

MEDICAL EDUCATION

How to organise the paediatric MRCP (UK) part II clinical examination

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Responsibility for the organisation of postgraduate examinations in paediatrics will soon transfer to the new Royal College of Paediatrics and Child Health (which will award the MRCPCH). The whole philosophy of how and when to examine is currently under debate, so it is appropriate to review recent experience with the current clinical examination, the Membership of the Royal College of Physicians (MRCP (UK)). The present clinical part of the examination includes a long case (60 minutes for candidates to take a history and examine the patient, and 20 minutes with the examiners), a selection of short cases (as many as are seen within 30 minutes), and a 20 minute oral. Each candidate is seen by a separate pair of examiners for each of these three components.

All paediatricians will be familiar with the mental stress experienced by candidates for postgraduate clinical examinations, such as part II of the MRCP (UK). However, most will probably be less aware of the perspective of those on the 'other side of the fence', including the organisers of the clinical examination, the examiners, and, very importantly, the children and families who act as 'patients', all of whom may face anxieties and difficulties for a variety of reasons. The host examiner and registrar take responsibility for the smooth and fair running of the clinical examination, which depends on their efforts and interactions with the patients, guest examiners, and candidates.

In recent years, the Royal Colleges of Physicians have found it increasingly difficult to find suitable venues with paediatricians willing to host postgraduate examinations. Traditionally, most examinations have been held in teaching hospitals, but competition from undergraduate examinations and an increasing shortage of suitable patients in specialised units has led to a move to hosting the MRCP (UK) in district general hospital paediatric units. Newcastle has hosted the MRCP (UK) part II clinical examination once each year since 1990, but only one day each year has been held in Newcastle itself, with one or two days being in other units in the Northern region, often up to 60 miles away. Even small district general hospitals have sufficient patients for one day (12 long cases and about 24 short cases), and if they only host the examination once every five or six years, patient and host 'fatigue' are unlikely. We would certainly recommend that even smaller

units offer their services for the examination. It is usually an enjoyable and memorable experience, and who knows, a future president of our new college may be able to say that he or she passed their MRCPCH in South Shields—after all, Baroness Lloyd once worked there!

Several recent papers in the *Journal of the Royal College of Physicians of London* have discussed various aspects of the MRCP general medicine clinical examination, from the point of view of the organising registrar,¹ the examiner,² and the patient.³ However, the specific aspects of the MRCP part II unique to the paediatric clinical examination have not been addressed. In this paper, we describe our experience in organising the paediatric option of the MRCP part II clinical examination. We discuss those aspects of the examination and its preparation that are different for the paediatric option, and the steps that we take to try and ensure that everything proceeds in as uncomplicated a manner as possible, for the candidates, examiners, and patients. Finally, we report the results of a questionnaire designed to document the experiences of children and parents attending the examination.

Advance planning

We start planning the examination about two months in advance. The college supplies detailed written advice and guidelines, and also holds a briefing meeting for examiners and registrars about six weeks before the examination. Compiling a worklist and timetable helps to ensure that nothing important is forgotten or delayed. The registrar and host examiner discuss the patient mix and ask colleagues for lists of appropriate children. Secretarial support is recruited early for the organisational and documentary tasks, such as writing to families, compiling the examination booklet, making signs/labels/badges, and acting as a receptionist during the examination. To ensure availability, we identify paediatric nursing staff at an early stage to help look after the children on the day, and a trusted helper (for example another paediatric registrar) to help ensure that everyone (that is patients, candidates, and examiners) is in the correct place at the correct time. Catering arrangements (for both patients and examiners), portering help (to move beds and cots), and car parking spaces are booked.

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Although we have usually held only one day of the examination in Newcastle, and the other one or two at other hospitals in the region, the Newcastle host examiner and registrar have provided advice in advance for these hospitals, and practical help on the day of the examination.

Appropriate documentation, including a wide variety of signs, labels, templates and checklists, is held on computer, allowing its modification and reuse in subsequent examinations.

Patients

Children with common chronic conditions, illuminating histories, or management issues to discuss make good 'long cases'. Rare conditions are less suitable unless they can be used to demonstrate the candidate's ability to work through a difficult problem. Children with good physical signs usually make better 'short cases', and are considered to be more discriminating between candidates of different abilities, but the signs should not be too difficult or unusual. We have an index file database of suitable children, many of whom have attended MRCP, Diploma in Child Health, or student examinations before. Although we prefer not to use the same patients repeatedly, some are often called again because they are 'known' and the families are 'reliable'. However, we are careful to avoid excessive demands on particular individuals, and we will remove someone from our active database if we think that a previous examination was difficult for them or if other circumstances dictate. It is important to check with the child's consultant before contacting the family as recent events may render the child unsuitable.

