

1 The Part 3 Clinical Assessment in the Context of the MRCOG Examination

This revision guide addresses the knowledge, skills, attitudes and competencies needed in preparation for the Part 3 MRCOG clinical assessment (the Part 3 exam). By using this book and the accompanying video resources at an early stage, exam candidates will have the best chance of honing their core clinical skills in preparation for the Part 3 exam. This chapter starts with a very brief summary of all three elements of the MRCOG examination. Further details can be found on the RCOG website (www.rcog.org.uk/en/careers-training/mrcog-exams).

The Format of the MRCOG Examination

The MRCOG examination consists of three parts and is set at the standard of a competent year-five specialty trainee (ST5). In training in obstetrics and gynaecology in the UK, the transition from ST5 to ST6 marks the completion of core training and the start of advanced skills training prior to the certificate of completion of training (CCT) at the end of ST7, and the move to independent practice as a consultant. A UK trainee who has completed five years of structured training should be able to manage the majority of problems encountered on the delivery suite, most common gynaecological emergencies and be able to run general gynaecological and antenatal clinics with minimal or indirect supervision. In addition, an ST5 trainee will have a working knowledge of most subspecialist practice even if they cannot manage those cases independently. Figure 1.1 shows the position of the Part 3 MRCOG examination within the UK Specialty Training Programme.

Over the years, the format of the examination has changed a number of times in line with developments in postgraduate medical education in order to ensure that the examination remains a rigorous assessment of competence. Each change is approved by the General Medical Council (GMC) and based in sound educational theory. The MRCOG examination is rigorously quality assured on an ongoing basis by the Examination and Assessment Committee and the Education Quality Assurance Committee.

The current format of the MRCOG examination consists of three parts, each of which was extensively piloted and analysed before being approved by the GMC and implemented.

The Part 1 MRCOG examination may be attempted at any stage of training after obtaining a medical degree. The Part 1 exam consists of two papers each lasting

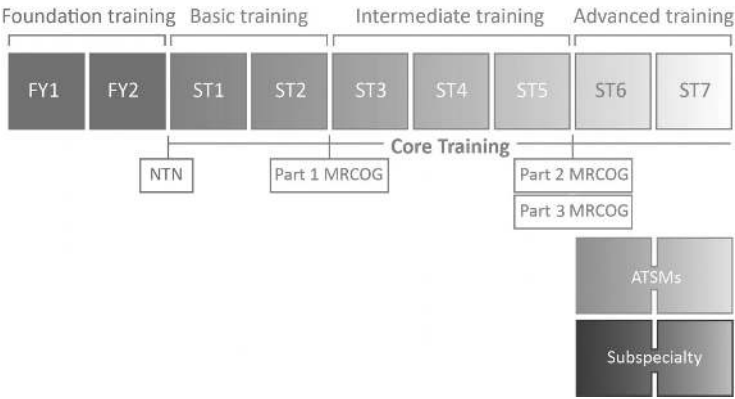


Figure 1.1 The position of the Part 3 MRCOG examination within the UK Specialty Training Programme.

2.5 hours and containing 100 single best answer (SBA) questions. The questions assess applied clinical sciences as defined in the Part 1 curriculum, which is available on the RCOG website. In UK training, Part 1 must be passed in order for the trainee to move from basic to intermediate training (ST2 to ST3).

The Part 2 MRCOG examination may be attempted once a trainee has passed the Part 1 exam and met the training requirements as specified on the RCOG website. Those doctors wishing to become a UK consultant must attempt Part 2 for the first time within seven years of passing the Part 1 examination (or ten years pro rata for less than full-time trainees or doctors not wishing to join the GMC specialist register). The format of the examination is two papers, each of which is three hours long and consists of 50 SBAs and 50 extended matching questions (EMQs).

The Part 3 exam may only be attempted after passing the Part 2 exam. The Part 3 exam is a clinical assessment of knowledge, skills, attitudes and competencies. Passing the Part 3 examination leads to the award of the Membership of the Royal College of Obstetricians and Gynaecologists (MRCOG) and remains the essential waypoint for UK trainees to pass from core training to higher training (ST6 and ST7).

