

The Intercollegiate Examiners'

ICBSE:

Newsletter 2 October 2009



Welcome to the second edition of the ICBSE intercollegiate examiners' newsletter.

Both this newsletter and the examinations continue to evolve. It was Charles Caleb Colton (1780-1832) who said 'Examinations are formidable even to the best prepared, for the greatest fool may ask more than the wisest man can answer'. However, in 2009, I believe that the MRCS is still a formidable, quality surgical examination but that the examination is now much fairer and delivers reasonable, reliable and reproducible questions. I am almost half way through my three-year chairmanship of ICBSE



Mr Chris Oliver
Chairman
ICBSE

(Intercollegiate Committee for Basic Surgical Examinations) and during this time the new MRCS Part B OSCE has been implemented and improved, the MRCS syllabus has been revised, and the whole examination re-submitted to PMETB for approval. We will

know the outcome by January 2010. This newsletter is to inform the intercollegiate examiners and bodies of some of the people and develop-

ments in ICBSE. In this edition, we have contributions from: Chris Butler, Chairman, Part B (OSCE) sub-group, on the future developments of the OSCE; Derek Skinner, Chairman, DO-HNS sub-group, defining the work and evolution of the Intercollegiate Diploma of Otolaryngology - Head & Neck Surgery; Mr Mark Fordham, Chairman, MCQ sub-group, outlining the hard work involved in getting the Part A, MCQ exam together; and Mr Kevin Sherman, Chairman of the Internal Quality Assurance Committee (IQA), who tells us about some of his group's work. We hear from June Laird of her experience as an OSCE candidate and FY1 Ewan Goudie, who tells us the difference between a syllabus and a curriculum; it's surprising how many don't know the difference! Finally, we have a short briefing about the work of the ICBSE Office. I would like to thank all the ICBSE and sub-group members and advisers, the Heads of Examinations of the Colleges, the ICBSE Office team and you, the ICBSE examiners, who have all helped to shape and run the MRCS exam so well - sometimes in quite severe adversity. Finally, if anyone wishes to contribute to the next edition of the newsletter, contributions and feedback can be sent to Rezi Bocz, Intercollegiate MRCS Coordinator, at: rbocz@icbse.org.uk.

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The OSCE of the future

It was always the intention to review and modify the MRCS Part B (OSCE) examination when we had enough information. By May 2009 over 850 candidates had taken the examination and we had accumulated a wealth of statistical evidence and a lot of feedback from candidates, examiners and administrative staff.

All members of the ICBSE OSCE sub-group, including the trainee and patient representatives, were invited to submit suggestions for change. The sub-group also received suggestions from a number of other sources including the RCSEng Court of Examiners. Constructive debate followed and there was broad consensus about the way forward.

It was agreed that the system basically worked: candidates felt they were fairly examined, the standard-setting method was standing up to scrutiny and the majority of examiners thought the standard was appropriate. Necessary improvements included the need to examine more basic sciences, particularly pathology, and more clinical

content. We needed to simplify the marking and question writing process by reducing the number of domains and broad content areas and to reduce candidate choice. It was also agreed that we should assess communication skills across more of the examination. A smaller group was tasked with working up detailed proposals.

In July, ICBSE debated these proposals and agreed to move to an OSCE of 18 examined stations. Rest stations will be replaced by examined stations. All stations will be manned. There will be a new surgical pathology station and two extra clinical stations which will be hospital-based to give easier access to real patients. Candidates will have less choice between the four specialty-specific areas.

There will be four, rather than five, broad content areas: anatomy and surgical pathology; applied surgical science and critical care; communication skills (including history taking); and clinical and procedural skills. The domain structure will be simplified and reduced from six to four: clinical

knowledge and its application; clinical and technical skills; communication; and professionalism. Domains will no longer be pass/fail criteria and the standard-setting group can now use higher marks for the content area and overall pass thresholds. One new station will be piloted in each circuit. When these proposals are approved by the regulator for May 2010, the MRCS exam will be longer than the three-part MRCS.

I am grateful to all of you who have provided feedback and suggestions. The OSCE sub-group considered them all. The proposed changes represent a significant improvement. With seven hours of examining we will be able to get the standards right and make sure that the assessment is rigorous and fit to give successful candidates the right to membership and the feeling that they have undergone a proper post-graduate examination.

Christopher M Butler MS, FRCS
Chairman ICBSE Part B (OSCE)
sub group

IQA: from behind closed doors

Several times a year the IQA sub-committee meets behind closed doors and wades through a (very) large volume of statistics and reports and then makes comments, suggestions and reports to the ICBSE. So, what is the purpose of this arcane group?

The IQA sub-group's remit is to ensure that the examination is doing what is claimed for it; this involves several different aspects: the examination should test those attitudes, skills and aspects of knowledge as set out in the syllabus; it should test these things in a way that is fair to the candidates; it should ensure that the standard, as laid down by the appropriate body, is maintained in a consistent fashion. To put this into plain English; the examination should be appropriate, fair and reproducible. As in all things educational, the above statement can be re-translated into very technical sounding educational jargon, designed to deter too many intrusive

enquiries – thus, in education terms, the examination must, amongst other things, have construct validity and reliability. Fortunately, in matters involving numbers, categories and statistical strategy, the sub-group is ably 'aided and abetted' and, above all, educated on a regular basis, by John Foulkes, whose analyses and explanations of the complexities of educational measurement are an essential component of the sub-group's work.

