The changing patterns of the Part 2 MRCOG examination

Sudipta Paul

Several changes to the Part 2 Membership of the Royal College of Obstetricians and Gynaecologists (MRCOG) examination have taken place over the last 2 years. The pass rate fell drastically from 38% in 1998 to 15% in March–May 1999 following a change in the marking system. This article gives a few suggestions about approaches to the examination.

The Part 2 Membership of the Royal College of Obstetricians and Gynaecologists (MRCOG) examination is an essential prerequisite for higher specialist training (year 4/5 specialist registrar) and to practise as a specialist in obstetrics and gynaecology in the UK.

Although the MRCOG Part 2 is primarily relevant to present British practice, its value as an international postgraduate qualification should be taken into account. This is highlighted by the fact that more than half of the Members reside outside the British Isles (Friend, 1997). The Royal College of Obstetricians and Gynaecologists (RCOG) conducts the examination in several centres around the world to encourage more doctors to become a Member. The Membership is not merely a postgraduate diploma endorsing the Member's knowledge and experience. Its true value is long-term. It enables Members to keep in touch with the Royal College which updates their knowledge about advances in their specialty. This has enormous value in maintaining the standard of practice.

Several changes have taken place in the format and eligibility requirements of the Part 2 MRCOG examination over the last 2 years. The examinees achieved a very low pass rate of about 15% in March–May 1999 examination compared to 38% in 1998 (RCOG, 1998), and are left in a difficult situation to keep pace with the changes.

Dr Sudipta Paul is Specialist Registrar in Obstetrics and Gynaecology in the Department of Obstetrics and Gynaecology, Arrowe Park Hospital, Upton, Wirral L49 5PE

AIM OF THE PART 2 MRCOG EXAMINATION

The aim has always been to maintain the position of the examination as a British-based international test of core knowledge and experience in obstetrics and gynaecology and allied subjects.

The Part 2 examination is neither designed to be an entry examination to the specialty, nor is it to be regarded as an exit examination, delineating the specialist from the trainee. When the Calman training scheme was implemented in April 1996, it was anticipated that Part 2 MRCOG would be obtained by specialist registrars in year 2 or 3 of their training. The suggested targets in the training programmes for specialist registrars reflect this (Johnson, 1998; Shaw, 1996a).

RECENT CHANGES IN FORMAT OF THE PART 2 MRCOG

Multiple choice question paper: March–May 1997

The previous multiple choice question (MCQ) papers (one each in obstetrics and gynaecology), consisting of 30 stems each with five responses, were amalgamated into one paper of 300 responses (Shaw, 1996b). The number of responses to each stem is no longer always five (it varies from one to any number, commonly two to five). It was expected that this would reduce the number of dubious questions and cover more topics.

Short essay paper: September–November 1997

The previous papers (one each in obstetrics and gynaecology), consisting of two long essays each, were replaced by five shorter, more focused essays in each paper. The answer of each short essay was also restricted to two sides of 1 page only (Johnson, 1998; RCOG, 1997). The aim is to check the candidate's ability to express objective knowledge on several topics with precision.

Dissertation: September–November 1998

The dissertation was withdrawn. The examination committee were firmly of the view that the dissertation was neither a fair nor a valid form of examination (Johnson, 1998).

Objective structured clinical examination: September–November 1998

The examination changed radically with the introduction of the objective structured clinical examination (OSCE) in November 1998, replacing the conventional clinical and viva voce examinations. It consists of twelve 15-minute stations making a 3-hour oral examination in total (Johnson, 1998).

Raw marking system: March–May 1999

The marking system has been changed to raw marks rather than a close marking system. The total marks available are 300, consisting of 100 marks in the MCQ paper and 200 marks in the essay papers. The pass mark for the written component is 175 out of 300 marks. Candidates who obtain the pass mark will proceed to the OSCE. The pass mark in the OSCE is 60 out of 100 marks (Johnson, 1998; Pickersgill et al, 1999).

The anticipated fall in pass rate: March–May 1999

As it is possible to sit the examination with only 2 years of experience in obstetrics and gynaecology, the RCOG expected, at least initially, that pass rates would fall (Johnson, 1998). This has been the case in the March–May 1999 examination.