Patients should be recruited at least two weeks before the examination. Unlike adult examinations, the children included will rarely be inpatients, and will nearly always need to be accompanied by a parent, who may need to make appropriate childcare or school transport arrangements for siblings and obtain time off work. Some parents may understandably be reluctant to allow their child to miss school for a day as suitable patients often have chronic illnesses that already reduce school attendance. Fortunately, either by careful planning or by good luck, dates for the MRCP part II examination often coincide with school half term.

We usually make the initial contact with families by telephone, or in person when they are in hospital for any reason. We then follow this with a standard letter when the family and child have agreed to help. Our initial conversation includes a proper introduction of who we are, how we have obtained their name and telephone number ('Professor Bloggs suggested that I ring you'), an inquiry about the child's current health, and an explanation of the examination's purpose and of what it involves for the child and family. If they say yes, we check their availability on the day in question, offer advice on appropriate clothing, and inquire whether the child has any particular wishes or needs, and how they will be travelling to the hospital. Arranging car parking, or occa-

sionally a taxi, may be an incentive for some families. In general, most families and children have been helpful and receptive to the idea of a paediatric clinical examination.

A few back-up patients may be identified on the wards during the few days before the examination. In addition, we find it helpful to select some short case children who can also act as reserve long case patients in case some children do not turn up on the day.

The follow up letter thanks the child and parent(s) for agreeing to attend, and tells them where to go, when, and outlines the timetable and events of the session. It includes the registrar's hospital (and home) telephone number and asks the family to ring if there are any problems. We ring the family during the weekend just before the examination to check that there are no last minute problems such as illness in order to give us more time to activate our reserve patients.

The college provides money for patient/parent travelling expenses, which may involve taxi journeys in some cases; and also provides a popular certificate and £5 'pocket money' per half day for each child. A crisp £5 note attached to the certificate may be a powerful incentive for some children.

One important difference between the adult and paediatric examination is that it is usually unwise to suggest that a child stays for both a morning and an afternoon session, even if they want to. It is a very long day, and even the best behaved child is likely to become bored, tired, and uncooperative.

Examination booklet

This is one of the most difficult and time consuming, but also important, aspects of organising the examination. The registrar must summarise the relevant history (presentation, findings, investigations, treatment, progress, current medication and status, and physical signs) of long cases, and lay it out clearly on one side (maximum) of A4 paper. Short cases require a few lines stating the diagnosis and current physical signs. We have found it helpful to indicate (highlighted in bold) when *x* rays, electrocardiograms, growth charts, etc are available, and to summarise briefly what they show. Access to up-to-date hospital notes is essential, and communication with the child's consultant may sometimes be necessary to check details. Examiners dislike being misled about a hereditary spherocytic child's splenomegaly when the offending spleen has been removed, but they do take delight in finding extra physical signs or even sometimes challenging the diagnosis. Conversely, a well planned booklet in which it is simple to find the relevant child, their location, examination number, signs, availability of *x* rays, and other details, is appreciated greatly by examiners.

Examination venue and equipment

The examination should ideally be held in a warm, bright, cheerful, and child friendly location such as a children's clinic or day unit. This needs to be booked early so that clinics or day case admissions can be cancelled. The venue

should provide three rooms for long cases where the candidates see the patients. Rooms are better than beds/cots in an open ward, for both privacy and quietness; clinic rooms are ideal. Each room should have an examination couch, at least two chairs, and an equipment tray, including a sphygmomanometer, ophthalmoscope, auroscope, patella hammer, spatulas, orange sticks, tape measure, simple developmental screening equipment, and growth charts. The patient's height and weight should be documented. Urine testing equipment should be nearby, even if rarely used now, as a particular examiner may request it. Failing that, a record of the urinalysis result should be available to the candidate on request.

The short cases should be located in separate rooms (preferably three—one per examiner/candidate group), or in a large open ward/day unit area. If a number of small rooms are used, we group patients so that each room includes a range of cases, for example, one cardiovascular, one respiratory, one abdominal, one neurological or developmental short case, among others. Many children need to be examined on a couch or in a cot, but some only need a chair. Privacy can be ensured by screens for older children. Each room needs an equipment tray (as described above), and spare equipment should be available nearby.

