OSCEs for the Final FFICM

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For Emma, Cerys and Bethan – thanks for the constant understanding and support and all the cups of coffee you brought down to the cellar whilst working on this book!

For Jaya, Neel and Taran – thank you for all your incredible encouragement, love and patience. Mum and Dad – for your untiring affection and strength of belief in me.

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Foreword

Intensive care medicine has become a speciality in its own right, bringing with it a new Faculty and examinations to become a Fellow of the Faculty of Intensive Care Medicine. A new examination needs new resources to help candidates prepare and revise and this book is aimed specifically at those preparing for the FICM OSCEs.

The authors have both had experience on both sides of the examining table and have been helping others through examinations since they completed their own training. The practice questions and model answers they have prepared are based on direct experience of the examination from recent candidates and represent accurately the type and range of questions one might expect. More importantly, the responses provided here are just what the examiners are looking for in answer to those questions.

This book will also have wider appeal to those wishing to broaden their knowledge of the sort of topics and situations that commonly arise in modern critical care practice. It is sure to also be invaluable to trainers and peers who are helping candidates prepare for these examinations and offer an insight into the complex and fascinating world of intensive care.

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Preface

The new Faculty of Intensive Care Medicine (FICM) comes with the inevitable faculty examinations and for the first waves of candidates, there were limited resources available to prepare from. For better or for worse, both of us have had plenty of experience of sitting examinations, both in intensive care medicine and other specialities. We both recognized the value of quality revision texts in focusing valuable revision time and in providing much needed exam-style questions to practice.

In our view, the ideal resource should reflect the examination question's style and content as much as possible, be a contemporary source of topical information and provide enough of an answer to save having to go and look something else up, saving time. This is what we have tried to achieve with this book and we hope you will find it extremely useful when preparing, revising or testing each other for the FICM OSCEs. We hope that it is also a valuable resource for anyone seeking to explore the curriculum of the FICM and gives an insight into the case mix, patients, technology and knowledge required to enjoy our speciality.

The questions are all matched to the syllabus domains and we have covered this as comprehensively as possible. The questions are largely based on candidate reports from recent exams. We have found the content both reliable and useful when preparing candidates over the last few years both informally and on our dedicated FICM examination revision courses. We thought it useful to incorporate an example marking scheme into the answers, we do however realize that we cannot replicate the examination marking scheme. In addition some questions have been left deliberately longer than what would be expected in a 7-minute examination, to allow us to cover as much relevant material as possible.

We would like to acknowledge the following people who have contributed to this book: Dr Andrew Bentley, Dr James Hanison, Dr Peter McDermott, Dr Daniel Nethercott, Dr Rob Thompson and Dr Anthony Wilson. We are grateful to the faculty of the North West FFICM Course for their help over the years and to candidates for their valuable feedback.

We hope that you will find the content useful. Good luck!

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The FFICM – the examiner's view

FFICM Examiner

FFICM examiners observe a strict code of conduct, contributing to the integrity of the Faculty of Intensive Care Medicine and of the examination. Examiners cannot contribute questions to local or regional exam practice days. If they 'mock-examine' they may only use material provided by the local organizers. Examiners will attempt to observe a high level of information governance for question writing and standard setting. With this guidance in mind, this section is written by a current FFICM examiner in order to give an examiner's perspective of the exam itself and of what examiners are looking for in successful candidates. Specifically, Dr Clarke has not contributed to, reviewed, nor commented on the material contained within this book.

The FFICM in perspective

The FFICM is an integral part of both the standalone certificate of completion of training (CCT) in intensive care medicine, and the dual programme. Passing the examination is an entry requirement to speciality training level 7 (ST7) and as such the examination has been defined both by the General Medical Council (GMC), and previous examination chairs as a 'high stakes' examination – vital for both trainee career progression and for the protection of patients. The examination is both realistic and 'real world' with the Objective Structured Clinical Examination (OSCE) attempting to recreate a normal working day on a critical care unit. The success of this approach is evidenced by the visitor's comments after the March 2015 examination; the lay visitor's surprise at some candidate's failure to use antiseptic gel being especially telling. Underlying the more scientific and intellectual debates within our speciality is a constant focus on the simple basics of our practice.

The candidates

As parts of the old Diploma in Intensive Care Medicine were adapted to the current FFICM a problem for the examiners was that nobody knew what to expect of an ST6 on the new programme. Various definitions have arisen – usually around a trainee who could be expected to manage the unit overnight with remote supervision. The situation was complicated by the fact that many of the initial tranche of candidates were training on the old programme and were attempting the exam around the time of consultant interview. In early sittings the pass rate for the OSCE reached 100% emphasizing the high standard of early cohorts of candidates. The current view of examiners on standards can be summarized as:[1]

> a doctor in training who is familiar with the syllabus and has done the necessary bookwork. They would clinically be at the level of a registrar who would be able to formulate a plan of care for a critically ill patient with appropriate consultant backup.

It is not surprising that the standard of the examination evolves, which is important in quality assurance and standard setting.

