Preface

*'MRCP; Member of the Royal College of Physicians . . . They only give that to crowned heads of Europe.'**

A short history of *An Aid to the MRCP PACES*

'Remember when you were young, you shone like the sun . . .'†

At the beginning of the 1980s, Bob Ryder, an SHO working in South Wales, failed the MRCP short cases three times (an SHO in modern parlance is a core medical trainee [CMT]).‡ On each occasion I passed the long case and the viva which constituted the other parts of the MRCP clinical exam in those days but each time failed the short cases. Colleagues from the year below who had been house physicians, with me the SHO, came through and passed§ while I was left humiliated and without this essential qualification for progression in hospital medicine.

The battle to overcome this obstacle became a two or more year epic that took over my life. I transformed from green and inexperienced¶ to complete expert in everything to do with the MRCP short cases as viewed from the point of view of the candidate. I experienced every manifestation of disaster (and eventually triumph) recorded by others in Volume 2, Section F. By the time of the third attempt, I was so knowledgeable that I was out of tune with the examiner on a neurology case simply because I was thinking so widely on the case concerned.‖ I believed at the time that I came close to passing at that attempt, although one never really knows and it was, after all, the occasion where I failed to feel for a collapsing pulse!** This was an important moment in the story because it was from this failure, along with the experience in the neurology case in my second attempt¶, that the examination *routines* and *checklists*, which are so central to this book, emerged. I finally passed on the fourth attempt whilst working as a registrar.†† During the journey, various consultants, senior registrars and colleague registrars tried to help in their various ways and amongst these, one of the consultants in my hospital, Afzal Mir, offered the advice that I should make a list of all the likely short cases and make notes on each and learn them off by heart. His exact advice was to 'put them on your shaving mirror'. An important point should be made at this juncture. In order to be able to achieve this, one needed to attain the insight that it was indeed possible to do this. In those days there was no textbook for the exam, like the one you are reading, and there was no syllabus. Things had perhaps improved a little since the quote at the top of this Preface from A.J. Cronin* but nevertheless, the MRCP did carry with it an awe, a high failure rate and an aura that the exam was indeed one consisting of cases you had not seen before and questions you did not know the answer to. Indeed, many of us sitting it at the time would have found this a reasonable definition of the MRCP short cases.

A crucial part of my two or more years, four-attempt, journey that formed the seed that eventually grew into the first edition of this book was the realization that, in fact, behind the mystique, the reality was that the same old cases were indeed appearing in the exam over and over again, that there was a finite list and, indeed, from that list some cases occurred very frequently indeed.‡‡ The realization of this led me to do exactly what Afzal Mir had advised (without the shaving mirror bit!). At the time there was a free, monthly journal that we all received called *Hospital Update* and it had a regular feature dedicated to helping candidates with the MRCP. In one issue the writer listed 70 cases which he reckoned were the likely short cases to appear in the exam and an eye-balling of this suggested it was fairly comprehensive.

And so I studied each of these 70 cases in the textbooks and made notes which were distilled into their classic features and other things that seemed important to remember and I wrote out an index card for each of the 70. Thus, the original drafts of the main short case *records* were penned whilst I was still sitting the MRCP.

Another major contributor to my final success with the exam was junior doctor colleague Anne Freeman. She had been on the Whipps Cross MRCP course with me prior to our first sittings of the exam and she passed where I had failed. Until that point, I think we would have considered ourselves equals in knowledge, ability and likelihood of passing.‡ I would describe Anne as being like Hermione Granger.§§ In her highly

organized manner, she had written down the likely instructions that might be given in the short cases exam and under each had recorded exactly what she would do and in what order, should she get that instruction. She then practised over and over again on her spouse (Dr Peter Williams, to whom she is especially grateful) until she could do it perfectly, without thought or mistake or missing something out, even in the stress of the exam.** I, on the other hand, was not like Hermione Granger. I could examine a whole patient perfectly in ordinary clinical life but had not actually thought through exactly what I would do, and in what order, when confronted with an instruction such as 'examine this patient's legs' until it actually occurred in the exam.¶ And so eventually I did what Anne Freeman had done and the first versions of the *checklists* (for which I am especially grateful to my wife, Anne Ryder, who wrote them out tidily and then ticked off each point as I practised the examining, pointing out whenever I missed something out!) and primitive versions of the examination *routines* were born, again whilst I was still sitting the MRCP.

