FREE CASES AND CONCEPTS FOR THE NEW MRCGP: CLINICAL SKILLS ASSESSMENT AND CASE-BASED DISCUSSION PDF

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Cases and Concepts for the new MRCGP 2e

Metrics details. Although the legal challenge was dismissed, substantial performance differences between white and BME Black and Minority Ethnic doctors undoubtedly exist. Detailed analyses by candidate ethnicity show that although White candidates out-perform BME candidates, the

differences are largely mirrored across the two examinations.

Whilst the reason for the differential performance is unclear, the similarity of the effects in independent knowledge and clinical examinations suggests the differences are unlikely to result from specific features of either assessment and most likely represent true differences in ability.

Peer Review reports. Assessments of all sorts, particularly high-stakes assessments, need to be valid. That is certainly the case for post-graduate medical examinations, where passing an examination provides entry into a specialist career, and failure means the abandonment of that career route.

Validity is a difficult concept, with many definitions and sub-categories, and changing ideas about its interpretation [1 - 4]. In this paper one of our aims is to concentrate on just one of those strands, one which has hardly been looked at for UK postgraduate assessments, which is the extent to which performance on one assessment correlates with subsequent performance on another.

For practical reasons it is rare for specialist examinations in different specialties to be taken by the same candidates. Nevertheless we have found a substantial cohort of individuals who have taken both MRCGP and MRCP UKtwo separate postgraduate examinations, which have different syllabuses, different methods of measurement, and are run by entirely separate organizations.

That group allows comparison of performance on the two separate examinations and as such is a form of concurrent validity, albeit that one assessment is taken somewhat later than the other.

Together those, and other such studies and arguments, suggest that postgraduate examinations in general are probably valid predictors of behaviour in actual clinical practice.

Issues of validity are closely tied up with issues of fairness. If a test score can be interpreted as valid, then differences in performance between different groups of doctors can be considered to represent true differences in ability, and hence the examination can be seen as fair despite group differences.

Many UK medical assessments, both at undergraduate and postgraduate level, show differences in performance according to ethnicity [9], including both Cases and Concepts for the New MRCGP: Clinical Skills Assessment and Case-based Discussion UK [10], and MRCGP where the issues has been flagged in annual reports sinceand in the current report [11]. Duringthis matter had become more controversial in the case of the MRCGP, in part due to increasing public agitation by BAPIO, and as a result the GMC instigated a review, a report on which was published by that body in September [12], along with a separate paper in the BMJ with somewhat different conclusions [13].

Reports on these studies were published in Aprilshortly after the Judicial Review ended [1415]. With the completion of the Court case and the publication of the papers on PLAB, it is important and now realistic to explore the issue of differential performance publicly and dispassionately. The first aim of this paper is to evaluate the general extent to which the performance of candidates on one examination predicts their performance on the other, which may be seen as indicating the extent of an aspect of their validity.

High-stakes, postgraduate medical assessments should be valid. However attempts to provide formal evidence of validity are, in practice, rare, for a host of reasons. In medicine, the scarcity of such data reflects the fact that there is no national UK qualifying examination taken by all graduates, and that relatively few doctors who are training in one specialty will subsequently take exams in another specialty.

The second, more specific, aim of this paper is to examine the performance of those candidates of different ethnicities who, unusually amongst UK doctors, sat the entirely separate assessments of two major examining bodies. Did they fare similarly under each? The examinations also each have knowledge and clinical assessments, and it seems reasonable to predict that there will be some congruence on those assessments. Our analysis therefore looked not only at overall performance on Cases and Concepts for the New MRCGP: Clinical Skills Assessment and Case-based Discussion examinations, but also at performance on the different components and in the case of the MRCGP, at the three separate marks which are available within the AKT.

