The DRCOG examination

In this chapter we explain the format of the exam and discuss the three different styles of questions as a foundation for giving you hints and tips about how to approach the questions and apply your knowledge logically in order to answer correctly. This will be consolidated in subsequent chapters as we explain each of the examples.

The exam format

The format of the examination was altered a few years ago with the first new-style paper appearing in April 2007. The OSCE has been replaced by two written papers lasting 90 minutes each with a short break in between. The first exam paper consists of ten extended matching questions (EMQs) with three parts to each question and 18 single best answer (SBA) questions. The EMQs and SBAs test the ability to interpret information and apply knowledge. After a short break this is followed by a multiple choice question (MCQ) paper consisting of 40 questions, each with five parts (200 questions in total). The MCQs are good for testing recall of core knowledge.

The questions are weighted differently. The EMQs score 3.5 for each correct answer and give you 30% of your total marks. The SBAs score 2.5 each and comprise 12.9% of your marks, whereas the MCQs are worth 1 point each and 57.1% of your total. The reason for this is that there is a lot more reasoning and application of knowledge needed when answering an EMQ so it is worth more. The RCOG recommends that you spend the majority of the time allowed – 60 minutes – on the EMQ and the rest on the SBA part of the paper. You will get a time warning 30 minutes before the end of the examination. In this book there is a complete mock examination – paper 1 and paper 2 – which you could use to practise time management under examination conditions, not forgetting that your answers must be transferred to the computer-marked answer paper before leaving the exam hall on the actual examination day.

The rationale for changing the exam was to improve reliability and validity by removing the subjective aspects of assessment in both the written and face-to-face elements of the OSCE. The whole paper is now marked by computer, significantly improving validity by standardisation. The exam is further improved by a standard-setting process whereby 'more difficult' exams will have a lower pass mark than 'easier' exams, ensuring that the pass mark constantly reflects a competent candidate with the necessary knowledge, skills and attitudes.

In reality the pass mark is somewhere between 60 and 70%, usually towards the upper part of the range. It differs between exams because of the standard setting but if you are scoring over 70% in your revision practice, you are probably doing well enough to pass. The top mark is usually between 85 and 95% and the highest scoring candidate is awarded the DRCOG Prize Medal. Could this be you?

Extended matching questions

It is likely that you will have come across extended matching questions (EMQs) before during your training. The exam has ten EMQs, each with three parts. In order to help you prepare for the examination we have provided you with two additional questions for each EMQ in the chapters of this book. This increases the breadth and depth of material covered to help your revision and your understanding of exam technique.

The format of the EMQs in the DRCOG examination is shown in this example:

OPTION LIST

A.	Continue shopping
B.	Walk out of the shop
C.	Call the police
D.	Lie on the floor and scream
E.	Smack the child
F.	Pick up the child and walk out
G.	Ignore the child till she stops screaming
H.	Pour water over the child
I.	Ask a shop assistant for help
J.	Give the child a bag of crisps

INSTRUCTIONS

Each of the following situations relate to parenting skills. For each situation select the single most appropriate course of action. Each answer may be used once, more than once or not at all.

1. A 29-year-old woman is carrying out her weekly shopping with her two-year-old child. Halfway round the supermarket the child becomes fractious and asks for a bag of crisps. When the woman says no, the child throws a temper tantrum lying on the floor, screaming and crying. Other shoppers are beginning to point and stare.

Don't worry, parenting skills aren't part of the DRCOG curriculum but this example can be used to show how knowledge, skills and attitudes can be applied to ensure the correct answer is selected.

How to tackle this question:

The best way of tackling the EMQs is to read very briefly down the list of options but then cover up the options and use your knowledge, skills and attitudes to work out the answer as if you were answering the questions verbally.

If the first answer that comes in to your head is on the list of options, it is very likely that this is the correct option. Now read the whole option list very carefully and double check that your chosen option is the 'single correct answer'.

Double check the question again to make sure you haven't missed a subtle fact and that you've interpreted the situation correctly. You should be aware that there is usually at least one 'distractor' on each list, i.e. an option that is nearly correct but good candidates will know why the distractor is not the correct option.

