgow. Our impression was that these were no different from the norm, and that it was only Edinburgh which stood out.

The logistical issues involved in running PACES were known, or believed, to be substantial. Several months beforehand potential patients had to be identified and asked to take part if required. After they had agreed, contact had to be maintained with them to ensure they were likely to be suitable when the time came. Provision had to be made for closure of a ward.

In the few days prior to the exam wards had to be re-configured and/or reorganised, with consequent reorganising of staff. On the day itself arrangements had to be made to get patients to where they needed to be at the right times, examiners had to be hosted and directed, and the timetable for candidates adhered to.

*"I found it very stressful actually because I was constantly worried people wouldn't turn up or would be late or too ill. You're constantly going to the wards trying to find backup patients that you can pull in. Then they get discharged the day before the exam and your plan is ruined."*

Junior doctor Scotland

All this took considerable work and generated stress for those involved, often for some months before the day. Some who had helped run PACES in their hospitals described the experience with a sense of weariness. Though there was some satisfaction to be had from having done it successfully, none had relished it or enjoyed it.

One supervisor suggested that PACES be run in venues other than hospitals, to reduce the burden it imposed. This did not seem viable,

given the logistical problems involved in getting patients, candidates and examiners to other places.

### 3.7 Benefits of hosting PACES

Several benefits of involvement in PACES were identified. For individuals, particularly examiners and host consultants, PACES helped them stay abreast of current learning. They were well aware of the speed of change in medical knowledge and knew they could learn by being involved in the exam process. They saw this as part of their continuing professional development and, as such it was a genuine, tangible benefit.

*“Quite apart from the higher duty of doing it and the honour of being a membership examiner, you also get CPD and I think that is quite a powerful motivator for a lot of examiners. It is a good way to pick up CPD and certainly clinical CPD is harder to pick up if you aren't doing it.”*

Postgraduate Dean

Junior doctors who had been asked to help host PACES, and some younger supervisors, said that it was good for their CVs. If there was a record of their having helped with PACES this would be a valuable addition, and it might well increase their chances of getting one of the better jobs.

*“You're kind of led to believe, in medicine, that if you are the person that's always helping out and going the extra mile doing things then at the end of the journey there might be a consultant job for you. It's all adding to the picture of you as a person, a provisional colleague. You're a good person, a good colleague to work with because you're not just clinically competent, you can pull off organising a PACES, or that sort of stuff.”*

Junior doctor Scotland

A few clinical directors, medical directors and other more experienced respondents believed that there could be a more general reputational benefit for Trusts and hospitals in hosting PACES. It was something good to say to hospital management and more widely could be positive PR for the Trust.

### 3.8 Support from MRCP in running PACES: more wanted

No one complained unprompted about lack of support from MRCP in running PACES, but when asked whether they felt MRCP gave them

enough help, some supervisors and junior doctors said they felt it did not. Several issues were raised.

Some said MRCP did not communicate much about what is required in hosting PACES, and seemed to assume that Trusts and individuals would know this. It may be that colleagues were better informed, but these respondents wanted more information in advance. Several thought MRCP could provide staff to help in the days leading up to PACES: someone to come to the hospital and assist with the organisation of the exam, including liaising with examiners.

Generally there was a sense of Trusts and individuals being taken for granted by MRCP. This particularly grated given the fees MRCP charge for the exam: the impression was of MRCP getting substantial help for free and then charging junior doctors a lot to sit the exam.

*“My impression is that this is a very expensive exam to sit that we all pay out of our own pockets generally. The college seems to get an awful lot from the hospitals and people organising it for nothing. Surely there's some money that could be focussed towards having a specific person employed to recruit patients, to organise centres.”*

Educational supervisor London

*“There is a huge amount of work that goes into the organisation and execution of an exam, a large part of which is done for free by consultants in trusts. So I think they've got it cheap as it is.”*

National Clinical Director

*“It's run a lot on goodwill. It's a massive amount of work for little or no thanks really.”*

Junior doctor Scotland

*“As long as the Royal College recognise it when someone is doing a task, then I think it's fair enough.”*

Clinical supervisor Wales

Two of the more experienced junior doctors who had been enlisted to help run PACES also complained that they had not received thanks from MRCP for their efforts, and perceived this as lack of due recognition and gratitude.