The examiners' rooms all need a desk, appropriate desk labels (for example Professor J Bloggs), and three chairs. One room should have six chairs to allow all the examiners to confer over coffee and biscuits. All rooms should be well labelled and signposted, especially the toilets. Large, simple, and numbered name badges (for example John Brown, short case 1) should be available for patients, as well as for the examiners and helpers.

The candidates should have a separate quiet waiting area, with refreshments and biscuits available, well away from earlier candidates and the patients, and ideally with entry to the examination venue by a different door to patients. The registrars can play an important part by being friendly and helpful to the candidates, while not being intrusive. They should explain how the examination works and is timed—a first time candidate should not be expected to know. It is essential to have adequate toilet facilities for the exclusive use of candidates as the autonomic effect of fear on bladder and bowels is demonstrated by the majority of candidates!

Other essential equipment for the paediatric examination includes a wide range of appropriate (but preferably relatively quiet) toys and books for the patients, including appropriate activities for older children. This is especially important for the short cases who will have to endure relatively long periods of inactivity. A supply of drinks and snacks is also very important, for both the children and their weary or bored parents.

The examination

We set up the venue as far as possible on the previous evening, by moving desks, beds, cots

and chairs, placing signposts, labels, x rays, and stocking equipment trays.

On the day of the examination, a list of patients with expected times of arrival facilitates recognition of non-attenders at an early stage, allowing activation of contingency plans and reserve patients. A secretary greets the patients and the nurses measure their weight and height before taking them to the right location. The helper greets the candidates and equips them with paper and a clipboard, while the registrar helps to orientate the examiners. He/she and the helper should time the various components of the examination fastidiously, ringing bells, knocking on doors, giving time warnings, moving patients to appropriate locations, and shepherding candidates from one pair of examiners to the next. This activity cannot be memorised and the detailed timetable provided by the college is very helpful. Although difficult, it is essential to chivvy the examiners along and keep the examination running to time. Another important role of the registrar is to keep a check on which short cases are being seen, and to ensure that all patients are seen, and none overused. In particular, patients and children dislike being asked to attend and then being underused. Finally, it is also important for the registrar to have a little time for the candidates before they depart. Even though the examination result will not be known, a friendly word or two is likely to help.

After the examination

We try to obtain some feedback from the examiners, in particular concerning the patients (those whose signs were good, who didn't behave, which case was too difficult, etc), but also regarding the venue, organisation, and booklet. Subsequently, we write to all the patients and parents and thank them for attending. Apart from being good manners, it may encourage future reattendance. It is also important to speak to parents before they leave to make sure they have not picked up any 'wrong messages' during the day (for example the mother who hears leukaemia being mentioned in a differential diagnosis list).

Patient and parent questionnaire

There have been suggestions that the clinical examination in paediatrics is a form of child abuse. In order to ascertain the attitudes of parents and children, we conducted a questionnaire survey of those attending two of the three venues in the February 1995 examination: a teaching hospital and a district general hospital. Of the 69 families given questionnaires, 63 (91%) responded. The median age of the children was 4.5 (range 0.1–16.0) years. Only one child was already on the ward; 55% travelled less than 10 miles, but 22% more than 15 miles, to attend the examination. The majority travelled by car, although 8% came by taxi. A parent took time off work in 25% of families. It is worth noting that parents are not reimbursed for lost earnings.

Most children (80%) and parents (74%) enjoyed the examination, although 9% of families expressed some dissatisfaction with the

catering, and 26% felt that the toys were insufficient, or of the wrong sort. Few children described any sense of embarrassment during the examination; 3% were slightly embarrassed by being asked questions, 9% by being talked about, and 2% by being examined. Three families (5%) described being slightly upset by their handling, one by a candidate, and two by an unidentified staff member. Of the written comments at the end of the questionnaire, only 9% were negative, mostly about the length or tedium of the examination. One child said 'Can I come again?'! A practical measure of family satisfaction was that 87% said they would be happy to return for a subsequent examination.

Conclusion

If it is decided that a clinical examination in paediatrics is essential, the current format of the MRCP (UK) part II can be made acceptable to the patients, parents, examiners, and possibly the candidates (especially those

who pass). However it requires meticulous attention to detail and careful planning. Other forms of examination, including the objective structured clinical examination (OSCE), are becoming popular at undergraduate level, but there is no substitute for real 'hands on' patients, with real histories and signs. The MRCP clinical examination may be a consultation in an artificial situation, but if candidates are schooled in the art of the consultation then they will be well prepared for this examination. As Spence said, 'the essential unit of medical practice is the consultation and all else derives from it'.⁴

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- 4 Spence JC. *The purpose and practice of medicine*. Oxford: Oxford University Press, 1960 273-4.