Previous detailed analyses of MRCP UK have shown that the mark at the first attempt is the best correlate of performance at other components of the exam, and it also predicts subsequent performance at the exam [18], and hence all analyses here are restricted to marks at first attempts. Standard-setting was by means of an Angoff process, with statistical equating across diets. From thethe number of cases was increased to thirteen and the standard-setting process was changed to the borderline group method, calculated on a daily basis [19].

The presentation of marks changed at the same time, and all marks Cases and Concepts for the New MRCGP: Clinical Skills Assessment and Case-based Discussion presented in the current marking scheme which was equated to a mean of and a standard deviation of for the reference cohort used for equating, with earlier marks being put onto the new scheme.

The marking scheme for PACES changed in [21], although almost all of the present candidates had in fact taken it before then. Although the current marking scheme for PACES has seven skills, with a pass being required in each, a total mark is also available for statistical purposes and it has been used here for the 63 candidates 6.

Marks for Part 1, Part 2 and PACES are expressed relative to the pass mark, positive or zero marks meaning a candidate passes and negative marks that they fail.

Alternatively, the much larger group of doctors who took MRCP UK Part 1, but then did not go on to take the other parts of MRCP UK may have been discouraged from a career in hospital medicine by their performance on Part 1, and may have therefore turned to general practice.

Column e shows the performance of all doctors in the MRCP UK database who had taken all three parts of the examination and hence had passed Parts 1 and 2. The results can be summarised succinctly as knowledge tests correlating better with knowledge tests and clinical tests with clinical tests. That pattern is supported by the sub-tests of AKT, where clinical medicine correlates most highly with MRCP UK Part 1 and Part 1 is almost entirely about clinical medicine and the applied biomedical science underlying itsomewhat less with evidence interpretation, and least of all with organisational aspects which relate particularly to NHS general practice.

Other comparisons are more significant. However, all measurements, be they of examinations or other behavioural measures, have error and hence are unreliable to a greater or lesser extent. Disattenuated correlations give a more accurate estimate of the shared variance between two tests r d 2. The pattern of correlations remains similar, with the knowledge tests predicting other knowledge tests and the clinical measures predicting the clinical measures.

Ethnicity was therefore classified as white if the candidate had declared themselves as white in Cases and Concepts for the New MRCGP: Clinical Skills Assessment and Case-based Discussion of the databases, and otherwise was classified as BME. Of the 2, candidates who had taken both examinations, The analyses described below for all candidates have been repeated for UK graduates alone and almost identical results have been found, and therefore results regarding ethnicity will be reported here for the full candidate group.

Understanding the mechanism is not straightforward, but having both MRCP UK and MRCGP data allows an additional handle on the problem, and we know of no other studies that examine performance in terms of this variable which look at the relationship between two examinations.

Part 2 also shows an effect of ethnicity, after taking Part 1 into account; and similarly PACES shows an ethnicity effect after taking Parts 1 and 2 into account. Similarly the sub-scores on AKT also show an ethnicity effect, and with the exception of AKT evidence Interpretation, the AKT sub-scores shown ethnicity effects even after taking other sub-scores into account.

The pattern is not completely clear, but is certainly not compatible with the new CSA being less valid than the old CSA, nor with the CSA and AKT correlating less in BME than white candidates, and in both cases the pattern may be significant in the opposite direction. Forward-entry regression was used, with lower order terms being entered before higher-order terms. Lines shown are fitted lines from multiple regression. The intercepts are for the point where the lines cross the vertical line indicating a PACES score of zero i.

A comparison of the performance of candidates who have taken both MRCGP and MRCP UK assessments helps in understanding a number of issues concerning the validity of both of the examinations, as well as the impact of other factors such as ethnicity and the change in the CSA assessment.

Before considering the issue of performance by ethnicity, it is helpful to reflect on the general relationship between the two sets of assessments and upon the demographics of candidate taking each. The two examinations do not include the same questions or the same technical material, although there is inevitably overlap in the broad domains of medical knowledge being assessed - the GP curriculum is broader, including coverage of clinical areas of obstetrics and gynaecology, psychiatry, otorhinolaryngology etc.