## 4. Other aspects of the exam

### 4.1 Timing

We asked for views on when the exam is taken.

Some had no concerns and felt the current timeframe worked well. Taking Part 1 in FY2 and completing PACES by the end of CMT meant junior doctors could start specialty training in good time: nothing was holding them back. For junior doctors this suited if they passed because most had had some idea by then of the direction in which they wanted to go.

Less positively a number of supervisors, TPDs and postgraduate deans raised concerns about the timing of the exam. The aim of getting junior doctors through it by the end of ST2 meant that they hurried through it, in a relatively short period of training. This could mean that they had passed it before they had accrued much clinical experience.

*"I would like to see core medical training extended by at least a year so that they pass their MRCP, they then decide what speciality they want to work in and they spend another year in the speciality, or at least 6 months in the speciality that they want to do at higher medical training before they apply for specialist registrar posts. I think that would be a much better system."*

TPD

They also had more specific concerns. A consequence of having to pass MRCP(UK) before applying for specialty training posts was that anyone who failed any part of the exam and spent some time passing all three parts might have to wait to apply for specialty training posts without currently being in a job. Whether they could get a job in such a situation or not seemed to be a matter of chance and local policy, but there was apparently a risk of them being stuck in limbo until they had passed. Alongside this, junior doctors had to apply for jobs before they had finished training and before taking MRCP.

*"I can see potential problems for people if they sit the exam in the autumn and fail they are then in a really difficult situation because they've finished their core medical training, what are they going to do then? They've then got to go off and get an SHO job somewhere then they've got to apply for higher medical training. If the core medical training was a year longer and they had the opportunity to sit it not just in*

*that autumn before the interviews for higher medical training that gives them a little bit more breathing space to pass the exam."*

TPD

*"What they say is you have got to have passed the MRCP to move into the next stage of training. A lot of people are being interviewed for their next job before they've got the MRCP. They have to do interviews in February, March or August. But if you had the exam testing then having only got through the first 18 months of training it wouldn't actually be measuring what they were going to achieve in the core medical training programme. As far I'm concerned, we just have to live with the timing."*

Postgraduate Dean

#### 4.2 Limit on number of attempts at the exam: accepted

Virtually all supervisors and above believed it is right to limit the number of times a junior doctor could take the exam.

Their view was that if someone cannot pass any part of the exam in six attempts it is more than likely that they lack basic competence. If they were given more chances, even if they did pass they could not be relied on to provide a sound service, or to be good enough to go on to specialty training. Having a limit on the number of attempts would weed out the less able and, importantly, would enhance public confidence both in the exam and in junior doctors' capabilities.

*"There should be a limit. I know the GMC's limit have recommended six. If you can't pass it after six goes there is a chance that when you do pass it, you have passed it by chance."*

Postgraduate Dean

*"I am quite happy with a limit. As long as it is done properly and I have the impression that MRCP is quite objective that is absolutely fine. If people simply can't pass it after 5 or 6 attempts, then they probably have to think about another career."*

Clinical supervisor London

*"Yes I think it's right to have a limit on it, simply on the basis that after a while you get to a point you know you're going to fail anyway so you fail. There's something about repeated performance that means that no matter how many times you go through it you will fail."*

Educational supervisor Scotland

*"You can have so many attempts and then that's your lot because otherwise there's a feeling that the more times you do it the less valid the test becomes."*

Professional body

*"I just don't see how we can justify to the public that we spend a quarter of a million pounds producing a doctor, they're paid a very good salary, pretty much guaranteed a job in the system somewhere and they can just go on and on trying to pass a key exam."*

Professional body

Junior doctors broadly accepted this. Their own observation of colleagues who failed parts of the exam several times suggested to them that they were likely to struggle as doctors. A junior doctor in one of the focus groups who had failed Part 1 but now passed all three parts gave the impression that it had been important to get through it with as few further attempts as possible to demonstrate his abilities and credentials.