Having finally passed the exam, it seemed a shame to waste all the insights into the exam and the experience I had gained, and all the work creating the 70 short case index cards and the examination *routine checklists* I had created and practised and honed so laboriously – and so I conceived the idea of putting them in a book for others to have the benefit without having to do so much of the work or, perhaps, to go through the ordeal of failing through poor preparation as I had done. I shortlisted what seemed to be the four major publishers of the moment and on a day in 1982 was sitting in the library of the University Hospital of Wales penning a draft letter to them. At a certain moment I got stuck over something – I have long since forgotten what – and on an impulse went down to Afzal Mir's office to ask him something to do with whatever it was I was stuck over. It was a defining moment in the history of these volumes. When I left Afzal Mir's office, the project had changed irrevocably. I was a registrar, he was a consultant. He was extremely interested in the subject himself and my consultation with him ended up with the project being one with both of us involved and me with a list of instructions (consultant to registrar!) as to what to do next!

And so an extremely forceful and creative relationship began, which led to *An Aid to the MRCP Short Cases*. It was not that we worked as a peaceful collaborative team – rather the thing came into existence through creativity on a battleground occupied by two equally creative and forceful (in very different ways) people with very different talents and approaches. There are famous examples of this type of creative force, e.g. Lennon and McCartney or Waters and Gilmour.¶¶ Looking back, there is no doubt that without the involvement of myself and Afzal working together, an entirely different and inferior book would have emerged (probably the short 100-page pocket book desired by Churchill Livingstone – see below) but at the time I did not realize this and only thought that I was losing control of my project through the consultant–registrar hierarchy! My response was to bring in Anne Freeman, who I am sure would be very happy to be thought of as the Harrison/Starr or the Wright/Mason of the band!¶¶

Anne and I, in fact, also became a highly creative force through the development of the idea of surveying successful MRCP candidates to find out exactly what happened in the exam. It started off with me interviewing colleagues and this led to the development of a questionnaire to find out what instruction they had been given, what their findings were, what they thought the diagnosis was and their confidence in this, what supplementary questions they were asked, and their comments on the experience of that sitting. I distributed it to everyone I could find in my own and neighbouring hospitals, whilst Anne took on, with tremendous response, the immense task of tracking down every successful candidate at one MRCP sitting and getting a questionnaire to them! We asked all to report on both their pass and previous fail experiences.

Our overture to the publishers resulted in offers to publish from Churchill Livingstone (now owned by Elsevier Ltd) and Blackwell Scientific Publications (now owned by John Wiley & Sons) with the former coming in first and so we signed up with them. They were thinking of a 100-page small pocket book (70 brief short cases, a few examination routines, hardly any illustrations) sold at a price that would mean the purchaser would buy without thinking. The actual book, however, created itself once we got down to it and its size could not be controlled by our initial thoughts or the publisher's aspirations. We based the book on the, by now, extensive surveys of candidates who had sat the exam and told us exactly what happened in it – the length and the breadth. This information turned the list of 70 cases into 150 and from the surveys also emerged the 20 examination *routines* required to cover most of the short cases which occurred. As to what should be included with each short case, that was determined by ensuring that we gave everything that the candidate might need to know according to what they told us in

the surveys. We were determined to cover everything that the surveys dictated might occur or be asked. It was also clear that pictures would help. We battled obsessively over every word and checked and polished it until it was as near perfect as possible. By the time it was finished three years later, the 100-page pocket book had turned into a monster manuscript full of pictures.

I took it to Churchill Livingstone who demanded that it be shrunk down to the size in the original agreement or at least some sort of compromise size. We were absolutely certain that what we had created was what the MRCP short case-sitting candidates wanted and we refused to be persuaded. And so we were rejected by Churchill Livingstone. This was a very depressing eventuality! I resurrected the original three-year-old offer letter from Blackwell Scientific Publications and made an appointment to see the Editorial Director – Peter Saugman. I turned up at his office carrying the massive manuscript and told him the tale. Wearing his very experienced publisher hat, he instantly and completely understood the Churchill Livingstone reaction but also understood something from my passion and certainty about the market for the book. He explained that he was breaking every publishing rule but that he was senior enough to do that and that he would go ahead and publish it in full on a hunch. In 1986, he was rewarded by the appearance of a 400-page textbook-sized book, which rapidly became one bought and studied by almost every MRCP candidate. Indeed, that original red and blue edition can be found on the bookshelves either at home or in the offices of nearly every medical specialty consultant in the UK.