Have the examinations been achieving their stated aim (I use the plural advisedly as we clearly now have several different examinations, each designed for a different group of trainees)? It is really too early to be passing a definitive view on the 'OSCE style' examination as there is not the same depth of historical data for this format of the examination as for the earlier formats and measures such as Cronbach's alpha must be interpreted with caution as many factors

may influence this score. The alpha score should therefore be seen as only one of a range of indicators of the quality of an examination; nevertheless the alpha score has been running at approximately 0.8, which is generally deemed acceptable although we will continue to strive to achieve a higher aspirational value. Feedback from the candidates taking the OSCE style examination appear to indicate that they are, in general, satisfied that the examination is fair and appropriate for their training.

No curriculum should ever be fixed and immutable and assessments and examinations must therefore be constantly reviewed and refined to reflect the changes that take place. The MRCS examination(s) will continue to evolve and I anticipate that IQA will be kept very busy for the foreseeable future!

Kevin Sherman
Chairman, IQA sub group

Intercollegiate DO-HNS

The Diploma of Otolaryngology - Head & Neck Surgery (DO-HNS) became an intercollegiate examination in 2008 and is administered through ICBSE. It replaced the Diploma of Laryngology and Otology (DLO) in May 2003. The DLO, originally introduced in 1923, had been used as an assessment for ENT surgeons who were becoming consultants before specialty-specific FRCS examinations existed. The new DO-HNS examination was designed, piloted and launched in 2003 – led by Maurice Hawthorne.

Lately, with MMC and the restructuring of surgical training, the DO-HNS has been used as a test of knowledge for ENT basic surgical trainees considering higher surgical training in ENT surgery before embarking on higher specialist training. The examination is also used as a specific and explicit standard of ENT knowledge for those doctors in non-career grades of ENT surgery and for general practitioners with a specific interest in ENT surgery.

The examination has generated considerable interest in the ENT surgery community of the United Kingdom and abroad. Indeed, the written paper



can now be undertaken in Cairo and Damascus. As the reputation of the examination has grown, the DO-HNS became a pre-requisite for entry into higher surgical training for specialist registrars and, more recently, with the inception of specialty registrars it has become a specific requirement for the recruitment process into ST3 for higher surgical training in ENT Surgery. The DO-HNS examination is in two parts: Part 1 is a two hour written paper comprising extended matching questions and multiple true false/single best

answer questions and Part 2 is an OSCE. It is now offered three times a year. At present, the DO-HNS Diploma, with the addition of the Part A MRCS, allows the award of an MRCS Diploma. Although this was accepted by PMETB in 2008, issues of equivalence have now been raised and we are now working towards an MRCS Diploma that is ENT-themed using the Part A MRCS and the DO-HNS OSCE to act as the MRCS requirement for ENT trainees entering ST3.

With this new innovation being actively pursued, the curriculum for the DO-HNS is being brought in to line with the themed ENT MRCS Diploma. However, is anticipated that the DO-HNS will also continue as a stand-alone examination. The curriculum is the ISCP curriculum for the Early Years of Surgical Training.

Much work remains to be done over the next few months, and the DO-HNS sub-group fully appreciates the support of the ICBSE and the Examination Departments at all the Colleges.

Derek Skinner
Chairman, DO-HNS sub group

Part A: An exam of two halves

The Part A MRCS is an examination of two halves: two hours for each written paper with a break in between. The first half consists of 135 single best answer questions testing applied basic science and the second half 135 items using extended matching questions, testing principles of surgery in general. Three areas are vital to make the examination reliable, fair and up-to-date: the questions, security and the standard.

Over 100 question writers, surgeons and basic scientists, meet in teams to write new questions, check poorly-performing ones and update ones where technology or practice has changed. A Question Quality Group (QQG) chaired by Peter Billings does the final 'kite-marking' of questions which are then entered into the computerised question bank by Greg Ayre, ICBSE Question Editor. New questions are pre-tested. A fixed number are included in each paper to assess how they perform but do not count towards the final mark.

The software uses a syllabus-based blueprint to randomly generate each new paper which is scrutinised by the Paper Panel, chaired by Mark Fordham, for balance of topics.

Security is vital. UK centres must conform to approved arrangements; international centres liaise with the British Council which oversees safe distribution. Each paper is produced in different question sequences identified by a coloured strip; adjacent candidates in the examination room work from different versions. The answer sheets are marked by an optical mark reader. Then comes the challenge of setting the standard.

When a new style of paper is developed, a standard-setting exercise is carried out with 20 or 30 experts judging what percentage of borderline candidates would get each question correct. Their judgements are pooled and analysed to give a measure of the difficulty of individual questions and the paper overall.