A minority, principally a few supervisors and junior doctors, were less sure about this. They believed that some people are simply not good at exams in spite of being able and competent as doctors, and that they should be allowed as many chances as they needed to pass. They tended to know junior doctors who had failed parts of the exam but who, in their view, would still make good doctors. If they could not progress because they could not get through MRCP(UK) they would be a loss to the system.

*"There are some good doctors who don't know the tricks and struggle to pass the MRCP."*

Junior doctor Birmingham

*"I have a colleague and she hasn't got through Part I. She is a good doctor, she'd be a great doctor, but she has sat it too many times now and she has no further MRCP opportunity. I think that is sad. They put a cap on how many times you can sit the exam, which is not unreasonable but I think perhaps in those cases they could be more flexible."*

Junior doctor London

#### 4.3 Time for revising and taking the exam

Among supervisors and others at higher levels the issue of junior doctors getting time for revision was not a concern. Their feeling was that junior doctors these days work reasonable hours and should have plenty of time to prepare for the exam. A few seemed surprised that this had been raised as a possible problem.

Some acknowledged that there could be difficulty for junior doctors if study leave clashed with rotas, or if they were not able to do weekend

courses because they were working. In their view this was partly a consequence of the increasing rigidity of junior doctors' rotas.

Junior doctors had a different perspective on this, especially those who were now, or had been, in district general hospitals. Most junior doctors said they had found it difficult to fit in revising alongside working, and had had to give up a lot of free time to do both. Spending time on PACES preparation courses was a particular issue. More generally, many junior doctors said there was not enough study leave for the revision they needed to do.

Junior doctors in one area in the South East said they had experienced difficulties in getting time off even to take the exam. They had encountered an unsympathetic attitude from consultants and management in their hospital and linked it to their position and status. They felt that later, in specialty training, they might not have the same problem. This was not a widespread problem, and did not happen among junior doctors in large teaching hospitals, where the attitude seemed to be that junior doctors should always be allowed time out of their service provision role to take exams.

*"I was doing A&E and I was supposed to be up in Darlington (for the PACES exam) at 10 in the morning and ... at 2 o'clock in the morning I was told that they couldn't let me go... I eventually did make it"*

Junior doctor South East

Some junior doctors felt that the length of MRCP(UK) Part 2 was a potential problem in relation to getting time off. Because it was spread over two days it caused problems in getting time off that did not occur with Part 1 and PACES. This complaint may have been as much to do with how difficult and demanding they found the exam as with the issue of service provision.

Junior doctors in one group said that it had been difficult for them to find time to take PACES when they were doing certain placements, and that their limited availability had determined where they could take it. They would have liked a little more flexibility on timing and more choice of locations.

## 5. Fees

Feelings about the fees charged for MRCP(UK) varied significantly between junior doctors and the remainder of the sample.

All junior doctors complained that the fees are too high and some of them felt strongly about this. Their complaints concerned not only the fees but the associated costs, and other issues which they believed were relevant.

For junior doctors the fees per se were hard to justify. They were especially exercised about Part 1, which they said is largely computerised and should take little work to organise and to mark. But some also felt strongly about PACES fees, given that they knew MRCP(UK) gets free help from Trusts and their staff to host and organise it.

*“Sometimes you wonder quite how much money is being spent on the exams and how much money is being paid for the exams.”*

Junior doctor Scotland

*“You just sit in front of a computer for the exam and I can’t understand how they charge so much for that”*

Junior doctor Birmingham

*“Part 1 is a computer marked exam. They have to rent out a hall but it’s not like they require 100 people marking thousands of different papers, it takes seconds.”*

Junior doctor London

*“I think if you knew everyone was being paid for their time that would be reasonable. Like if the patients were getting paid something other than a hospital lunch and the people who organise it were being paid. The fact that you’re paying this huge quantity of money for an entirely voluntary set up...”*

Junior doctor Scotland

In addition to their exam fees, junior doctors pointed out that for many candidates, taking PACES involves travelling to and staying in a different part of the country, which adds to the expense. They also took courses to help them prepare for PACES, which were expensive, often several hundred pounds. Their resentment at this was compounded by the fact that NHS consultants apparently teach on the courses and make substantial sums from doing so.

