Part 2 MRCOG

Single Best Answer Questions

Andrew Sizer, Chandrika Balachandar, Nibedan Biswas, Richard Foon, Anthony Griffiths, Sheena Hodgett, Banchhita Sahu and Martyn Underwood

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Contents

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Andrew Sizer completed specialist training in 2005 and was appointed as Consultant Obstetrician & Gynaecologist at Shrewsbury and Telford Hospital NHS Trust in 2007 and as Senior Lecturer at Keele University School of Medicine in 2008.

He is currently Clinical Director for Gynaecology and Lead Medical Appraiser for the Trust. He is the Chair of Intermediate training (ST3-5) at the West Midlands Deanery.

At the RCOG, he was a member of the Part 1 exam sub-committee from 2008 to 2011. At the end of this time he wrote 'SBAs for the Part 1 MRCOG' (RCOG Press) in conjunction with Neil Chapman.

From 2011 to 2014 he was Convenor of Part 1 revision courses. In 2014, he was appointed as Chair of the Part 1 exam sub-committee. He is an examiner for the Part 2 MRCOG.

Chandrika Balachandar

Chandrika Balachandar has been a Consultant Obstetrician and Gynaecologist at Walsall Healthcare NHS Trust since 1995. She has been Director of Postgraduate Medical Education for the Trust since 2010 and has established simulation training following training and certification as an instructor from the Center for Medical Simulation, Harvard, Cambridge MA. She is an examiner for Part 2 MRCOG since 2007 and coordinates the DRCOG examinations in Birmingham. She is a faculty member of the RCOG Part 2 revision courses, was a moderator for the RCOG Enhanced Revision Programme in 2013 and 2014 and member of the RCOG Assessment sub-committee from 2009 to 2012. From June 2015 she has taken on the role of Chair – Part 2 MRCOG Extended Matching Questions sub-committee. Mrs Balachandar is a generalist with special interests in High Risk Obstetrics, Colposcopy and Paediatric and Adolescent Gynaecology.

Nibedan Biswas

Nibedan Biswas completed his specialist training in Wessex Deanery in 2011 and worked as a locum Consultant at Poole hospital before joining Shrewsbury and Telford Hospital NHS Trust in 2012 as Consultant

Obstetrics and Gynaecology. He is the audit lead for the department and led the team that was successful in obtaining CNST level 3 status.

He is an undergraduate tutor for Keele University School of Medicine.

Richard Foon

Richard Foon started his professional career as a secondary school teacher before entering medical school.

He completed his training in Obstetrics and Gynaecology in 2012, which included 3 years of Subspecialty training in Urogynaecology in Bristol/Plymouth.

He has been a Consultant in Obstetrics and Gynaecology (with a special interest in Urogynaecology) at the Shrewsbury and Telford Hospital NHS Trust, since April 2012.

Currently, he is the Urogynaecology lead for the unit, the lead for Practical Obstetric Multi-Professional training and also the RCOG College Tutor.

Anthony Griffiths

Anthony Griffiths completed his specialist training in 2006 and was appointed as Consultant Obstetrician and Gynaecologist at the University Hospital of Wales the same year. He works closely with Cardiff University delivering postgraduate training for an MSc programme in ultrasound.

He holds postgraduate diplomas in both medical education and advanced endoscopy. He was awarded fellowship of the higher education academy in 2007.

Previously he served as an RCOG college tutor during 2006–2012 and is now Clinical Director for Obstetrics and Gynaecology. He is a preceptor for the ATSM in advanced laparoscopic surgery.

At the RCOG he was a member of the Part 1 examination subcommittee during 2011–2014. At that time he wrote an MRCOG Part 1 SBA resource. Since 2014 he has been convenor for the RCOG London Part 1 revision course. He also teaches on several international MRCOG courses.

Sheena Hodgett

Sheena Hodgett was appointed Consultant Obstetrician and Gynaecologist in 2000, and was initially at University Hospitals of Leicester prior to her appointment at Shrewsbury and Telford Hospital NHS Trust in 2009.

Her specialist areas of interest are intrapartum care and maternal and fetal medicine. She is the departmental lead for obstetric guidelines and for clinical research.

She is an examiner for Part 2 MRCOG having previously been a DRCOG examiner and undergraduate examiner at the University of Leicester. She has participated in MRCOG Part 2 courses in the United Kingdom and abroad.

Banchhita Sahu

Banchhita Sahu is a Consultant in Obstetrics and Gynaecology at the Shrewsbury and Telford Hospital NHS Trust. She completed specialist training in Obstetrics and Gynaecology in India and the United Kingdom.

She complemented her clinical training by working as a Clinical Research Fellow at University College London, a post with a substantial teaching and research commitment.

She has several first author publications in peer reviewed journals.

Her special interests include minimal access surgery, gynaecological oncology and simulation training in obstetrics and gynaecology.

Martyn Underwood

Martyn Underwood was appointed as Consultant Obstetrician and Gynaecologist to the Shrewsbury and Telford Hospital NHS Trust in 2014. He has interests in Ambulatory Gynaecology, Colposcopy and Minimal Invasive Surgery. He has taught on the RCOG Part 1 revision course for several years and also on the ACE Courses MRCOG Part 1 course in Birmingham. More recently, he has contributed to the Part 2 MRCOG course led by Andrew Sizer in Birmingham.

He has an interest in research in field of Gynaecology and Early Pregnancy and has recently contributed to several books in the field of Gynaecological Surgery.