That would be supported, but only partly supported, by Part 1 correlating most highly with the clinical medicine component of AKT and least with the organisational questions material which does not appear in MRCP UK. However the latter correlation is still. It might be felt that there is perhaps little surprising about the fact that candidates who do well on one examination also do well on another, and so it is worth considering how a low or zero correlation could have been achieved and how it might have been interpreted.

Had either of the assessments had a zero reliability in effect producing random numbersor been reliable but assessing arbitrary material of no relevance to medicine, then performance of the two assessments would have been uncorrelated.

That they are in fact substantially linked supports the idea that both are assessing cognate areas of relevance to medicine. Of course that alone cannot demonstrate validity, for, as has been emphasised earlier, the argument for validity requires information from multiple strands of evidence. The correlation is however compatible with validity, and the argument for validity would be compromised if such a correlation not present. In general the present sample of candidates perform better at MRCGP than typical candidates, suggesting either that studying for MRCP UK has benefited them, or that they were anyway higher-flying or more ambitious candidates.

Having said that, they have not performed as well as candidates taking all three parts of MRCP UKand the move to MRCGP may have reflected a realisation that they were not likely to succeed as well at hospital medicine, or that their interests were more outside of hospital medicine. Cases and Concepts for the New MRCGP: Clinical Skills Assessment and Case-based Discussion there could also be many other reasons for the undoubted differences including lifestyle changes including personal relationships, child-rearing and health.

Having an external measure which is correlated with performance at MRCGP provides a tool for analysing issues which might otherwise be hard or perhaps impossible to assess. The issue of the underperformance of ethnic minority candidates and the relationship between the old and the new CSA examination are good examples of that. The explanation for such effects is not clear, but the fact that the effects occur across two independent examinations, in both MCQ and clinical examinations, and after taking previous performance into account, suggests that the effects are unlikely to be due to particular features of any one assessment, component of an assessment or style of assessment.

A similar effect has been reported in several cohort studies, ethnic minorities underperforming at successive stages, even after taking previous performance into account by structural equation modelling. Detailed studies of both MRCGP and MRCP UK suggest that differences in performance of BME candidates are unlikely to be due to bias on the part of clinical examiners, in part because differences also exist for MCQ assessments, and because marks awarded seem to show only very small relationships to ethnicity of examiner interacting with ethnicity of candidates [102829].

Cases and Concepts for the New MRCGP: Clinical Skills Assessment and Case-based Discussion differences between the old and the new CSA assessment are of interest, the new CSA having been introduced with the intention of producing a more valid, more reliable assessment of clinical skills, although there have been concerns that this might not be the case particularly for some sub-groups [30]. The regression also assessed whether there was an interaction between ethnicity and the old and new CSA assessments, and there was no evidence of an effect either on the intercept or Cases and Concepts for the New MRCGP: Clinical Skills Assessment and Case-based Discussion slope.

If the new CSA were unfairly biased against BME candidates then Cases and Concepts for the New MRCGP: Clinical Skills Assessment and Case-based Discussion interaction would be expected, and the present data therefore Cases and Concepts for the New MRCGP: Clinical Skills Assessment and Case-based Discussion not support any suggestion of bias.

The current analyses have shown that additional value can be added to analyses of postgraduate examination performance by combining data from several colleges or examination boards, to contrast the performance of those taking both assessments.

Although the numbers doing so may be small compared with the numbers taking only a single assessment, they are still large enough in the case of two large examinations such as MRCGP and MRCP UK to achieve substantial sample sizes: this allows detailed analysis which can contribute to an understanding of the behaviour of both assessments, and make an additional contribution to arguments for the validity of each.

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Case based Discussion (CbD) tool - old WPBA programme

They continue in development and should not be considered as the final versions, rather as the latest. It describes the purpose and format of the RCA, and provides information about how to make an application, and how to collect and submit consultations.