So how should you answer this question? Firstly use your experience; if you have looked after a toddler (i.e. for a clinical question you will be using your experience of working in obstetrics and gynaecology) this will be a familiar situation. You will need some knowledge of the psychology of parenting (clinical knowledge gained from reading textbooks) and you will need to be aware of child protection issues and safety concerns (ethics and law). Applying your skills/experience, knowledge and attitudes you can correctly select the answer G – ignore the child till she stops screaming – which will ensure you finish your shopping and avoid child protection services.

The EMQs are specifically designed to test interpretation of a scenario and demonstrate application of knowledge, skills and attitudes and therefore are unlikely to be found as a paragraph in a textbook. We have deliberately constructed the questions to reflect potential clinical scenarios that could be encountered by a GP or GP trainee.

Three questions follow each option list. Each option may be used more than once or not at all, i.e. it is possible that one of the options could be the correct answer for two of the questions. If the list of options looks a bit unusual, the reason for this is that the committee writes many more questions to go with each option list so that there is a large bank of questions available looking at various aspects of a clinical scenario. Each year only three of them are selected from the bank for the examination paper, so an unusual option may belong to another question on the bank. Don't fall into the trap of assuming that because it's an unusual option that you hadn't thought of, then it must be the correct answer.

Single best answer questions

Single best answer (SBA) questions – used to be called 'best of fives' – are similar to EMQs in requiring application of knowledge as opposed to direct recall of facts. The majority of SBAs are also based on a clinical scenario which requires interpretation of facts in order to select the single best answer but this can be either the most appropriate or the least appropriate answer depending on how the question is phrased. For example, an SBA based on a similar scenario to that above might be:

A 29-year-old woman is trying to cope with her two-year-old child who is having a temper tantrum in the middle of a supermarket. Which of the following is the most appropriate course of action?

1. To pacify the child with sweets
2. To remove the child to a safe place
3. To ignore the child until she calms down
4. To leave the store and go home
5. To distract the child with something interesting to look at

These options initially all look plausible and very similar, however if you reflect on your reading of parenting manuals (textbooks) you will recall that bribing with sweets will set up a vicious cycle resulting in worsening behaviour and your experience tells you that a toddler in a full-blown tantrum is not distractible. Leaving the store rewards bad behaviour and if you review carefully the scenario it's hard to imagine a supermarket as being a particularly dangerous place (experience) unless you 'over think' the question and imagine the child to be next to an unstable display of baked bean cans or something similar. Again the answer is 3 – ignore the child till she calms down.

The message here is: carefully assess the information given but don't read complexity into the scenario where there is none.

Multiple choice questions

Multiple choice questions (MCQs) are best for testing factual recall, hence our advice that you will need to do some revision before the exam. It is extremely unlikely that you can get all the background knowledge you need to be sure of passing this examination just by working in an obstetrics and gynaecology department.

Continuing our theme of parenting skills, the same scenario written as an MCQ might look like:

Regarding the management of toddler tantrums in public:

1.	Police intervention may be necessary	[F]
2.	Smacking will reduce crying by 90%	[F]
3.	Withdrawing attention is a useful strategy	[T]
4.	Child safety must be considered	[T]
5.	Bribes help to establish good behaviour patterns	[F]

The MCQ format is the one most of us are familiar with and the good news for candidates sitting the DRCOG exam is that the MCQs are not marked negatively. The answer is either unequivocally true or false; no marks are deducted for incorrect responses. You don't need to miss out questions where you really don't know the answer as you lose nothing by guessing.

In the actual examination, you can use the question booklet to write on and make notes (as it is not read when it is returned to the RCOG) but you must transfer your answers to the computer-marked sheet before the examination finishes. The risk of leaving gaps on the answer sheet as you progress through the examination is that you might incorrectly transcribe your answers and lose marks when your answers were originally correct. You are supplied with an eraser to make corrections and you must be very careful when you've finally chosen your answers to make sure that you complete the answer sheet correctly.

Another common mistake is to assume that not all five answers can be correct (or incorrect). The examiners try hard to avoid predictable patterns when selecting the questions. Great care is also taken to avoid questions that have 'always' or 'never' as these are obviously incorrect given the nature of clinical medicine. If a question looks like an 'always or never' scenario, re-read it as you may have missed a crucial part of the question.