After this, our first and best, we all pursued solo careers, with Afzal making clinical videos of patients depicting how to examine them, and writing other books such as *An Atlas of Clinical Diagnosis* (Saunders Ltd, second edition, 2003), Anne developing services for the elderly and people with stroke in Gwent, and me pursuing diabetes clinical research in various areas. Meanwhile, Anne in particular continued to accumulate survey data and in the second half of the 1990s we came together again to make the second, blue and yellow, edition of the book (1999). The surveys (which by this stage were very extensive indeed) had uncovered a further 50 short cases that needed to be included and the original material all needed updating.

Then, in 2001, the Royal Colleges changed the clinical exam to PACES. Until then the short cases exam had been a room full of patients of all different kinds with the candidate being led round them at random – according to the examiner's whim – for exactly 30 minutes. Anything from four to 11 patients might be seen. This was now transformed into Stations 1, 3 and 5 of the PACES exam, each 20 minutes long, thus doubling the time spent with short cases and ensuring that patients from all the main medical specialty areas were seen by every candidate. Hence, *An Aid to the MRCP Short Cases* was transformed into *An Aid to the MRCP PACES Volume 1*, with the short cases divided into sections according to the Stations. Specialists helped us more than ever with the updating and by now surveys had revealed that there were 20 respiratory cases that might occur, 19 abdominal cases, 27 cardiovascular cases, 52 central nervous system cases, 51 skin cases, 19 locomotor cases, 18 endocrine cases, 21 eye cases and eight 'other' cases. The long case and viva sections of the old clinical exam were replaced by Stations 2 (History taking) and 4 (Communications and ethics). To help us with these we recruited new blood – a bright and enthusiastic young physician who had recently passed the MRCP – Dev Banerjee, and he led on the Volume 2 project. Dev now confesses that 'one of the hardest aspects of writing Volume 2 back then before 2003 was coming up with enough surnames. You cannot believe how hard it was. Should I refer to the Bible? Should I refer to the Domesday Book? I decided in the end, as I had grown up in Leeds and supported Leeds United all my life, to use the 1970s Leeds United team sheet for surnames. It's not obvious, but if you look carefully, it is there!'. Finally, in 2003, the third edition was published in silver and gold.

After many years intending to do this, we also created a medical student version of the short cases book on the grounds that medical student short cases exams are essentially the same as the MRCP in that it is the same pool of patients and the examiners are all MRCP trained so that is how they think. However, whilst most MRCP candidates continue to use our books, most medical students have not discovered their version – it has the wrong title because medical students no longer have short cases exams – they have OSCEs! Those who have discovered it report that they have found it useful for their OSCEs.

And now the Royal Colleges have changed the exam again. And so *An Aid to the MRCP PACES* has become a trilogy. Stations 1 and 3 remain roughly the same and hence Volume 1 covers Stations 1 and 3 and Volume 3 has been created to deal with the new style of Station 5. Each short case has been checked and updated by one or more specialist(s) and these are now acknowledged at the start of the station concerned against the short case they have taken responsibility for. The same applies

to the short cases in Station 5. Nevertheless, I have personally checked every suggestion and update and took final editorial responsibility, changing and amending as I thought fit. The order of short cases was again changed according to new surveys (now done online) and yet again a few more new short cases were found from surveys: only four for Volume 1 – kyphoscoliosis and collapsed lung for Respiratory, PEG tube for Abdominal and Ebstein's anomaly for Cardiovascular. New young blood has again been recruited – a further two bright, young and enthusiastic physicians. The updating of Volume 2 covering Stations 2 (History taking) and 4 (Communications and ethics) has been led by Nithya Sukumar. For Volume 3, covering the new Station 5, Ed Fogden has created the new Section H (Integrated clinical assessment).