*"They're making a profit at the expense of junior doctors who are in a position where they feel they cannot progress their careers unless they go on those courses. The reality is that people who go on the courses are more likely to pass by quite some margin than the people who don't go on the courses. So it's not just a feeling, there's evidence there as well. For that reason I think it's a racket."*

Junior doctor London

Some junior doctors calculated the full cost of all three parts of MRCP(UK), taking account of the exam fees, accommodation and travel to take them, courses to prepare for them, and question banks and text books to help them revise at a minimum of £4,000 and possibly quite a lot more.

*"I did a revision course for each part of it because I was so adamant that I was only going to sit each part once so I just decided to throw money at the problem. I would say on a personal level it probably cost me £5000. I passed each part first time but £5000 is a phenomenal amount of money."*

Junior doctor Scotland

*"Yeah, M, R, C, P, it's about a grand a letter."*

Junior doctor London

They regarded this as putting an unreasonable strain on junior doctors, given that NHS salaries have gone down in real terms in the last few years, they are still paying off student debt and the expenditure on exam fees is not tax-deductible. Several compared their situation, unprompted, with that of people they knew in other professions, especially law and accountancy, who have their professional exams funded by employers, and who get support from employers around taking time off for study.

*"I think it is genuinely not right that we are in a position where we pay thousands of pounds for our postgraduate qualifications that are essential to allow us to progress in our careers."*

*"And they're not tax deductible."*

Junior doctor London

*"If you worked in the private sector it would be paid for you."*

Junior doctor London

*"If my brother wants to do exams to further his career he gets money thrown at him, courses, breaks, time off."*

Junior doctor Birmingham

*"Given that they all know we work in the NHS and we have a very primitive salary at the best of times, it is a lot to find."*

Junior doctor London

On the specific issue of MRCP(UK) fees, a few junior doctors said that there is no information on how the money is spent. They wanted to know how it used on the exams, and wanted reassurance that it does not go to fund 'sherry and leather armchairs' for the Royal Colleges.

*"I think if the Royal College are getting an earful about the exam fees they could do with just a little bit of transparency. The word on the grapevine is that you're lining the Royal College's cellars with very nice ports. Of course most of that's not true."*

Junior doctor South East

Among other respondents feelings about fees were rather different. A few felt, like junior doctors, that MRCP(UK) fees are too high, especially taking into account the associated costs of preparing for the exam, and the low cost input into the exams from individuals and Trusts. Most others felt the fees are not unreasonable, but that they should be tax deductible.

*"I think they're not tax deductible and that's always struck me as a bit unfair because why would you be doing them if it wasn't necessary for your career? I think it's a big chunk of money, particularly when you might have to do any one part two or three times. I suppose it's an incentive to try and pass. I'm not personally that impressed with the junior doctors' contract at the moment. I know they've had a pay freeze for a couple of years. It's a big chunk of money."*

Clinical supervisor London

## 6. Perceptions of MRCP(UK) as a body

MRCP(UK) did not have a well established identity.

A better informed minority, typically supervisors and TPDs who had set questions for the written parts or had examined for PACES, regarded it as a separate body from the three Royal Colleges which worked with the Federation to run the exam.

*"It is an exam jointly owned by at least the RCP and the RCP Edinburgh so I do see the exams as being separate from the Royal College of Physicians."*

Postgraduate Dean

*"I know it runs a separate office but it is part of the structures of the three colleges. It has an identity the same as PTB has, the same as the Federation has. Yes, I suppose it does function semi-autonomously. It is an integral part of the colleges."*

Postgraduate Dean

Most others referred to the provenance of the exam as ‘the college’, or occasionally the Federation. A few tentatively mentioned the JRPCTB but were not certain what role it had in relation to the exam. They tended not to see the exam as distinct from one or all the Colleges, and often assumed that the exam fees went to and paid for the Colleges.

