MEDICAL EDUCATION

How to organise a paediatric MRCP (UK) part II training course

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Articles and correspondence about the organisation of the paediatric MRCP (UK) part II examination^{1 2} have appeared in *Archives of Disease in Childhood*, and the Royal College of Physicians has published minimum standards for clinical courses.³ However, little has been written about how a training course for this examination should be organised, and, having organised study weekends, we have gained some experience and feel it may be of value to share it.

A course and the examination itself are obviously similar in structure, content, and the type of patients invited to be examined. However, the organisers should consider various issues in advance of the course, particularly how best to present the children and their problems to the candidates. Thus, course design should be the result of careful planning based on sound educational principles.⁴

Course design

There are conflicts between providing teaching or practice sessions, personal exposure or observational experience, and continuous feedback or realistic intimidation. Each of these needs to be considered in the context of the appropriate section of the examination.

Short cases

Both before and after the course, candidates for the examination ask for maximum exposure to clinical material, as if they wish to be confronted with a series of signs and symptoms rather than a patient; they also seem to prefer to observe the treatment of the patient. However, personal experience and feedback after the examination indicate that although the number of cases seen is immaterial, how these cases are approached is not. Many candidates fail the short cases because they are unprepared for the intensity and speed of the examination, not because they have little experience of the cases presented to them. One of our candidates stated:

"My first real experience of short cases was in the exam. I'd been to so called short case teaching in a tertiary centre where six of us would stand around a bed, one of us would examine and then the rest of us would elicit the relevant signs, generating a thirty minute discussion. This did not prepare me."

We considered how we could prepare the candidates for this section: we could not create an examination situation, but we could provide a candidate to examiner ratio of 2:1, and we could allow each examiner access to two or three short case patients. Therefore, we created a setting which would provide candidates with appropriate experience. The candidates moved in pairs every 20 minutes. They were each asked to examine one of the short cases under examination conditions, observed by their colleague, and were then given feedback. This took about 10 minutes, after which the candidates and cases changed place. This process had a further benefit of allowing both candidates to elicit the signs.

However, this system did not work particularly well in practice, where there were more difficult short cases or weaker candidates. The examiners found that they had to change the emphasis in their sessions from observation and critique to demonstration and teaching. Additionally, the candidates were frustrated that they missed some cases, despite having spent an entire morning being examined on approximately 14 short cases, and ultimately, they seemed to feel cheated out of clinical material.

Finally, resuscitation scenarios are an increasingly important aspect of the short case section of the examination.⁵ On the most recent occasions that we have hosted the examination, we have provided a station for this. Our experience suggests that two thirds of examiners feel confident that they could examine on this and so tend to use the station for every candidate they see. We found that half the candidates had not previously attended any formal resuscitation training, and even candidates who had attended resuscitation courses experienced a significant decline in skills within three months.⁶ Therefore, we ran a two hour, four station resuscitation session. We received positive feedback on this aspect of the course.

Long cases

The long case generates the least anxiety for candidates. We gave each candidate a long case, allowing them one hour for history, examination, and consolidation. The candidate was then examined for 20 minutes, with an examiner for each candidate. Furthermore, to

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increase clinical exposure, we allowed the candidates to see the long cases en masse in a 20 minute session led by one of the senior examiners. Once again, many candidates felt this was not enough and were conscious of the clinical material they had missed. A number of candidates suggested that we provide two long cases in later courses but it is unlikely that we will do this. Firstly, it would be difficult to find enough patients and, secondly, candidates do not usually fail the examination solely on the basis of their performance in the long cases. The skills needed for success in this part of the examination seem to be the ability to think in terms of current problems and to know how to manage these problems, as well as being able to take a history and perform an examination of the patient. This can be taught verbally, without recourse to further clinical material.

Viva

Textbooks are available on this section of the part II examination. However, despite the excellent information they contain, they answer viva questions as if they were essays and do not reflect the flexibility of the examiners' responses—for example, supplementary questions, interruptions, and deviations from the original question. Furthermore, most candidates are used to a Socratic dialogue—that is, a two way conversation. In the viva, the examiners pose the questions but rarely respond conventionally. Their response is often non-committal and not encouraging; therefore, we tried to recreate the pattern of this exchange.

We taught the viva in two ways. We paired up the examiners and gave each pair two candidates. One candidate was to observe, the other was to be examined. Each examiner then questioned the candidate for five minutes while the other examiner took notes. No feedback was given during the first 10 minutes. Then, with the help of the observing candidate, 10 minutes of feedback and constructive criticism were given to the candidate who had been examined. The candidates then swapped over for a further 20 minutes. Each pair of candidates saw two different pairs of examiners.