Revising for the exam

The DRCOG exam strives to be relevant to General Practice and therefore focuses on core knowledge rather than rarities and minutiae; however facts such as maternal mortality rates, prevalence and incidence rates are considered core knowledge and may feature in the exam. These facts are unlikely to be the topic of your ward rounds, handovers or reflective practice sessions so it really does pay to revise.

The DRCOG is blueprinted to ensure that all areas of the syllabus are covered, so the best advice is to ensure that you have covered the whole syllabus in your reading and revision, rather than trying to 'spot' questions.

In addition to the textbooks you used as an undergraduate, there are several books on the market covering issues relevant to women's health in General Practice and we suggest that you also access specific texts on contraception and genitourinary medicine. We have provided a list of websites where you will find helpful information about some topics which could come up in the examination and although this list is not exhaustive, we think you will find that they contain interesting revision material.

Doing exam questions is a very good way to revise and it is highly recommended that you re-read a topic where your score is disappointing – you will be even more disappointed if it comes up in the examination and you have neglected to revisit that topic and top up your knowledge.

While you are revising don't forget to eat, sleep and relax too – all these things will improve your performance!

Conclusions

The DRCOG uses three different question formats to test objectively the knowledge, skills and attitudes of all areas of the syllabus to the standard of a GP practising in the UK. To pass the exam, reading and revision is required but understanding the style of questions and practising questions will improve your chance of success.

Curriculum module 1

Basic clinical skills

Syllabus

- You will be expected to understand the patterns of symptoms in patients presenting with obstetric problems, gynaecological problems, sexually transmitted infections and patients in a family planning setting.
- You will be expected to demonstrate an understanding of the pathophysiological basis of physical signs and understand the indications, risks, benefits and effectiveness of investigations in a clinical setting.
- You will be required to demonstrate an understanding of the components of effective verbal and non-verbal communication.
- You will need to be aware of relevant ethical and legal issues including the implications of the legal status of the unborn child, the legal issues relating to medical certification and issues related to medical confidentiality. You will be expected to understand the issues surrounding consent in all clinical situations including postmortem examination and termination of pregnancy.

Learning outcomes

This module covers history taking, clinical examination and investigation, note keeping, legal issues relating to medical certification, time management and decision making, communication, ethics and legal issues. It is easy to set clinical questions on history, examination or investigation but quite a challenge to set written questions to test the other areas. Previously viva voce examinations such as the OSCE were used to test communication skills. The OSCE component of the DRCOG has now been abandoned because in reality nobody ever failed due to poor communication skills.

Although you might imagine that attributes such as 'good time management' could not be tested in a written format, we can test this to some extent – for example whether a candidate can prioritize clinical cases safely – using both EMQ and SBA formats.

We have also tried to look at attitudes and behaviour using written questions concentrating on issues such as consent, domestic violence and confidentiality. We recommend that you have a look at the GMC website (especially *Duties of a Doctor*) to find information about these attitudinal and ethical issues, and of course you should discuss cases with your supervisors in both O&G and General Practice.

MULTIPLE CHOICE QUESTIONS

1.1 Concerning symptoms caused by endometriosis:

A.	Patients often complain of deep dyspareunia	[T]	[F]
B.	There is a correlation between the severity of pain symptoms and the extent of the endometriotic lesions found at laparoscopy	[T]	[F]
C.	Dyschezia is caused by endometriosis in the rectovaginal septum	[T]	[F]
D.	Patients with endometriosis may suffer from chronic fatigue	[T]	[F]
E.	Primary dysmenorrhoea is a common symptom of endometriosis	[T]	[F]

1.2 Regarding early pregnancy complications:

A.	Diarrhoea may be due to intra-abdominal bleeding	[T]	[F]
B.	Hyperemesis is a recognized presentation of hydatidiform mole	[T]	[F]
C.	Missed abortion usually presents with light bleeding	[T]	[F]
D.	Pain in the shoulder indicates that the patient may have an ectopic pregnancy	[T]	[F]
E.	A patient with an ectopic pregnancy may not have missed a period	[T]	[F]