HOW TO PREPARE FOR THE PART 2 MRCOG

The written examination

This is the first hurdle to cross. The pass mark to qualify for the OSCE is 175/300 marks. The short essay paper accounts for 200 marks. There are standard model answers for the essays and the marks awarded depend on the number of correct points mentioned matching the model answer (Johnson, 1998; RCOG, 1997). As it is not possible for candidates to know the points in the model answer, it is difficult to obtain very high marks in the essay papers. The MCQ paper accounts for 100 marks. As the MCQ paper is objective, it is possible to obtain higher marks with proper preparation.

The MCQ paper

Facts: There are a variable number of stems (topics) with a variable number of responses to each question. The total number of questions are 300, each carrying equal marks. Of these, only 200 are genuine and will be considered while marking the paper. The other 100 are test questions which are not considered when marking the paper. These MCQs are repeated a few times to check their standard, before being included in the question bank, which is the source of the genuine questions. The MCQ question bank is continuously being updated, replacing outdated and controversial questions with new standard questions (neither too easy nor too tough). Unfortunately, the contents of the MCQ bank are not published.

Preparation: Try to remember common facts and figures, causes, clinical features, complications and management of all important topics from textbooks and other literature. Practise answering MCQs under examination conditions and get your performance assessed by a senior colleague (Paul, 1999). There are only two MCQ books on the market which follow the present style of the MCQ paper of Part 2 MRCOG (Khaled, 1998; Pickersgill et al, 1999).

Technique: Read the question carefully and answer it at face value, do not try to find any hidden meaning (Paul, 1999). Answering 300 questions on different topics in 2 hours is a challenging exercise which often leads to technical errors in answering.

It is worth answering familiar MCQs first, and then proceeding to unfamiliar MCQs. It would be better to answer the MCQs you are certain about in the first round, the familiar but less certain questions in the second round and the rest in the third/fourth round (Paul, 1999). This approach has three advantages:

1. After the first round the standard of the MCQ paper will be obvious
2. It will reduce the number of technical errors in answering familiar MCQs
3. If the number of MCQs answered in each round is noted it will give some idea about the candidate's performance, which may be useful for future MCQ examinations.

It will save time if you mark the true/false answers on the question paper and transfer them to the answer sheet later, to prevent you being distracted between questions. Allow at least 30 minutes to transfer answers or do it after each round, which is safer (Paul, 1999).

Alternatively, lightly block in your answers on the answer sheet as you go along, and then boldly mark over them at the end. As there is no negative marking, all MCQs should be answered as you have nothing to lose (Paul, 1999; Pickersgill et al, 1999).

The short essay papers

Facts: These consist of two papers, one on obstetrics and one on gynaecology, each containing five short essays carrying equal marks. Most of the essays will be on practical problems faced in the clinics, wards, labour ward and theatres. A formal introduction and conclusion are not essential. The answer should contain three components:

1. Background to and context of the topic/concept
2. Clinical judgment
3. Justification for the proposed management.

These should not be written under headings but as separate paragraphs. Marks will only be awarded for points which are included in the model answers. There are marks for critical discussion and clear English. The question is printed on the top of the page and the answer must be completed within two sides of that page (RCOG, 1997). The total time for each paper is 120 minutes, 24 minutes per essay.

Preparation: The preparation for these questions cannot be done by sitting in the library. First, make a list of all common problems and uncommon but important situations encountered at work, according to their importance. Also check the specimen short essays with model answers, guidelines and other recommendations distributed by the RCOG. Then go through the literature and discuss with a colleague who is academically up to date. Write down the important aspects and the management of the topics on your list.

Making a list of topics has several advantages:

1. The actual workload will be known
2. The most important topics will be clear
3. As you go through the list you can assess your progress and modify your plan accordingly
4. Once you have completed the list you can feel confident that you have not missed any important topics
5. It is easier to recall information that is learned systematically (Paul, 1999).

Try to implement your knowledge in your clinical practice. This will make it easier to remember and reproduce in the examination. The need for adequate involvement in day-to-day patient management cannot be overemphasized. Practise writing short essays on two sides of a page (A4 size) in 20 minutes and have them assessed by a senior colleague.