The Knowledge and Skills Being Assessed in the Part 3 MRCOG Examination

The Part 3 exam consists of 14 tasks which are linked to 14 of the knowledge-based modules in the UK obstetrics and gynaecology curriculum. The 14 modules of the Part 3 exam and the link to the respective module of the core curriculum are shown in Table 1.1.

A detailed description of the knowledge criteria for each of these modules is to be found in the core curriculum on the RCOG website.¹ Chapter 3 of this book

¹ www.rcog.org.uk/en/careers-training/specialty-training-curriculum/core-curriculum/

Table 1.1 The 14 modules of the Part 3 exam and the link to the respective module of the core curriculum

Part 3 module name		Corresponding core curriculum module
1	Teaching	2 (teaching part only)
2	Core surgical skills	5
3	Post-operative care	6
4	Antenatal care	8
5	Maternal medicine	9
6	Management of labour	10
7	Management of delivery	11
8	Postpartum problems (the puerperium)	12
9	Gynaecological problems	13
10	Subfertility	14
11	Sexual and reproductive health	15
12	Early pregnancy care	16
13	Gynaecological oncology	17
14	Urogynaecology and pelvic floor problems	18

describes how the knowledge criteria for each module will be tested in the Part 3 exam.

Each of the Part 3 modules is assessed in the context of five domains:

- 1 patient safety
- 2 communication with patients and their relatives
- 3 communication with colleagues
- 4 information gathering
- 5 applied clinical knowledge

Each task will assess three or four of the domains to reflect everyday clinical practice where, for example, communicating with patients is inextricably linked with applied clinical knowledge, or communicating with colleagues also involves aspects of patient safety.

Chapter 2 of this book describes the professional behaviours being assessed in each of the five domains.

Practical Arrangements

The examination consists of a circuit of 14 tasks, each relating to one of the 14 modules to be assessed. Each task will be 12 minutes in length, which includes two minutes of initial reading time.

There may be several circuits running simultaneously in the London centre on each day of the examination and there may also be overseas centres.

The tasks in the morning and afternoon sessions will be the same, but there will be different tasks for each day of the examination. Candidates from the morning circuits will be kept separate from the afternoon candidates to ensure that the second cohort don't have an unfair advantage.

At the start of each task, candidates will have two minutes outside the booth to read the background information and instructions for the task. The buzzer will then sound and candidates will enter the booth and have ten minutes to complete the task. The information displayed outside the booth will be duplicated inside the booth, usually affixed to the desk.

Tip: This isn't a test of short-term memory, so if you've forgotten the name or age of the patient etc., you can glance down at the information to remind you. More importantly, you should not be spending your valuable two minutes of reading time copying down information outside the booth when you should be preparing to show the examiner your skills.

There are two types of task in the Part 3 MRCOG: **simulated patient or colleague** tasks where the candidate interacts with an actor and **structured discussion** tasks in which the candidate interacts with the examiner. Marking is carried out in real time to ensure that no marks are forgotten and there is no recall bias. At the end of ten minutes, the buzzer sounds again and candidates move to the next task, where they again have two minutes to read the background information and instructions, and so on until all 14 tasks have been completed. The duration of the examination is slightly under three hours.

The purpose of the Part 3 MRCOG exam is to assess the skills that are expected of an ST5 in the clinical practice of obstetrics and gynaecology. The examination therefore tests, in a fair and reproducible way, how candidates behave with patients and colleagues, as well as how obstetrics and gynaecology is practised in the NHS.

Tip: You may find it helpful to view the simulated patient tasks as being similar to seeing patients on the wards and in clinics, and the structured discussion tasks as being similar to either case-based discussions with your consultant or clinical governance tasks.

Simulated Patient or Colleague Tasks

In simulated patient tasks, candidates interact with an actor who has been trained and fully briefed in the role they are to play. They will know all the relevant details pertaining to the case and will have some scripted questions to prompt you if needed. They will show emotions such as anger, anxiety or distress if it is appropriate to the scenario; however, they won't display extreme behaviours such as shouting or swearing and they won't leave the station during the ten minutes of your examination.

