MRCGP pass rate by medical school and region of postgraduate training

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Initiatives to measure and enhance the quality of higher education for both undergraduates and postgraduates (academic audit, teaching quality assessment) will shortly start to impact on medical schools in the United Kingdom.

We believe that it would be helpful to consumers of medical education (prospective students), to its providers (medical schools and their curriculum designers, postgraduate training schemes), and to its customers (medical care providers) if comparative output data on medical schools and postgraduate training were available. Without a national medical qualifying examination this is probably possible only by examining the performance of candidates for the major postgraduate examinations of the royal colleges.

Methods and results

To start such a process we analysed the pass-fail result of seven recent diets (December 1988-December 1991) of the membership examination of the Royal College of General Practitioners (MRCGP) by clinical

MRCGP pass rates by United Kingdom medical school of training and region of postgraduate training

Medical School	No taking exam	% Pass	Region	No taking exam	% Pass
Oxford	70	94·3	Devon and Cornwall	109	94·5
Bristol	125	92·8	Overseas	18	94·4
Nottingham	124	91·1	Northern Ireland	141	92·2
Southampton	98	90·8	East Anglia	108	90·7
Cambridge	74	90·5	North West Thames	118	89·8
Royal Free	63	90·5	Trent	206	88·8
Newcastle	138	89·9	Oxford	152	88·8
King's	48	89·6	Northern	225	88·4
St Mary's	77	89·6	Avon and Somerset	138	88·4
Birmingham	120	89·2	North East Scotland	51	88·2
Leicester	72	88·9	Wessex	181	87·3
University College-Middlesex	115	87·8	Yorkshire	139	87·1
Guy's-St Thomas's	151	87·4	South East Thames	112	85·7
Manchester	225	84·9	Wales	129	84·5
Leeds	92	84·8	South East Scotland	126	84·1
Queen's, Belfast	241	84·6	Northern Scotland	42	83·3
Edinburgh	155	83·9	South West Thames	127	82·7
Charing Cross-Westminster	153	83·7	West Midlands	178	82·0
The London	101	82·2	North East Thames	115	81·7
St George's	39	82·1	Armed Forces	20	80·0
St Bartholomew's	104	81·7	North West	238	79·4
Sheffield	119	80·7	Mersey	84	72·6
Aberdeen	102	79·4	West of Scotland	271	70·5
Dundee	86	79·1	Scotland (Tayside)	50	68·0
Wales	95	76·8			
Liverpool	86	72·1	Not known	13	84·6
Glasgow	218	69·3			

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medical school and region of vocational training. To avoid bias, only first time United Kingdom and Irish born takers, currently finishing their training, were included (n=3091).

The summary data are given in the table. Differences were highly significant between medical schools (χ^2=92·46; df=26; p<0·001) and training regions (χ^2=100·34; df=23; p<0·001). Although medical school and training region were related (42% of trainees carried out postgraduate training in the same region as their undergraduate training), there are no differences overall between those who stayed in their region for postgraduate training and those who left. Log-linear modelling using the program GLIM (generalised linear interactive modelling) showed that differences between training regions were significant after differences between undergraduate schools were taken into account (χ^2=56·6; df=23; p<0·001), and differences between undergraduate schools were significant after differences between training regions were taken into account (χ^2=49·7; df=26; p<0·01). The rank ordering of schools and regions was little altered by taking into consideration the effect of the other, and the top and bottom six schools and regions remained the same as in the tables.

Comment

The differences shown in the table may well be the result of true differences in the training ability of medical schools and regions. Alternative explanations are, however, not inconceivable. It might, for example, be the case that good students from high scoring medical schools and poor students from the low scoring schools consistently tend to opt for general practice.

The proportions of trainees from the different regions who attempt the examination vary (but the available data on which to calculate these are unsatisfactory).[1] The figures also take no account of the academic qualifications of students entering the various medical schools and the relevant "value added," though there are medical schools traditionally admitting well qualified applicants well down the list. (Controlling for this variable is exacerbated by the different school leaving qualifications in the United Kingdom.) Moreover, the relevant training programme may have changed by now.[2] The medical school courses taken by the subjects of this study were those in the early to middle 1980s. Initiatives are currently being taken with a view to improving postgraduate training and assessment.[3]

Taken together with data from the other major postgraduate examinations—for example, the membership of the Royal College of Physicians and the fellowship of the Royal College of Surgeons—these findings will, among other things, be relevant considerations for the location of the expansion of undergraduate medical education recently recommended in the report of the Medical Manpower Standing Advisory Committee.

We thank the examination board of the Royal College of General Practitioners for their encouragement to analyse and publish these data.

1 *Members Reference Book 1992.* London: Royal College of General Practitioners, 1992:48.
2 Rees L, Wass J. Undergraduate medical education. *BMJ* 1993;**306**:258-61.
3 Campbell LM, Howie JGR, Murray TS. Summative assessment: the West of Scotland Pilot Project. *Br J Gen Practice* (in press).

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Correction

Is screening and intervention for microalbuminuria worthwhile in patients with insulin dependent diabetes?

An authors' error and an editorial error occurred in this paper by K Borch-Johnsen and others (26 June, pp 1722-3). On p 1723 the last sentence of the first paragraph should have read: "The impact of treatment was calculated by using three different levels of effect, decreasing the proposed progression rate of 20% in microalbuminuria by 33%, 67%, and 100% (see table II) [not table I]." Also on p 1723 the symbols in the legend to figure 2 were incorrectly designated. The legend should have read: "Median life expectancy at onset of diabetes in patients developing microalbuminuria without intervention (□) and at treatment effect 33% (■) and 67% (○). Life expectancy of general population of Germany shown for comparison (●)."

National Health Service breast screening programme results for 1991-2

A typesetting error occurred in this article by J Chamberlain *et al* (7 August, pp 353-6). In table I the United Kingdom (all ages) percentage response rate should read 71·26, not 51·26.