From November onwards, Cases and Concepts for the New MRCGP: Clinical Skills Assessment and Case-based Discussion regulations for submissions for the RCA have changed. It will now be mandatory to submit cases from across the GP curriculum that include: physical examination; a child; an elderly person; a mental health problem; and specific clinical problems, such as involving a long-term condition.

Candidates for those diets are encouraged to read the guidance on cases to submit to demonstrate skills and capabilities, consent and examination of patients when preparing for those diets, and to refer to the regulations when they are published. The RCA is a summative assessment of a doctor's ability to integrate Cases and Concepts for the New MRCGP: Clinical Skills Assessment and Case-based Discussion apply clinical, professional, communication and practical skills appropriate for general practice.

It uses pre-recorded video or audio consultations to provides evidence from a range of encounters in general practice relevant to most parts of the curriculum and also provides an opportunity to target particular aspects of clinical care and expertise. If a consultation is submitted, where this guidance is breached, examiners have been advised that they should not continue to watch or assess it, and no marks will be awarded for that consultation.

Cases and Concepts for the New MRCGP: Clinical Skills Assessment and Case-based Discussion aim of the RCA is to test a doctor's ability to gather information and apply learned understanding of disease processes and person-centred care appropriately in a primary care context, make evidence-based decisions, and communicate effectively with patients and colleagues.

This guidance is offered to encourage candidates to demonstrate their skills across a breadth of the curriculum and General Practice which would normally be selected for you in the CSA. It is not an exclusive list, nor do you have to consult with every example listed.

However, the best way to ensure you demonstrate your skills across a breadth of the curriculum is by including a wide range of different consultations. In response to trainee feedback requesting further guidance on case submissionand learning from the emergency Recorded Consultation Assessment RCA diets, mandated and recommended case criteria have been developed. Read our guidance on case submission. We would suggest where possible you utilise new patient contacts rather than follow up patients as these are more likely to allow you to demonstrate your competence in consultation skills.

Whilst it is recognised that many of the patients will have been triaged before the consultation begins, you should at the very least check with the patient whether your understanding of that triage process and its outcome aligns with theirs. You should use the full breadth of the curriculum topic guide areas in preparing recordings for submission.

However, the RCA handbook currently contains only the clinical topic guide headings. Please ensure you enter a short description of the case. Low challenge cases are unlikely to give you the opportunity to demonstrate your Cases and Concepts for the New MRCGP: Clinical Skills Assessment and Case-based Discussion skills fully and will make it difficult for examiners to find evidence to meet the required performance

criteria.

Examples of low challenge consultations might include simple lower urinary tract infections, straightforward skin conditions such as viral warts, uncomplicated upper respiratory tract infections and some follow up consultations.

However, any of these apparently low challenge cases can become more complex if, for example, significant psychosocial factors become apparent during the consultation. In general, more complex consultations are likely to give you the opportunity to demonstrate your consultation skills fully and meet the performance criteria required.

Examples of complex consultations might include consultations with patients who are new to you, those with a significant psychosocial component, patients presenting with more than one problem, patients with multimorbidity, and consultations with more than one person.

Each consultation that is recorded must be done with the informed consent of the patient and there should be no coercion. Informed consent must be sought before the consultation takes place, but it must also be confirmed after the consultation is over. Once your booking is confirmed by the RCGP Examination Department you will be provided with a link to access the FourteenFish RCA platform on to which you will be able to submit recordings, or record directly.

The platform contains clear guidance about its functionality and Cases and Concepts for the New MRCGP: Clinical Skills Assessment and Case-based Discussion you can use the system to directly contact the patient and link to your chosen mode for example, mobile telephone.

You will be able to upload a variety of recorded file formats to the platform. Recording of your consultations can, therefore, begin immediately.

Apply for the RCA exam. If you are in any doubt, please clarify this with your Educational supervisor or TPD. Specific Learning Difficulties, such as dyslexia, may qualify for extra time in written exams like the Applied Knowledge Test where a candidate is expected to read and assimilate a lot of information in a limited time.