Once candidates have sat the paper each question is analysed to give it a level of discrimination. Questions have a positive discrimination value where high performing candidates get them correct and low performing candidates incorrect. Questions have a negative discrimination value where good candidates get them wrong and poor candidates right; these questions are reviewed by the QQG.

High positive discrimination questions are used as marker or 'benchmark' questions in subsequent papers and used to help calculate the pass mark. This analysis is prepared by ICBSE's professional educationalist John Foulkes, discussed at the Paper Panel, and a final pass mark decided. It is a requirement of passing that at least 50% is obtained in both sections of the paper. The final results are made available on College websites.

Mark Fordham
Chairman, MCQ sub group

No fear!

June Laird overcomes her exam nerves and writes about her experience sitting the MRCS OSCE

I woke up in Edinburgh with that all too familiar pre-exam nausea and feeling of impending doom. As I was getting ready to head to the College I thought of when I had attempted, unsuccessfully, to pass the 'old' MRCS viva five months earlier. That exam took the format of three oral stations: critical care and applied physiology, applied pathology and generic clinical skills, and applied and surgical anatomy. Each station was a 20-minute long interrogation covering a variety of topics. Similarly, with regard to the anatomical specimens presented, there were about a dozen on the table but of the four I was subjected to, only one was of an area in which I had been operatively involved as a general surgical trainee. Unfortunately, the ground did not swallow me up there and then and I was not allowed to progress to the clinical component. I consoled myself by thinking that now I knew what to expect and I would be better prepared next time.

This was not the case. By the time I was applying to re-sit, the format of the exam had changed and I was now going to be involved in the first sitting of the MRCS OSCE. Looking at the candidate guidance notes it seemed to mimic the format of the assessment I was familiar with from undergraduate years. There were to be 16 stations covering six domains: clinical knowledge; clinical skill; technical skill; communication; decision making, problem solving, situational awareness and judgment; and organisation and planning. In addition, I had to select two specialty contexts. Trunk and thorax was the obvious first choice for me but, after my previous skull/parotid/mandible based nightmare, I elected for limbs. There were four specialty context stations – one for anatomy and pathology, one for history taking and two for clinical examination. To pass I had to achieve the overall pass mark and the pass in each of the domains and content areas.

The OSCE was much less intimidating than the viva; there was a feeling of 'safety in numbers' as there were more of us being assessed simultaneously; the style was more clinically oriented, reflecting what we do on a day-to-day basis; and I knew there would be a bell in nine minutes. I was also better prepared. The stations included: data interpretation with a follow-up station involving communication with an 'on-call consultant' by telephone; suturing of a simulated wound while interacting with the patient; looking at radiological investigations followed by discussion about relevant pathology. The Quincentenary Hall was a perfect venue with sufficient space to accommodate the stations. There were plenty of staff on hand to help keep candidates moving in the right direction. Overall, I thought the exam was a better representative of modern specialty training and there is no surprise as to which format I prefer.



What's the difference?

We are all aware of the terms curriculum and syllabus. However, we may find it difficult to describe the differences between them since they are often used loosely or interchangeably. It is, however, important for trainers and trainees to have a common understanding of what they mean, the difference between them, and their relevance to training. This is particularly the case since the implementation of the Intercollegiate Surgical Curriculum Programme (ISCP) (www.iscp.ac.uk). The Postgraduate Medical Education and Training Board (PMETB) provided definitions of both terms (visit: http://www.pmetb.org.uk/fileadmin/user_upload/Assessment/Assessment_system_guidance) which were adopted by each of the Specialist Advisory Committees (SACs) when they outlined their modernised training programmes for the ISCP.

A curriculum is a statement of the aims and intended learning outcomes of an educational programme. It states the rationale, content, organisation, processes and methods of teaching, learning, assessment, supervision and

feedback. Essentially, it is a strategic document that provides teachers, educationalists and supervisors insight into the range of activities within an educational programme and gives them an indication of the resources required to deliver it. It gives the learner a detailed overview of the breadth and depth of a training course and can provide prospective trainees with detailed knowledge of what a programme will entail and can inform choice.

A syllabus is a list or summary description of course contents or topics that might be tested in examinations. It identifies important, relevant, measurable outcomes which usefully reflect the performance of learners and helps to prioritise learning.

In modern medical education a syllabus should not be regarded as an adequate substitute for a curriculum.

Ewan B Goudie

FY1 Orthopaedic surgery

Chris Oliver

Chairman ICBSE

Edinburgh Royal Infirmary

The ICBSE Office

The ICBSE office is based at the Royal College of Surgeons of England. It co-ordinates and manages the development of the Intercollegiate MRCS and DO-HNS examinations and related question banks on behalf of, and in conjunction with, the four Royal Surgical Colleges. It also supports the work of the Chairman and all members of the ICBSE committee and its sub-groups by producing documents and policy papers (including examination papers, OSCE scenarios, regulations and guidance notes) and ensuring the smooth running of the Intercollegiate Membership Examinations.

The ICBSE office consists of the following staff:

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Full details of the MRCS and DOHNS examinations can be found at
www.intercollegiatemrcs.org.uk.

If you have any comments on this newsletter, or would like to contribute to the next edition, please email:
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