1.3 Considering domestic abuse in an O&G setting:

A.	Pregnancy is known to provoke episodes of domestic violence	[T]	[F]
B.	Community midwives are required to ask about domestic violence during routine antenatal care even if it seems unlikely (e.g. the patient works as a doctor)	[T]	[F]
C.	Female relatives can be used to translate when asking about domestic violence to ensure a non-English speaker has understood the question	[T]	[F]
D.	There is a recognized association between domestic violence and repeated requests for termination of unwanted pregnancy	[T]	[F]
E.	Domestic abuse may involve control of a woman's finances	[T]	[F]

1.4 These conditions may cause amenorrhoea:

A.	Polycystic ovarian syndrome	[T]	[F]
B.	Endometrial hyperplasia	[T]	[F]
C.	Mullerian agenesis	[T]	[F]
D.	Asherman syndrome	[T]	[F]
E.	Anorexia nervosa	[T]	[F]

1.5 A 37-year-old woman attends your surgery to inform you that she is six weeks pregnant. She has a BMI of 38 and has had four previous caesarean sections, delivering babies of over 4 kg each time.

She is at increased risk of the following pregnancy complications:

A.	Placenta accreta	[T]	[F]
B.	Postpartum haemorrhage	[T]	[F]
C.	Intrauterine growth retardation	[T]	[F]
D.	Gestational diabetes	[T]	[F]
E.	Pre-eclampsia	[T]	[F]

1.6 **The following factors contribute to the 'Risk of malignancy index' when evaluating the likelihood of an ovarian cyst being malignant in nature:**

A.	Solid areas in the cyst on ultrasound scan	[T]	[F]
B.	The age of the woman	[T]	[F]
C.	The CA125 tumour marker level	[T]	[F]
D.	The menopausal status of the woman	[T]	[F]
E.	A family history of ovarian cancer	[T]	[F]

1.7 **A 42-year-old nulliparous woman consults you in the surgery about her urinary problems. She has been suffering with urinary frequency and urge incontinence for over a year. The following should be considered as a possible cause of her symptoms:**

A.	Uterine fibroid	[T]	[F]
B.	Multiple sclerosis	[T]	[F]
C.	Urinary tract infection	[T]	[F]
D.	Detrusor instability	[T]	[F]
E.	Interstitial cystitis	[T]	[F]

1.8 **When assessing a gynaecological patient with pelvic pain, these examination findings are recognized signs of endometriosis:**

A.	Fixed retroversion of the uterus	[T]	[F]
B.	Palpable nodules in the rectovaginal septum	[T]	[F]
C.	A tender swelling situated within the umbilicus	[T]	[F]
D.	Adnexal tenderness	[T]	[F]
E.	Contact bleeding of the cervix	[T]	[F]

1.9 **Non-sensitized, Rhesus-negative women should receive anti-D immunoglobulin in the following situations:**

A.	Miscarriage below 12 weeks when the uterus is evacuated surgically	[T]	[F]
B.	Ectopic pregnancy	[T]	[F]
C.	Incomplete miscarriage over 12 weeks	[T]	[F]
D.	Complete miscarriage under 12 weeks when bleeding is heavy	[T]	[F]
E.	Threatened miscarriage below 12 weeks when the fetus is viable	[T]	[F]

1.10 **Concerning maternal death:**

A.	The maternal mortality rate is lower in the UK than in the USA	[T]	[F]
B.	Reducing the number of maternal deaths worldwide by the year 2050 is a 'millennium development goal'	[T]	[F]
C.	The maternal mortality ratio is defined as the number of maternal deaths per 100 000 pregnancies	[T]	[F]
D.	The details of every maternal death in the UK are scrutinized to look for elements of substandard care	[T]	[F]
E.	There has been an increase in maternal deaths from sepsis related to sore throats	[T]	[F]

SINGLE BEST ANSWER QUESTIONS

1.11 Taking over the gynaecology on-call duties one evening, you are given this list of tasks to be done. Which one would you do first?