The Recorded Consultation Assessment does not restrict the Cases and Concepts for the New MRCGP: Clinical Skills Assessment and Case-based Discussion for reading case notes or information in advance of recording the consultation.

Adjustments in the time allowed, for dyslexia alone, are not usually eligible to be considered for a reasonable adjustment. Candidates should liaise with the GP training practice or their employers about adjustments. Complete a reasonable adjustment request form including the adjustments made in the workplace already with additional adjustments you would like made.

Please refer to the guidance below before submitting your request. The best preparation for the RCA is experience in general practice and seeing patients. Find guidance for educators in Top tips to help your trainee prepare for the RCA: an educator's guide. Each consultation will be viewed independently by at least one examiner Cases and Concepts for the New MRCGP: Clinical Skills Assessment and Case-based Discussion will make a global judgement of that consultation, attributing marks in three domains - data gathering, clinical management and interpersonal skills.

The first ten minutes of the consultation submitted will be assessed. This time will not include any time for verbal consent that is recorded. There may be allowance made for needing to leave the room for example, to collect a urine bottle, but the time taken for examinations will be part of that ten minutes. The camera should run continuously and not be turned off during the consultation submitted. The candidate demonstrates a high level of competence, with a justifiable clinical approach that is fluent, appropriately focussed and technically proficient.

The candidate demonstrates an adequate level of competence, with a clinical approach that may not be fluent but is justifiable and technically proficient.

The lack of complexity in the case presented restricts the achievement of a Clear Pass grade. The candidate fails to demonstrate adequate competence, with a clinical approach that is at times unsystematic or inconsistent with accepted practice. Technical proficiency may be of concern. There is limited new evidence provided to demonstrate capability of a doctor sufficient for safe independent UK General Practice.

The candidate clearly fails to demonstrate competence, with a clinical approach that is incompatible with accepted practice, arbitrary or technically incompetent.

There is no evidence or very limited evidence provided to demonstrate capability of a doctor sufficient for safe independent UK General Practice in this domain. The patient is not treated with adequate attention, sensitivity or respect for their contribution.

Data Gathering, Technical and Assessment Skills. Interpersonal Skills. You are responsible for ensuring that consultations are uploaded to the FourteenFish RCA platform by the published due date.

You are responsible for checking the quality of sound and picture of all the consultations you choose to submit. Guidance on recording consultations, consent and the short summary workbook are described in the relevant sections above.

The result of your examination along with any formative feedback will be published in your ePortfolio on the date given in the table on the Recorded Consultation Assessment tool page.

Please bear in mind that the nature of the training cycle means that candidate cohorts differ considerably. The results for a particular diet should not therefore be used to draw any conclusions about the likely pass rates for other cohorts. The results for the first RCA in July Cases and Concepts for the New MRCGP: Clinical Skills Assessment and Case-based Discussion split into two cohorts; prioritised in order to process CCTs for candidates in order of urgency.

It is not a straightforward comparison to the previous CSA diet as this is a new exam and would represent a cohort who may have sat the previous CSA during March, April or May However, it can be noted that the overall CSA pass rate for academic year was The proportion of candidates sitting the clinical skills examination for the first time was The mean score on this occasion was out of and the highest score was A further 5 candidates obtained overall scores of marks or more.

A further 4 candidates obtained overall scores of marks or more. The proportion of candidates sitting the RCA for the first time was Close This site uses cookies. If you continue without changing your settings, we will assume that you agree to our use of cookies. Find out more. New regulations: changes to submissions From November onwards, the regulations for submissions for the RCA have changed.

Format of the RCA The RCA will provide an objective assessment of clinical skills from real life settings provided across 13 consultations and undertaken by the candidate from their own current working environment.