We are grateful to Julie Elliott from Wiley Blackwell for collecting, in person, the manuscripts edited by the specialists to ensure no possibility of them being lost, for the initial processing of these manuscripts and for overseeing the production of all three volumes; and we are especially grateful to Helen Harvey, freelance project manager for Wiley Blackwell, for working with us painstakingly on every word, and every page of the trilogy which is now the fourth edition. Throughout this process she had maintained her calm, cheerful efficiency and kept us all in line with her enduring support, patience and understanding.

We are grateful to the specialists, now listed in the appropriate sections, who have checked and updated the short cases in their specialties in Volumes 1 and 3, and who helped Ed Fogden with the scenarios in Section H, Volume 3; and we are especially grateful for the enthusiasm with which they have done this despite the considerable workload involved. We are grateful to Mrs Jane Price, Lead Nurse for Patient Experience, Aneurin Bevan Health Board, for her significant input to the section on Station 4. Her knowledge/experience in communication skills and medical ethics and her years of experience in dealing with these situations in clinical practice and guiding doctors in real-life scenarios have given great insight into the needs of PACES candidates. She has, therefore, contributed significantly to the development of the new cases included in this edition, and she also updated and enhanced the Introduction to Section E, Volume 2. Our surveys have always dictated the content of the books and so we are especially grateful to all the PACES candidates who have taken the trouble to fill in the online MRCP PACES survey at www.ryder-mrcp.org.uk. Finally, we are particularly grateful to our colleagues for their support in the ongoing project, which is a considerable undertaking, and we reiterate the deep thanks to our families expressed in the previous prefaces to Volume 1.

'*Life is what happens to you while you're busy making other plans.*'‖‖

The above, my all time favourite quote, of course can be applied to the candidate who passes when he should have failed and even more so perhaps to the one who fails when he should have passed; especially when this happens more than once as in the case of the SHO working in South Wales mentioned at the the start of this Preface. More so, it seems to me, it is really quite staggering the extent to which this quote seems to apply to life in general.

Bob Ryder
2013

*From *The Citadel* by A.J. Cronin.
†From the song *Shine on You Crazy Diamond* by Pink Floyd from the album *Wish You Were Here* (1975).
‡'The result comes as a particular shock when you have been sitting exams for many years *without* failing them.' Vol. 2, Section F, Quotation 374.
§Vol. 2, Section F, Experience 108.
¶Vol. 2, Section F, Experience 109.
‖Vol. 2, Section F, Experience 145.
**Vol. 2, Section F, Experience 144.
††Vol. 2, Section F, Experience 175. I measured my pulse just before going in to start this, my final attempt at the MRCP clinical, and the rate I remember is 140 beats/minute, but in retrospect I feel it must have magnified in my mind through the years – nevertheless whatever it was, it was very high. It is clear, though, that stress remains a major component of the exam – see Vol. 2, Section F, Experience 15.
‡‡Vol. 2, Section F, Useful tip 328 and Quotations 349 and 411–415.
§§A prominent character in the Harry Potter books by J.K. Rowling. Highly organized; expert at preparing for and passing exams.
¶¶Lennon and McCartney were the writing partnership of the Beatles with Harrison and Starr as the other members of the band. Similarly Waters and Gilmore for Pink Floyd with Wright and Mason as the other band members. In both cases it is believed that there was a special creativity through the coming together of the different talents of the individuals concerned, though the relationship was sometimes adversarial.
‖‖John Lennon, from the song, 'Beautiful Boy (Darling Boy)' from the album *Double Fantasy* (1980). It is particularly poignant that this quote should come from John Lennon, considering what happened to him later in the year of the quote.