A. Site an intravenous infusion for a severely dehydrated patient with hyperemesis
B. Sign a death certificate as a patient's husband is waiting on the ward for it
C. Review the scan report of a woman with a suspected ectopic pregnancy
D. Review a woman who has just miscarried an 18-week fetus but not delivered the placenta
E. Clerk a new patient that the GP has sent in to hospital with a suspected torted ovarian cyst

Answer [ ]

1.12 You are trying to persuade a postoperative woman with a haemoglobin of 55 g/l that she would not be so breathless if she had a blood transfusion, but she is concerned about the risk of acquiring HIV. The chance of acquiring HIV infection as a result of blood transfusion in the UK is approximately:

A. 1 in 6000
B. 1 in 60 000
C. 1 in 600 000
D. 1 in 6 million
E. 1 in 60 million

Answer [ ]

1.13 The community midwife doing an antenatal clinic in your GP surgery asks you to see a 37-year-old obese woman who has come for a routine check-up at 32 weeks gestation in her first pregnancy. Her booking blood pressure in the first trimester was 130/88 but it is now 160/95 and the midwife has checked the blood pressure twice. The woman is asymptomatic. Which is the most appropriate course of action?

A. Urinalysis and prescribe antihypertensives if no proteinuria
B. Send urgent full blood count, urate and liver function test
C. Refer her urgently to hospital for further investigation and treatment
D. Urinalysis and request urgent antenatal appointment if no proteinuria
E. Twenty-four hour urine collection for protein analysis

Answer [ ]

1.14 A 52-year-old woman presents to your surgery with a very sore vulva. On examination you find thickening of the labia minora with a couple of shallow ulcers on both sides and a split area at the fourchette. What is the most likely diagnosis in her case?

A. Eczema
B. Genital herpes
C. Lichen planus
D. Lichen sclerosus
E. Vulval intraepithelial neoplasia

Answer [ ]

1.15 **The clinical scenarios detailed below describe gynaecological patients admitted as an emergency. Which patient is most likely to have a diagnosis of ectopic pregnancy?**

A. Acute onset of central abdominal pain and nausea at 12 weeks gestation. On examination severe lower abdominal tenderness with generalized guarding and rebound, also fetor oris. White cell count is 18×10^9/l and urinalysis is negative

B. History of 11 weeks amenorrhoea and brown vaginal discharge but no pain. Pelvic examination reveals no tenderness but uterus is small for dates and the cervical os is closed. Serum βhCG is 2010 IU/ml and scan is awaited

C. Seven weeks amenorrhoea and vaginal bleeding. Pelvic examination reveals no tenderness. Uterus is soft and slightly enlarged with an open cervical os

D. Admitted with bleeding and lower abdominal pain at eight weeks gestation. Transvaginal ultrasound scan shows intrauterine sac with a fetal pole but no heart pulsation detected. Serum βhCG is 150 000 IU/ml

E. Patient with lower abdominal and shoulder tip pain who has a copper coil fitted. Last menstrual period was two weeks ago and on examination has a tender abdomen with guarding. Urinary hCG test positive in A&E

Answer [ ]

1.16 **A 46-year-old woman presents to her GP seeking help with her period problems which date back almost a year. Her cycles are still regular with a cycle of 26 days but the bleeding is now very heavy with clots. She complains of severe secondary dysmenorrhoea but no other pelvic pain. On examination there are no masses palpable in the pelvis. The uterus is enlarged to the size of an orange, smooth and very tender but mobile with no adnexal tenderness.**

Select the most likely gynaecological cause of this clinical picture:

A. Adenomyosis
B. Chronic pelvic inflammatory disease
C. Endometriosis
D. Endometrial hyperplasia
E. Fibroids

Answer [ ]

1.17 **A 39-year-old woman asks for a hospital referral so that she can be investigated for recurrent miscarriage, having suffered three first-trimester pregnancy losses. She believes that her miscarriages are due to stress. She works long hours as a computer programmer and smokes 15 cigarettes a day. Which of the following factors is the most likely cause of her recurrent miscarriages?**

A. Working with visual display units
B. Smoking
C. Advanced maternal age
D. Natural killer cells
E. Bacterial vaginosis

Answer [ ]