Due to the response to the pandemic situation it is likely that the majority of these will be conducted remotely. The RCA will be sat during the ST3 year or Cases and Concepts for the New MRCGP: Clinical Skills Assessment and Case-based Discussion of training and recordings will be made during this time.

They may be any combination of audio, video or face to face consultations. Cases submitted should be of an appropriate level of challenge for an ST3 trainee to demonstrate safe and independent practice. These cases will be assessed by trained and calibrated examiners who are experienced GPs. Each consultation will be viewed independently by at least one examiner who will make a global judgement of that consultation, attributing marks in three domains and blind to other marks the candidate receives for that or any other consultation.

It is the responsibility of the candidate to obtain consent from the patient under the usual guidance for training and GDPR. Recordings submitted for the RCA will be deleted from the central IT platform after the Examination Board has ratified and published results. Material uploaded to the central IT platform but not submitted for the RCA will be deleted after 26 weeks days.

Recordings of individual consultations should be continuous. The camera should not be turned off during consultations and recordings must NOT be edited in anyway. The use of any service to screen cases prior to submission to the RCA is expressly prohibited. Failure to adhere to this Guidance may result in referral to the GMC. RCA consultations The aim of the RCA is to test a doctor's ability to gather information and apply learned understanding of disease processes and person-centred care appropriately in a primary care context, make evidence-based decisions, and communicate effectively with patients and colleagues.

Specifically: Knowing yourself and relating to others Develop the attitudes and behaviours expected of a good doctor Treat others fairly and with respect Provide care with compassion and kindness Establish an effective partnership with patients Maintain a continuing relationship with patients, carers and families.

Applying clinical knowledge and skill Apply a structured approach to data gathering and investigation Interpret findings accurately to reach a diagnosis Demonstrate a proficient approach to clinical examination Adopt appropriate decision making principles Apply a scientific and evidence-based approach Provide general clinical care to patients of all ages and backgrounds; Adopt a structured approach to clinical management Make appropriate use of other professionals and services Provide urgent care when needed Managing complex and long-term care Enable people living with long-term conditions to improve their health Manage concurrent health problems in an individual patient Adopt safe and effective approaches for patients with complex health needs Work as an effective team member coordinating a team-based approach to the care of patients.

Caring for the whole person and wider community Demonstrate the holistic mindset of a generalist medical practitioner Support people through individual experiences of health, illness and recovery; Understand the health service and your role within it. Guidance on cases to submit Updated 14 September This guidance is offered to encourage candidates to demonstrate their skills across a breadth of the curriculum and General Practice which would normally be selected for you in the CSA.

Mandatory Case selection criteria for RCA from November In response to trainee feedback requesting further guidance on case submissionand learning from the emergency Recorded Consultation Assessment RCA diets, mandated and recommended case criteria have been developed. Your workbook will help you check the variety in your submission, for example: The GP curriculum and topic guides can be found on the RCGP website. For reference please review the clinical topic areas as set out in the curriculum.

Topic guides about clinical topics: Allergy and immunology Cardiovascular health Dermatology Ear, nose and throat ENTspeech and hearing Eyes and vision Gastroenterology Genomic medicine Gynaecology and breast Haematology Infectious disease and travel health Kidney and urology Mental health Metabolic problems and endocrinology Musculoskeletal health Neurodevelopmental disorders, intellectual and social disability Neurology Population health Respiratory health Sexual health Smoking, alcohol and substance misuse.

Please note: It is the responsibility of the candidate to be aware of the deadline for submission of cases and to work within this to make their submission in good time. It is the candidate's responsibility to ensure the consultation recordings submitted are of good quality in sound and picture.

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Kiranpreet Gill. A lady with a headache. Georgina Yan. A drowsy baby. Andrea Dann. A lady with jaundice. A lady with haematemesis. Tanya Dhir. Collapse on the beach. Dr Lewis Potter. A lady presenting with loss of consciousness. A man who is hearing things. Dr Ash Birtles. Join the community. See all results.