Tip: It is often not possible to match the physical characteristics of the actors to the demographic and characteristics of the role they are playing. You may, for example, encounter a young actor in her twenties playing a 45-year-old woman with a gynaecological problem or vice versa. Similarly, your task might say the patient weighs 140 kg, but this is not reflected in the physical characteristics of the actor. It is therefore vital to read the background details of the case carefully and conduct the task according to the written instructions, not the apparent characteristics of the actor. Remember, these instructions will be affixed to the desk inside the station.

In a simulated patient (or colleague) task the examiner(s) will be ‘a fly on the wall’, meaning that they are observing the task and awarding marks but will take no part in it. They will have a neutral facial expression and will be making notes throughout the task. Candidates must not attempt to interact with the examiner by explaining things to them or asking them questions. It might help to imagine that they are the healthcare assistant (HCA) sitting in the gynaecology clinic. The HCA’s role is to be a chaperone and not to interfere with the consultation or to interrupt. Candidates are advised to regard the examiner in exactly the same way as an HCA and only interact with the role player.

Tip: Don’t forget to introduce yourself to the actor and address her or him by name. Communication skills will be covered in more detail in the next chapter.

Structured Discussion Tasks

In structured discussion tasks, candidates interact directly with a clinical examiner who will have detailed instructions about the task and a list of questions that they can use to prompt the candidate or to move the task on to ensure the candidate does not run out of time. The examiner may give the candidate further information (e.g. results of investigations or more clinical details) as the scenario evolves and then ask further questions. They may also ask the candidate to explain or expand on an answer. It may help to think of a structured discussion task as being similar to a handover, presenting a patient on a ward round or phoning a consultant out of hours. These are conversations that happen every working day, where information is exchanged and the consultant clarifies details or asks for further information where necessary.

Tip: The examiner’s role is to ensure that all candidates with the necessary knowledge, skills, attitudes and competencies pass the MRCOG examination. It is widely assumed that examiners are there to fail candidates, when in fact the opposite is true. All examiners are trained to ensure that candidates are given the opportunity to demonstrate their skills. Examiners appreciate how stressful such a high-stakes examination is and want to help candidates overcome their nerves to perform at their best and achieve the marks they deserve. Don’t assume that you are doing badly if the examiner moves you on; they are trying to ensure that you are able to cover all aspects of the scenario in the time available so that you have the best chance to demonstrate all your skills.

Linked Tasks

In addition to each task corresponding to a module from the above list, tasks may also be linked in some way. For example, there could be a task about intrapartum management (module 7) with an evolving scenario resulting in an adverse event such as a caesarean hysterectomy, which then could be linked to postnatal care (module 8) in the next task where issues of clinical governance are addressed or the patient needs to be debriefed. It is important to understand that although the scenarios are linked, the tasks will be marked independently and the two examiners will not discuss a candidate's performance. A poor performance in the first task, for example, will not affect the marks awarded in the second task.

Examiners

All Part 3 examiners have been formally trained in how to assess the skills, award the marks and conduct the examination. Prior to each examination there is a detailed examiner briefing at which all the examiners marking a particular task meet to review the instructions, the scenario and the marking scheme. This detailed training session ensures that each candidate is assessed against the same criteria and level of skills, irrespective of which circuit or examination centre they are allocated to. Similarly, there is also a detailed briefing and rehearsal for the simulated patients to ensure that they fully understand the role they are to play as defined in their instructions and to ensure that they perform their tasks in the same way and to the same standard in each circuit or examination centre.

Clinical Examiners

All clinical examiners are Fellows or Members of the RCOG in current clinical practice, selected through an appointments process and required to undertake a training programme. They understand the level of knowledge, skills and competencies of an ST5 trainee and are skilled in assessing whether candidates have the appropriate professional attitudes and behaviours to pass the MRCOG examination.

The examination is marked in real time. Notable aspects of the candidate's performance are documented as the task progresses and in the two minutes at the end of each task. The standard required to achieve a pass in each of the tasks and domains assessed is agreed before the start of the examination at an examiner briefing. Each examiner is provided with individual feedback on their performance in the examination as part of the quality assurance of the examination.