Standard setting

As a 'high stakes' examination, standard setting becomes crucial. The FFICM examination has to fulfil the standards outlined in the GMC's 'standards for curricula and assessment', especially ST8 and ST12. Since 2014, the GMC has been able to access results at trainee level. A variety of tools are used in standard setting the examination – principally the Angoff, Ebel and the Hofstee scores.[2] The Angoff method is based on the concept of the borderline or minimally competent candidate whose knowledge, skills and attitude are just enough and who has a 50:50 chance of passing the examination. In other words, the borderline candidate is the marginal student: one whom on some days might just barely pass the examination but on other days might fail. It is important to note that this 'student' has done a reasonable amount of preparation for the theoretical examination. Importantly, this means the FFICM is *not* 'norm referenced'. In theory, 100% of candidates could pass (or fail). There is some evidence that examination pass rates are higher with the Angoff method than with norm-referencing.[3]

Angoff referencing is difficult for examiners and this bears on the debate around expectations of ICM trainees at the ST6 level. The essential point is that the FFICM is a fair examination. At the examiners 'call round' following the SOE and OSCE, debates have always been decided in favour of candidates, with the sole exception of ensuring that unfortunate precedents for the future are not set.

Examiners

The examiners are a mixed group. Although predominantly from teaching hospitals there are examiners from smaller units. Many will have held roles in training and education (often as regional advisers) and all have considerable experience in assessment. Some examine for other Royal colleges and have brought this experience to the FFICM. Specific examiners have been recruited as they have expert knowledge of standard setting, usually from involvement in medical school examinations.

You can't 'read' your examiner! They will invariably be pleasant and empathetic with you but this is no predictor of outcome. In the OSCE in particular, examiners must not prompt and you should not misinterpret a relatively flat affect as disengagement. There is an ongoing process of quality assurance and the floor supervisors, other examiners (on audit duty) and the visitors constantly assess and feed back on the examiner performance individually.

The MCQ

The multiple choice question (MCQ) is mapped to the curriculum domains and all questions are sampled to some extent. Single best answer (SBA) questions are now established and arguably are a better test of understanding as opposed to simple factual knowledge. The 'cover-up' test, whereby the stem and question are read and possible answers considered before looking at the available answers, is widely used by examiners in assessing new SBAs and can be invaluable to candidates in attempting the question. The pool of SBA questions is rapidly expanding, and unlike the multiple true false (MTF) questions, none are adapted from other colleges' question banks. The MTF questions are under constant review and redrafting in order to ensure they are fair and up to date. Unlike, say, the Royal College of Anaesthetists, the FFICM examiners have little historical data on

the performance of MTF questions. At the standard setting meeting following each MCQ examination examiners have to justify the Angoff score they have given the question and it is this process that ultimately determines the pass mark.

The SOE

The Structural Oral Examination (SOE) seems to be the hardest part of the examination to pass – the pass rate in March 2015 being 62.3%. Candidates repeating the SOE, with a previous OSCE pass, struggle in particular, the pass mark for these candidates being 25%. There is some evidence from the initial sittings of the examination that the SOE is the most discriminating part of the examination.[4] The topics covered in the previous diet of the examination are listed on the FICM website, and really demonstrate how widely the curriculum is sampled. It really must be emphasized that in addition to 'state-of-the-art' research there is a concentration on the basics of clinical management and the day-to-day organization of a critical care unit. The March 2015 chairman's report comments on difficulties candidates had in describing the safe insertion of a nasogastric tube. Domain 11 of the curriculum deals with administration and management and Domain 12 deals with professionalism (and communication – invariably examined, usually in the OSCE). Attempts are made to map questions to all domains of the curriculum.

The OSCE

The OSCE can be intimidating, although traditionally candidates have done well in this part of the examination. There are stations on data interpretation, diagnosis and management, procedural skills, emergencies and communication. Simulation and actors are used. The OSCE is marked out of 20. It is perhaps the hardest part of the examination to examine as both candidates and the examiner are under pressure. There is additional pressure as the room can be noisy and the mannequin station especially can become intrusive. For the examiner, there is pressure to get the candidates through the entire question, such that marks at the end of the question can be scored.

Candidates should remember . . . !

- It's an OSCE – if you realize you have answered a question incorrectly you have not failed the OSCE. You have only lost 1–2 marks out of the 20. Keep moving forward and scoring the additional points.
- Should you remember an answer to a previous question after moving on, the examiner cannot go back and award marks. This is reasonable, as often subsequent questions will have given hints towards the answer, or even given a diagnosis.
- The examiner can't prompt, and indeed it is easy to foresee OSCEs being marked on tablet computers with only floor supervisors. If your examiner appears impassive they are only giving you adequate time to gain a mark.
- Equally, if your examiner cuts you short or moves you on, you should remember that their concentration is on ensuring you reach the available marks at the end of the station. There could be three marks available in the last 30 seconds. The examiner is acting in your best interests.
- There really are no killer stations and the eventual pass mark for the OSCE is determined by a standard setting process

There will be occasions where you have completed the OSCE with time remaining and either an uncomfortable silence will ensue or your examiner will engage in some small talk.

In preparing for the OSCE it is useful to remember that the chairman's report has constantly commented on candidate's relatively poor standards in data interpretation, especially ECGs. Continued data interpretation stations seem inevitable.

Good luck!

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