Additionally, we gave a short lecture, with handouts, on “golden” areas in the viva. These are areas in which the candidate needs to perform well, and some areas that we have noticed are particularly poorly done. We also suggested some hot topics, and discussed answering questions about audit, evidence based medicine, and counselling.

Marking and feedback to candidates

Feedback was given at two levels. Firstly, during each session, informal feedback was given by the examiner. Secondly, based on actual examination scoring, the examiner was asked to mark and comment on their contact with a candidate. These comments were passed on to the candidate's mentor, and discussed in a short interview. We attempted to use well established guidelines,⁷ but time constraints meant that this was not always possible.

Interestingly, middle grade examiners were often less generous than their senior col-

leagues, including experienced examiners. This may reflect the middle grades examiners' more recent examination experience or indicate a tendency of these examiners to restrict entry to the level they have just attained; this, however, is unsubstantiated.

Examination booklet

The construction of the examination booklet has been dealt with elsewhere⁸; the information can be less rigorously researched for the course.

Course organisation

The course was organised along the following schedule, starting two months before the course date:

Eight weeks before—we invited local consultants and middle grade staff with an interest in teaching to help with the weekend, and specific individuals were asked to give short lectures. Nursing staff were invited to help as they have proved valuable in organisation and administration of courses and examinations. Trained nurses also provide part of the resuscitation training.

Six weeks before—a detailed advertisement was placed in the *BMJ*. Children to be examined (and their families) were recruited. Principally, we asked children who had been used previously in DCH or MRCP examinations, thus ensuring a good variety of cases. This does not create a conflict of interest as the college excludes candidates from attending an examination centre where they have worked or studied. To provide enough clinical material for 18 candidates—nine examiners, one long case session and two rotating short case sessions—we estimated that we would need approximately 12 long cases and 22 short cases per session, allowing for some last minute withdrawals. Families were asked to indicate whether they were able to attend and, for short cases, which session they would prefer and whether they would need transport. Reply slips and a telephone number were supplied.

Four weeks before—we began to collect the patients' notes; summary information was then updated.

Two weeks before—attendance of the children and their families was confirmed with a letter telling them when and where to attend, and, if necessary, informing them of transport arrangements. Contracts were arranged with the hospital catering department for meals for the children, candidates, and examiners, and with a local taxi firm for transport for the children. We arranged to borrow a slide projector, overhead projector, and screen.

One week before—a provisional arrangement was made to decide which candidates would start with which examiners and which children; our intention was to rotate the candidates through as many examiners and as many candidate pairings as possible. This was to prevent a weak candidate from slowing down a strong candidate, and to allow the candidates to experience the approach of as many examiners as was practicable. Additionally, each

candidate was assigned with a mentor for feedback during and after the course.

Three days before—all families were telephoned to check availability.

One day before—the department was rearranged as if in preparation for the examination.

Course day 1—candidates were greeted and the balance of their fee received. The long cases and vivas were completed in the morning and the short cases were seen in the afternoon. These were followed by a short lecture and a free discussion of any difficulties that had arisen.

Course day 2—the day started with a short lecture, followed by the short cases. At lunchtime, feedback was given by the mentors, and resuscitation training took place in the afternoon. The day ended with a final lecture and feedback session. Formal, written feedback on most areas of the course was requested.

Conclusion

Our experience shows that an MRCP course is the most effective use of local resources to prepare junior members of staff for the examination. Needs analyses indicate that the primary educational need of senior house officers is to pass MRCP.

Advantages for the examiners include the insight provided by being on the opposite side of the desk or bedside. The medical adage, "See one, do one, teach one" is applicable to this setting. Additionally, there is the enjoyment of seeing children, often with unusual signs, in an environment that is less stressful than everyday practice. Importantly, there can

be a financial component as this course will earn less than a weekend as a locum but is probably more fun.

The disadvantages include the time and effort needed to arrange a good course, and the inevitable erosion of spare time. There may be a conflict with the candidates being tutored by people who examine them in the real examination; the college only checks the candidate against the centre, not the examiner. This could lead to a situation where the examiner assures the candidate that he will pass, only to be required to fail them when they meet in the examination. With careful planning, this can be avoided.

A large number of candidates are looking for good courses. Twice as many applicants apply for our course as there are places. Therefore, we suggest that any centre that feels confident about being able to host the examination could also run a course like ours.

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- 6 David J, Prior-Willeard PFS. Resuscitation skills of MRCP candidates. *BMJ* 1993;306:1578–9.
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