Lay Examiners

The involvement of lay examiners in the assessment of doctors is reflective of the contemporary approach to obstetrics and gynaecology in which patients are expected to be partners in their own care and to be involved in shared decision-making about their

condition and any management plans. Lay examiners are recruited from the general public and do not have any clinical training or background, in order to ensure that they accurately represent the vast majority of patients that obstetricians and gynaecologists encounter on a daily basis. In at least four of the simulated patient tasks in any single exam there will be both a clinical and a lay examiner present.

The task of lay examiners is to mark the communication skills of the candidates in their interaction with patients and/or their families, as represented by the actors. They attend the briefing and rehearsal sessions for the task they will be examining, along with the clinical examiners and actors. As with clinical examiners, they award marks in real time during the task and in the two minutes after the candidate has left the booth. They do not discuss their marks with the clinical examiner, nor do they modify those marks after the candidate has left the booth.

All lay examiners have undergone an initial recruitment and selection process as well as a rigorous training programme to understand their role within the Part 3 MRCOG examination. All examiners are required to undertake equality and diversity training.

The Examination Blueprint

Each of the MRCOG examinations (Part 1, Part 2 and Part 3) are blueprinted separately to ensure that each module of the core curriculum is assessed at an appropriate level in each exam. Examples of the blueprints for each part of the examination are on the RCOG website.²

In the Part 3 examination, all 14 modules will be represented in every exam. Unlike the previous arrangement where the Part 2 written and oral exams shared a common blueprint, the Part 3 clinical assessment stands separately. The purpose of this is to ensure that the MRCOG examination as a whole is a thorough and comprehensive test of clinical knowledge and its application.

In the past, the Part 2 Oral Assessment contained similar topics on each day to fulfil the shared blueprinting requirements. The Part 3 exam is different. Each day of the Part 3 exam will be set and marked completely independently, with no links between the questions other than the modules from which they come. Thus, candidates on each day of the examination will have no prior knowledge of how each module may be tested. Each of the 14 modules will be tested with a separate task, so it is essential to have revised all the required subject areas.

Standard Setting

The Part 2 and Part 3 MRCOG examinations are criterion referenced against the level of an ST5 trainee, meaning that the standard required to pass remains consistent between examinations regardless of the relative difficulty of a particular examination.

² www.rcog.org.uk/globalassets/documents/careers-and-training/mrcog-exam/part-2/p2-blueprinting-grid.pdf

The level of knowledge and skills required in the Part 3 exam is that of a specialty trainee at level 5 (ST5), who has completed core and intermediate training. Each task will assess a minimum of three core clinical skill domains. For each domain being assessed, the examiner will be required to assess a candidate's performance as either Pass, Borderline or Fail. The judgements will be converted into numerical scores, which will then be used to calculate the candidate's mark. It is important to understand that this is a compensatory approach meaning that no single domain has greater importance than any other.

Medical training has been likened to a spiral in which subjects are first covered in breadth at medical school and then with an increasingly narrow focus as doctors specialise and increase their depth of knowledge to the level of a generalist at first, then a specialist and finally an expert. The syllabus for the MRCOG defines the knowledge level expected for each part of the curriculum and clearly shows that some areas will require significantly more in-depth knowledge than others.³ For example, management of pre-eclampsia is a routine part of practice in obstetrics, which trainees will encounter repeatedly during a working week and therefore will be expected to have a high level of knowledge and skills in this area. In contrast, disorders of puberty are relatively uncommon and so trainees would be expected to have a sound theoretical knowledge but have less hands-on experience of managing such cases.

The MRCOG examination assesses knowledge and skills relating to both common and less common conditions and therefore some topics will be inherently more complex than others. This is dealt with in an examination by standard setting. The standard expected for each question or task will be set according to how difficult it is. The standard for a task relating to the management of pre-eclampsia, for example, will be higher than that for a task relating to precocious puberty as defined by the skill level of an ST5 specified in the syllabus. Standard setting ensures that if a trainee sat every diet of the examination, they would have the same chance of passing because for each examination the passing standard will be based on a combination of their skills and how difficult the exam is. The clinical examiners are all in current practice as consultants in obstetrics and gynaecology and therefore have a good understanding of what a competent ST5 should know and be able to do. This means that the passing standard may be different on each day of the examination, but candidates will stand the same chance of passing irrespective of which day they appear.