Introduction

*'My Station 5 was a complete nightmare.'**

The MRCP PACES (Practical Assessment of Clinical Examination Skills) exam in general is discussed in the introduction to Volume 1 of *An Aid to the MRCP PACES*, and Volumes 1 and 2 deal with Stations 1–4 of the PACES exam. The volume you are now reading devotes itself entirely to Station 5. In the autumn of 2009, Station 5 changed. Prior to that Station 5 concerned itself with the clinical cases that were not addressed by Station 1 (respiratory and abdominal) and Station 3 (cardiovascular and neurological). These came under the headings Skin, Locomotor, Endocrine, Eyes and Miscellaneous. With the change in format of Station 5, we felt it important to establish what the Colleges' aspirations and intentions were with regard to these groups of clinical cases. We therefore communicated with the Station 5 group of the MRCP (UK) Clinical Examining Board. The following are quotes from those communications we received from the Colleges:

'*. . . there is no plan to remove skin, locomotor, endocrine, and eye problems from the clinical issues that may be assessed in the new Station 5. Candidates must prepare to be examined in these areas as they do now.*'

'*New Station 5 opens the opportunity to test integrated clinical thinking about a range of clinical problems from the curriculum in a way that junior doctors practise every day – including skin, locomotor, endocrine, and eye problems as well as others. It also offers the opportunity to assess communication skills in a further two encounters and so the new PACES exam is capable of assessing these crucial skills explicitly.*'

'*. . . trainees will then need to think on their feet about real issues relevant to everyday medicine, including the traditional disciplines of old Station 5.*'

'*. . . the existing components of Station 5 can feature in new Station 5 – and so candidates must learn and prepare for these cases. The difference is that the cases will be presented as clinical problems – so the candidate can take a relevant history and examine appropriately and not just look.*'

'*There is no intention to replace real patients in Station 5 with actors. It is possible to use surrogate patients in the new Station 5 for particular scenarios – and many real patients do not have physical signs. These are often a good test for the candidate provided they do not know they are facing a surrogate patient. Surrogate patients will form a small minority of encounters – just as we allow at Stations 1 and 3 in the exam now. They are a safety net for the host centre to ensure delivery of candidate assessments when there are problems sourcing patients.*'

'*Ophthalmoscopy is specifically included as a skill that candidates may have to demonstrate in the exam – in Station 3 or new Station 5. Additionally, recognition of fundal abnormalities on photographs will continue to feature in the Part 2 written paper.*'

Thus, the Colleges made it clear that there was no intention to reduce the requirement for candidates to be skilled in the disciplines of the old Station 5.

If you look through the Station 5 experiences in the 17 recent PACES experiences in Volume 2, Section F, of *An Aid to the MRCP PACES*, you will see that the Colleges' aspirations have indeed come to pass. The old Station 5 cases are continuing to occur – goitre, exophthalmos, Graves' disease, hyperthyroidism, acromegaly, psoriatic arthropathy, systemic sclerosis, mixed connective tissue disease, arthropathy associated with inflammatory bowel disease, Marfan's, swollen knee, psoriasis, rash of uncertain cause, Raynaud's, pemphigoid, yellow nail syndrome and diabetic retinopathy all being reported and ophthalmoscopy still being called upon to be undertaken.

In view of this we have in this volume, in Section I, provided all the clinical cases from the old Station 5

*Vol. 2, Section F, Experience 10.

disciplines that have occurred in the MRCP over the years and have had them updated by specialists in the same way as we did for Stations 1 and 3.

Reading the 17 experiences in Volume 2, there were old Station 5 short cases but with a twist – a diabetic with vision problems that turned out to be due to homonymous hemianopia, a patient with ankylosing spondylitis and a dense hemiplegia, a diabetic with visual problems and diabetic maculopathy, but also possibly amaurosis fugax and a patient with heartburn, dysphagia and breathlessness but only debatable sclerodactyly as evidence of systemic sclerosis.

The Colleges have also achieved their aspirations in that, reading the 17 experiences in Volume 2, it is clear that Station 5 now has further new challenges, as well as the old ones. Cases such as dementia, polymyalgia rheumatica, migrainous headaches requiring the use of an ophthalmoscope, mononeuritis multiplex, falls in a patient with lots of potential causes, headache followed by diplopia, a patient with a pansystolic murmur and SBE, TIA, vasovagal attack, palpitations after cocaine use, watery diarrhoea (an actor), diabetic with collapse with several possible causes and upper motor neurone facial palsy. It is clear that many of these represent the challenges faced in the medical assessment unit (MAU) and we are sure this is the intention of the Colleges in supporting them.