*“I’ve always regarded it as a department within the royal college.”*

TPD

Views on communications between MRCP(UK) and doctors were mixed. Those closer to MRCP(UK) – exam question setters and examiners, and a few others with direct links to it or to the Colleges – felt that communications were good. They received regular newsletters which kept them up to date, they sometimes had informal contact with people involved in the exam and they tended to feel they knew what was going on with it.

Most others, and almost all the junior doctors, had no sense of any relationship with MRCP(UK) or any of the three Colleges. They would have liked more contact between MRCP(UK) and supervisors about the exam, especially in relation to changes to anything of substance concerning its content or timing.

*“It is possible for you to be involved in education and maybe not linked in with the Royal College”.*

Educational Supervisor South East

Most supervisors felt MRCP(UK) should do more to communicate with them, and with consultants generally, to encourage them to become examiners, and to spell out the benefits in this. One clinical director suggested more communications between MRCP(UK) and senior management in trusts, to let them know how the exam worked and what benefits it brings to individuals and trusts.

Beyond comments about PACES in Edinburgh (see p 43) we did not identify any differences in perceptions of MRCP(UK) between members of the Royal Colleges of Physicians of London, Edinburgh or Glasgow. In all areas the tendency was to refer to ‘the College’ or ‘the Royal College’ without specifying which one, but meaning the college of which they were a member.

## E. CONCLUSIONS

1. The MRCP(UK) diploma is clearly highly regarded. Everyone who has taken it feels it was a major step in their career, and passing it confers a great sense of achievement.
2. The exam commands respect because it is difficult and demanding: it is a stern test of a junior doctor's knowledge, skill and ability to perform under pressure. Alongside these marks of achievement it carries prestige because it is the exam of the RCP.
3. Though MRCP(UK) is seen as an entry exam and not an exit exam, passing it is effectively an acknowledgement from one of the RCPs that a Junior doctor is good enough to join the medical establishment. This is important to junior doctors, who tend to feel they do not have high status.
4. This research was conducted during a period of flux in the NHS and in aspects of postgraduate medical training. These have generated concerns and some anxiety among consultants and those with an interest in training, and they had a bearing on views of the exam.
5. As far as the content of the exam is concerned, clearly it is difficult to meet all expectations and to match current procedures exactly in questions, especially given the pace of change in treatments. The fact that questions need to be discussed and set some way ahead of the exams means that it can be difficult for it to be fully up to date.
6. There appears to be a tension between maintaining MRCP(UK) as it is, to support a sense of consistency and continuity in training, and keeping it up to date to show that it still meets needs in medical training and in the NHS.
7. The impression is that the exam has largely achieved a balance between these two requirements. In addressing the CMT curriculum it covers a broad range of subjects, and PACES seems to work well as a gauge of practical skills. Station 5 is seen as a significant step forward and is regarded as an indicator of the exam as a whole maintaining currency.

8. There is a case for considering the content of Part 1, which generates considerable resentment among junior doctors. If its content could be shifted closer to the substance of their day-to-day work this would be welcomed. Alternatively, if it was communicated to junior doctors that Part 1 has a value to their training, this would help address their concerns.
9. Given the complaints made by junior doctors about fees, it may be worth letting people know how the fees are spent. Greater transparency would make them feel better about their expenditure and more positive towards the exam and the Colleges generally.
10. Among supervisors and others who interact with the exam directly or indirectly there is a case for more communication about the exam. They tend to feel they do not hear much about it, and they would appreciate some sense of interest in them and their role.
11. It may be worth being more proactive in communicating to supervisors and others about the exam, perhaps via email once or twice a year, to let them know about any changes, about pass rates, to invite any who want to take part in question setting, or otherwise contribute.
12. It is unlikely that many would respond to communications, but doing this would help keep them informed about the exam and make them feel a little more involved in it. And it might prompt some to be more active in helping their students prepare for it.