Quality Assurance

The RCOG makes every effort to ensure that all parts of the membership examination are developed and delivered fairly, in line with the latest evidence-based research. In the Part 3 exam, particular attention is given to consistency between circuits and between the two diets of the examination in May and November each year. There is a careful checking process to ensure that all examination material is accurate. The training and

³ www.rcog.org.uk/en/careers-training/mrcog-exams/part-2-mrcog/syllabus

performance of examiners is assessed to ensure that examiners' marking is consistent and standardised. There is also a transparent appeals process for candidates who feel that they were not given the opportunity to demonstrate their skills.

Why Do Candidates Fail the Part 3 Exam?

It is inevitable that some candidates will be disappointed to find that they have not passed the clinical examination. This is rarely due to a lack of knowledge as these candidates would have already passed two written examinations. In this situation it is usually one of two problems: either the candidate has allowed the stress of the examination to affect their performance, or they have been unable to demonstrate the required core clinical skills. In the first case, these candidates need to practise and rehearse, especially in relation to time management. They should consider accessing face-to-face courses to build their confidence. In the second case, working through the chapters of this book, including the written and video examples, should provide useful guidance in improving their skills in order to succeed.

Additional Resources

Anastasi A (1976) *Psychological Testing*, 4th edition. Macmillan Publishing, New York.

Blueprint: www.rcog.org.uk/globalassets/documents/careers-and-training/mrcog-exam/part-2/p2-blueprinting-grid.pdf

Curriculum: www.rcog.org.uk/en/careers-training/specialty-training-curriculum/core-curriculum/

General Medical Council: www.gmc-uk.org

MRCOG exams: www.rcog.org.uk/en/careers-training/mrcog-exams

Royal College of Obstetricians and Gynaecologists: www.rcog.org.uk

Syllabus: www.rcog.org.uk/en/careers-training/mrcog-exams/part-2-mrcog-syllabus

2 Core Clinical Skills

In order to practise safe obstetrics and gynaecology as a senior trainee and ultimately as an independent practitioner, it is essential to have a thorough and comprehensive understanding of obstetrics and gynaecology, including the evidence base underpinning this knowledge. The MRCOG examination has consistently been shown to be an excellent assessment of the knowledge required to move from core to higher training. The knowledge that will be assessed by the MRCOG examination is clearly defined in the MRCOG curriculum and has not changed despite alterations in the structure of the exam.

There is much more to the practice of clinical medicine than being really clever and having a comprehensive knowledge of anatomy, physiology and pathology. The practice of clinical medicine requires an understanding of how to apply clinical knowledge to an individual patient and, in modern medicine, also requires a patient-centred approach. The General Medical Council (GMC) has identified that deficiencies in pure knowledge are seldom the reason for patients' complaints or referral to the GMC's fitness-to-practice panel. Therefore this demonstrates that becoming a senior medical practitioner is about more than pure acquisition of knowledge. It includes being able to apply those core clinical skills, competencies and attitudes to each individual patient in a framework based on safety and team working. These additional skills are defined in the curriculum and are assessed by a combination of workplace-based assessments and the MRCOG examination. The Part 1 and Part 2 MRCOG exams have been shown to be robust assessments of core and applied clinical knowledge.

The Part 3 MRCOG exam tests those same core clinical skills in the context of a patient-centred knowledge and skills framework to ensure that passing candidates have the necessary skills to move to higher training and independent practice. Throughout the Part 3 exam, the clinical and lay examiners are asked to identify the 'competent candidate' and they are given detailed descriptions about the skills that a competent candidate would be expected to demonstrate. The importance of understanding this is that they aren't looking for a 'good' or 'excellent' candidate and the passing standard isn't set at an unreasonable level.

This chapter will define the five core clinical skills as introduced in the previous chapter and explain how they will be assessed in the Part 3 exam. As you will see, while these five core clinical skills or domains are explicit within the Part 3 assessment template, within any individual clinical scenario or task they will be intimately entwined.