Thus, in Section H, we have addressed the new Station 5. As is clear from the above, from more survey information and from discussions with examiners, whilst the disciplines in the old Station 5 are indeed addressed in the new Station 5, cases can occur from all disciplines. Thus we have, in Section H, provided examples addressing the new exam format, not only from the old Station 5 disciplines but also from other disciplines that have turned up in the exam. Indeed, as the old Station 5 disciplines are addressed so comprehensively in Section I, we have concentrated especially on examples from the other disciplines in Section H. With the possibility of clinical examination skills from any discipline being required in the new Station 5, we have reproduced our examination *routines* from Volume 1 in Section G of this volume.

The marking system for PACES is subject to change and you should study it at www.mrcpuk.org. At the time of writing, marking was being done in the skills of:

- Physical examination
- Identifying physical signs
- Clinical communication
- Differential diagnosis
- Clinical judgement
- Managing patient concerns
- Managing patient welfare.

The following table shows, at the time of writing, the stations at which each of these skills are tested, with Station 5 in particular highlighted.

Skill	Station 1: Respiratory	Station 1: Abdominal	Station 2	Station 3: Cardiovascular	Station 3: Neurological	Station 4	Station 5: Brief clinical consultation 1	Station 5: Brief clinical consultation 2
Physical examination	✓	✓	✗	✓	✓	✗	✓	✓
Identifying physical signs	✓	✓	✗	✓	✓	✗	✓	✓
Clinical communication	✗	✗	✓	✗	✗	✓	✓	✓
Differential diagnosis	✓	✓	✓	✓	✓	✗	✓	✓
Clinical judgement	✓	✓	✓	✓	✓	✓	✓	✓
Managing patient concerns	✗	✗	✓	✗	✗	✓	✓	✓
Managing patient welfare	✓	✓	✓	✓	✓	✓	✓	✓

At the time of writing the system is that, on the marksheet, the examiner in the station concerned gives for each skill being tested in that station one of the following marks:

Satisfactory mark = 2
Borderline mark = 1
Unsatisfactory mark = 0.

If you study the marking system, and you can be bothered to do the analysis, you will be able to work out the minimum number of scores of 2 that you need assuming all other scores are 1. However, in practice, this is probably of limited use because undoubtedly you will be trying to get a score of 2 in everything regardless. Two things are important, however.

1. At the time of writing the College states on its website that: *'The onus is on the candidate to demonstrate each of the skills noted on the marksheet for each encounter (see above table) and, in the event that any one examiner decides that a skill was not demonstrated by a candidate in any one particular task, an unsatisfactory mark (score = 0) will be awarded for this skill'.* Thus, it is important to always be aware of the station that you are in and to be proactive, as far as you can, in ensuring that you attempt to demonstrate your abilities in each of the headings concerned – the ones that are relevant to that station according to the above table. With regard to Station 5, it is especially noteworthy that it is the only station where all seven skills are being marked simultaneously. Thus in Station 5 more than any other station, you must be very aware of the seven skills and ensure that during the 10 minutes of the Station 5 case, a deliberate effort is made to demonstrate the skills under all seven headings. The marking system with regard to Station 5 is considered further in Section G.

2. It is essential to remember as you move from station to station that all 10 examiners mark independently and as you go into the next station, the examiners have no idea how you did in the station you have just left so essentially you start with a blank sheet with them. If you have done badly in a station and fear you have scored some zeros, these can be compensated for by scoring more 2s in other stations. In the 5 minutes between stations it is crucial to recharge yourself psychologically, forget what has just happened in the station you have left and give yourself a complete fresh start – see 'Getting psyched up' in Section A, Volume 1.*

As emphasized above, you should read the first 17 experiences in Volume 2, Section F, of *An Aid to the MRCP PACES* to find actual accounts of the new Station 5 – please also, whenever you sit the MRCP, whether you pass or fail, fill in our survey at www.ryder-mrcp.org.uk for all the cases you meet, but especially the ones in the new Station 5. It is only because of the candidates in the past who have filled in our surveys that we have the information that we pass on to you. If you find our books useful, please in your own turn do the same – for the candidates of the future.

*See also introductory comment to Station 5, and overall comment on the exam in Vol. 2, Section F, Experiences 1 and 16.