Technique: The most important factor is to consider all the essays as having equal importance and to answer them properly. It is prudent to complete each essay in 20 minutes, allowing 20 min-

utes at the end for revision. It may be better to start with essays on topics you are familiar with, and answer unfamiliar essays later. Do not waste extra time on one essay because you know a lot about it; it is better to allow more time for unfamiliar topics as you will have to think about the answer.

Read the question carefully and identify the key points which you have to cover in your answer. Once you understand what it is about, plan the answer and write it down. Always use your common sense and consider how you would manage the problem in your practice. Do not hesitate to mention that you (as a registrar) would involve senior colleagues if you think it is appropriate. Do not ever forget to inform the consultant immediately if you are dealing with a case of major obstetric haemorrhage.

While it is not vital, it would be useful to include a brief introduction and conclusion to give a professional touch to the essay, as there are marks for coherent discussion. Always answer the question. It is wise to mention as many relevant points as possible because the points in the model answer are unknown (Paul, 1999). Potential marks may be missed if relevant points are not mentioned, but there is no negative marking for extra points which are unnecessary. There should be a balance between how much you write and the time it takes, and remember that there is a page restriction as well.

This balance is an important factor which is checked in the examination, as it is relevant in clinical practice. Conclude each essay with a brief clinical message and check each one carefully before you leave (Paul, 1999).

The OSCE

Facts: The OCSE consists of twelve 15-minute stations, making a 3-hour oral examination in total. There are two preparatory stations where the candidates are given some information (a short paper, case report or patient information leaflet) which will be used for critical appraisal at the following station (Johnson, 1998).

Preparation: There is no alternative to practical experience. Be familiar with the investigation reports and their interpretations (e.g. ultrasound scan, hysterosalpingogram, X-rays, cystometry, frequency–volume chart, cardiotocography, fetal blood sampling, blood reports, laparoscopic pictures). Be prepared to answer questions about common instruments and operative procedures (e.g. ventouse, forceps, caesarean section, fetal blood sampling, hysterectomy, laparoscopy, colposuspension).

Make sure you have a firm logical view about the management of common problems, especially emergencies (such as antepartum and postpartum haemorrhage, shoulder dystocia, cord prolapse, breech presentation and vaginal breech delivery, delivery of second twin, prelabour rupture of membranes, preterm labour, ectopic pregnancy).

Thoroughly prepare all the counselling you may have to provide in day-to-day practice (such as preconceptional, missed abortion, recurrent miscarriage, antenatal screening, fetal anomaly, perinatal death, sterilization, hysterectomy, hormone replacement therapy, abnormal cervical smear, diagnosis of cancer). Be prepared to express your views on topical controversial issues. Do not forget to consider how to prioritize patients on the labour ward. Be clear about the basic principles of audit and research. You may be asked to plan an audit protocol or to critically appraise a paper. Practise answering in an OSCE setting with another candidate or a senior colleague.

Technique: The OSCE is quite demanding, so sleep well the night before. Take it as it comes. Imagine the examiner as your supervising consultant, as if you were discussing problems at work. Be practical in your answers.

Outline how you would manage the problem usually, and be ready to justify it. Do not be frightened if the examiner disagrees with your views, as he or she may be testing your confidence. Try to avoid arguments, but do not change your answer illogically just because an examiner does not agree with you (Paul, 1999).

Always remember that you have to show the standard of a year 2/3 specialist registrar and tailor your answer to that. Although the OSCE has replaced the conventional viva, the elements of a successful performance remain similar (Farquharson, 1998). HM

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KEY POINTS

- Achieve the standard of year 2/3 specialist registrar in your knowledge before taking the Part 2 Membership of the Royal College of Obstetricians and Gynaecologists (MRCOG) exam.
- Practical experience in patient care is more important than theoretical knowledge.
- Keep up to date and implement your theoretical knowledge in clinical practice.
- Short essays are usually practical and problem based.
- Practise writing short essays on all important problems.
- It is easier to obtain a higher mark in the multiple choice question paper than the short essay papers.
- Read the question before you write and check each answer before you leave.
- Be democratic, give equal importance to all questions and use your common sense.
- In the objective structured clinical examination, respond to the examiner as you would to your supervising consultant.