How to pass the MRCP

As part of our series to help you succeed in the current postgraduate royal college exams, Sabina Dosani *and* Peter Cross *give the lowdown on the membership exam of the Royal College of Physicians and interview examiners and candidates for their tips on passing*

The MRCP part 1 examination consists of two "best of five" (candidates choose the best answer from five answers) papers, each lasting three hours. These questions test a wide range of common or important disorders. In part 2, two written papers contain up to 100 best of five questions. All questions include a clinical scenario.

If you pass both written sections, you can sit the practical assessment of clinical examination skills (PACES). The PACES examination consists of five clinical stations, each assessed by two independent examiners. Candidates start at any station, before moving on to others, at 20 minute intervals. Part 2 must be completed within seven years of part 1.

How much will it cost?

- Part 1 examination £275
- Part 2 written examination £275
- Part 2 clinical examination (PACES) £450
- An additional £180 diploma fee before you can put MRCP after your name

Who writes the questions?

The Royal College of Physicians' specialty question groups devise new questions.

The candidate's view

Mark Westwood is a cardiology specialist registrar at Barts and the London. He passed part 1 first time, but passed part 2 at his second attempt. He often helps senior house officers preparing for the MRCP exam, sharing his successful formula.

Part 1

"The part 1 syllabus looks like the first year of medical school, only twenty times harder. Three months before part 1, I bought lots of MCQ books and ploughed through them. I went on the Pastest course four months before the exam. I recommend going on a revision course early as it showed me how much work there was. On the Pastest course I was given a folder of questions that previous candidates have memorised, so when I sat the exam I had seen some of the questions before.

Examiners may change the question slightly, but if someone has explained it to you and you understand what you are being asked, you are likely to score very well. Candidate's mark distributions are so close that probably all you need to pass is some past questions. Read and learn *Multiple Choice Questions for MRCP* by Hugh Beynon. He's a clever bloke. His questions are very difficult, but the explanations are superb and you will learn a lot about weird and strange diseases that creep up because examiners like asking about them. It gives you an insight into how questions are written."

Part 2

"I recommend Sanjay Sharma's *Rapid Review of Clinical Medicine for Part 2*. It got me through the written, but I messed up the clinical. If a station goes badly it can mar the whole exam. The clinical component is unbelievably stressful and it is easy to muddle up clinical signs. If examiners are watching you and ticking boxes it is very easy to do badly because it isn't the same as real life. I don't think any clinical exam is like real life."

Pass rates

"They only let a third of people pass at each sitting. The vast majority of candidates are doing busy district general hospital jobs and cram their revision around that. Most people will pass, just not at their first sitting."

PACES

"Keep your head during PACES. As you do each station, forget the previous one. Even if you have said something silly, like mentioning a collapsing pulse on a patient with aortic stenosis, forget it. When I failed I was thinking about something I did wrong for the next half hour. Move on and do your best, over and over. I did that the second time. It worked."

Stress

"Each time you sit the exam, it exposes you to extreme stress, which gets easier to deal with. Courses recreate mock PACES, but because you know it's a mock, however mean and horrible your examiners act, it is nothing like the big day."

Final advice

"This is going to be one of the most miserable periods of your life. You are working very hard and being a student in your spare time. It feels like a treadmill, and that's exactly what it is. Remember you may not pass this time but if you are determined, you will get MRCP in the end."

Claire Collett also took more than one attempt before passing MRCP at the end of last year. She recommends, "doing a bit each day and finding someone to revise with as you can motivate each other. I did thousands of MCQs for part 1. For part 2 I did lots of bookwork but with hindsight feel that Ryder's *An aid to the MRCP Short Case* and Baglia's *250 Cases in Clinical Medicine* are the only books worth getting. I revised for PACES by using those two books and by seeing lots of patients. The first time round I got too nervous to think for the PACES exam."

The examiner's view

Dr Neil Dewhurst is an experienced examiner for MRCP:

"Most UK candidates will be on an SHO rotation and after eighteen months should be able to get through MRCP. Some do part 1 after house jobs, but the fastest to the final clinical is two and a half years. We are looking at a doctor of that vintage."

Part 1

"Part 1 has a pass rate of 35%. It's tough. Many doctors underestimate the scope of clinical knowledge expected. They are unprepared. We may not want incredible detail, but we do want breadth."

Written exams

"Best of five questions test basic science as well as statistics, clinical pharmacology, and other specialties. Areas that give specialist registrars the knowledge base and powers of deduction to use basic information in clinical settings.

"Part 2 has a pass rate of 60-65%. Candidates tend to trip up on interpretation of scientific information. "

Obstruction

"The college isn't being obstructive by producing an exam that is too difficult or irrelevant. Any assessment will be flawed, but there has to be some sort of written assessment and it has to be wide ranging."

Revision courses

"Preparation takes months. Crammer approaches are difficult to uphold educationally. There are always instances in PACES where you see they've been taught this way or that way.

Textbooks

"We use the *Oxford Textbook of Medicine* as our reference. If it isn't in there then it won't be in the exam. We don't look for obscurity."

Professor Peter Kopelman is the incoming chairman of the MRCP clinical examining board. His area of expertise is PACES.

*Resources**

- The Royal College of Physicians website exams page can be found at www.rcplondon.ac.uk/professional/exam/index.htm (accessed 7 Feb 2004).
- Anchor statements, examiners' feedback and mark sheets are available from www.mrcpuk.org.
- Montgomery H, Goldsack H, Marshall R, Ashrafian H. *My first MRCP book*. London, New York: Remedica, 2003.
- Sharma S. *Rapid Review of Clinical Medicine*. London: Manson, 2000.
- Ryder REJ, Mir MA, Freeman EA. *An aid to the MRCP short cases*. Oxford: Blackwell Science, 1998.
- Baliga RR. *250 cases in clinical medicine. MRCP Study Guides*. Saunders, 2002.
- 123doc.com online MRCP course.

**The resources mentioned in this article are not a complete list but those recommended by the candidates and examiners the authors interviewed for this article*

PACES

"Station 1 is on the respiratory system and abdomen. There is an introductory spiel like, 'This 44 year old man gives a three month history of progressively worsening shortness of breath.' Just as in real life, there might be patients without physical signs. At six minutes candidates are warned that there is one minute left, then they are asked to present findings and discuss management and investigations. At the end of ten minutes, candidates move to a patient with abdominal problems.

"The candidate has five minutes outside station 2, on history taking. They read a general practitioner's letter, for example, 'Dear Dr X, I'm very concerned about this patient who has had an increase in bowel motion and is passing blood.' They carry out a task in the letter, like 'give your opinion.' At 14 minutes the patient leaves, the candidate has a minute to reflect and examiners ask questions.

"Then the candidate goes to station 3 and faces a 10 minute examination of a patient with a cardiovascular problem and 10 minutes with a patient with a neurological problem.

"Station 4 is the communication station. It may be breaking bad news, explaining a procedure to a patient or relative, explaining withdrawal of feeding or a decision not to resuscitate. My colleagues and I vet scenarios before they are used. We rehearse scenarios with simulated patients and agree what a doctor should do. We are trying to replicate real life.

"The last station includes other systems: eyes, skin, and locomotion. Candidates are asked what they find, how they would investigate and manage, so it is more than just a spot diagnosis.

"Candidates fail because they have poor examination technique or poor history taking skills. Others are unable to interpret findings to put together a differential diagnosis. Increasingly young doctors are aware that revision courses only tell you about exam method, and that application and interpretation of physical signs comes from experience.

"My advice to candidates is to be as experienced as you can. Go back to day one of medical training and read a clinical methods book. Appreciate the applied physiology. Understand what physical signs mean. A lot of junior doctors are poor at analysing them. Be observed in your clinical method by a senior doctor prepared to compliment or criticise. Courses can't provide that but the consultant on your post take ward round can."

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P+ *Go to web extra for a full list of acronyms and their meanings, used throughout this series*

THE WAY I SEE IT...

Why a middle aged general practitioner sat the MRCP

They say that there is no fool like an old fool. So you might think that a 49 year old general practitioner (GP) taking the exam for membership of the Royal College of Physicians (MRCP) either has delusions of grandeur or has something missing. Having lived through the adventure and survived, I would disagree.

As a rural GP with an interest in education and assessment, I found myself questioning the ways we teach clinical skills and decision making. I was also becoming increasingly disillusioned about the lack of communication and understanding between primary and secondary care. Was I becoming pompous as well as old? To justify my scepticism, I decided that the first thing I had to do was to make sure I was up to scratch myself.

It seemed logical to use my prolonged study leave to spend a few months in secondary care—so I did, in a busy "no stars" hospital with some excellent clinicians but little cohesion. The senior and junior staff gave me free rein and I gained enough from the experience to produce 4000 words for the secretary of state for health. Starting on the emergency assessment unit, I was asked to demonstrate that GPs' risk management skills could reduce the patient admission rate. A government report backing up the idea followed shortly afterwards, and the same hospital now has several GPs performing this role.

The MRCP exam followed logically. I befriended some senior house officers who were taking the exam and jumped on the bandwagon. Part 1 was tough, with its emphasis on basic science. I realised how the world had come on over the past 30 years. When I was at university there were no cytokines and no polymerase chain reactions. We knew that genes made proteins but not exactly where the genes lived. The part 2 written paper was different. The real challenge was concentrating for six hours while reading long, drawn out hospital type cases. To tick a box (one correct from five) at the

end was almost an anticlimax. For each part I did a course and on each of those courses the audience listened diligently to the speaker with little interruption. How different from our Tuesday GP meetings, which are almost always interactive.

I expected the clinical section to be a welcome relief. Preparation included rustling up as many consultants as I could and trekking around the hospital with them, examining body systems. The bodies were not allowed to speak and, as in the exam, would be described only as "breathless" or "losing weight." From my standpoint, picking up the patient's hand in silence first (as one does) seemed decidedly unnatural. Poking people's offal for self interest seemed decidedly rude. Still, rules are rules, and I gradually became skilled at lifting up every arm to check for collapsing pulses and saying that I would do a rectal examination while not actually doing one.

I passed, but not without a splutter. Although I had scored 100% half way through the examination, I ran out of time in one of the clinical cases and didn't fully examine a patient's chest. At this point, I collapsed like an English test cricket side, crashing from 200 for no wicket to 210 all out. My confidence was in tatters. I had never heard crackles above the clavicle before (or since) but interpreted them incorrectly because at that moment my brain had turned to porridge. The head porter would have done better with the abdomen that followed.

So why am I reliving all this? Firstly, because I would like to commend the Royal College of Physicians for allowing me to break the usual rules and take the exam at my age. And, secondly, to share some of what I learnt. I am happy that the exam is valid and, my own hiccups aside, reliable.

I have learnt that I picked the right career as a GP, with or without a special interest. I have learnt that my hospital colleagues want good communications as much as I do. I have been reminded that candidates are in a state of fragility and when examining I will avoid untimely interruptions. Instead, I will try to bring out the best in them. Finally, I have learnt that no person can know everything and, in the words of Alfred Lord Tennyson, "Knowledge comes, but wisdom lingers."

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