Foreword

The RCOG's decision to add a Single Best Answer component to the Part 2 MRCOG examination was taken with the aim of making the examination more valid and relevant to clinical practice. I am therefore delighted to introduce this extremely useful and timely resource for candidates preparing for the new format of the examination.

The book's helpful layout mirrors that of the Curriculum to ensure full coverage of the relevant topics and their ease of reference by readers.

Candidates will find this book an invaluable aid to revision and examination practice when professional lives are increasingly busy and time is short. The authors have extensive experience of preparing candidates for MRCOG examinations and also of writing questions as members of the various College examination committees. As practising clinicians the authors are fully aware of the need to match theory to practice, and this book reflects the important role of the MRCOG in setting professional standards.

Dr Michael Murphy
Deputy Chief Executive
Royal College of Obstetricians and Gynaecologists

Preface

In 2014, cognizant of the introduction of single best answer (SBA) questions into the Part 2 MRCOG examination, a group of us, predominantly based in the West Midlands Deanery, decided to produce an SBA question resource.

Our aim was to produce questions mapped across the relevant modules of the curriculum and to use the following sources as our primary references:

RCOG Green top guidelines
NICE guidelines
Articles in 'The Obstetrician & Gynaecologist'

Between us we have produced 400 questions. The styles of the questions are different, but we envisage this will mimic the actual examination since many authors have contributed to the RCOG SBA question bank.

At the time of writing, very little was known about the actual style and content of SBA questions for the Part 2 MRCOG. We have used our experience and knowledge of medical education to develop questions that we feel are appropriate.

Knowledge accumulates, practice alters and guidelines change. We will be grateful for feedback.

We hope that candidates for the Part 2 MRCOG find this book helpful in their preparation for the examination.

For further examination practice for the Part 2 MRCOG, please visit www.andragog.co.uk

Acknowledgments

We would like to thank the following trainees for being our 'guinea pigs' in our initial attempts at question writing and for their useful feedback.
Dr Kiri Brown MRCOG
Dr Guy Calcott MRCOG
Dr Will Parry-Smith MRCOG
Dr Dorreh Charlesworth MRCOG

List of Abbreviations

BASHH	British Association for Sexual health and HIV
BHIVA	British HIV Association
CGA	RCOG Clinical Governance Advice
FSRH	Faculty of Sexual and Reproductive Healthcare
GTG	RCOG Green Top Guideline
NICE	National Institute for Health and Care Excellence
NICE CG	NICE Clinical Guideline
NICE IPG	NICE Interventional Procedure Guidance
RCOG	Royal College of Obstetricians & Gynaecologists
RCOG CA	RCOG Consent Advice
SIGN	Scottish Intercollegiate Guidelines Network
TOG	The Obstetrician and Gynaecologist

Introduction

Attainment of the membership to the Royal College of Obstetricians and Gynaecologists (MRCOG) is an essential component of specialist training in Obstetrics and Gynaecology in the United Kingdom. Possession of the MRCOG is also highly prized by specialists working in many countries worldwide.

In March 2015, there were some significant changes to the format of the written component of the Part 2 MRCOG examination, although there was no change in the syllabus.

Previously, the examination had consisted of short answer questions (SAQs), true-false (TF) questions and extended matching questions (EMQs). However, in order to keep abreast of modern thinking in medical assessment, the SAQs and TF questions were dropped in favour of single best answer questions (SBAs).

SBAs had already been introduced into the Part 1 MRCOG examination in 2012, so many candidates were familiar with them. From March 2015, the Part 1 exam consisted solely of SBAs.

Format of the Part 2 MRCOG Written Examination

The exam consists of two written papers with a short break (approximately 30 minutes) between them.

The two papers are identical in format and carry the same amount of marks.

Each paper consists of 50 SBAs and 50 EMQs, but the weighting between the two question types (reflecting the different format and time taken to answer) is different.

The SBA component is worth 40% of the marks and the EMQ component is 60%.

Each paper is of 3 hours duration, but in view of the weighting the RCOG recommends that candidates spend approximately 70 minutes

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Andrew Sizer, Chandrika Balachandar, Nibedan Biswas, Richard Foon, Anthony Griffiths, Sheena Hodgett, Banchhita Sahu and Martyn Underwood.

on the SBA component and 110 minutes on the EMQ component. There are however, no buzzers or warning regarding this, so candidates are responsible for their own time management.

Traditionally, Paper 1 is mainly Obstetrics and Paper 2 mainly Gynaecology, but there is no guarantee that this is the case and theoretically, any type of question or subject could appear in either paper.

Why Have SBAs Been Introduced?

SBA questions have been used as a form of written assessment for decades in a variety of subjects at a variety of levels, but have found increasing use in undergraduate and postgraduate medical examinations over the past 15 years as well as in the General Medical Council (GMC) assessment of poorly performing doctors.

SBAs allow much wider coverage of the syllabus when compared to SAQs and questions can be mapped to the entire syllabus using a blueprinting grid.

Compared to TF questions, SBAs are considered to be a higher level form of assessment. When considering their assessment ability according to Millers pyramid, they can assess 'knows how' and 'knows' as opposed to 'knows' alone (see Figure 1).

An SBA question usually consists of an introductory stem, which in a clinical question could recount a clinical history or scenario. There is then a lead-in question that should ask a specific question. Following this, there will be five options, one of which is the correct, or best, answer.

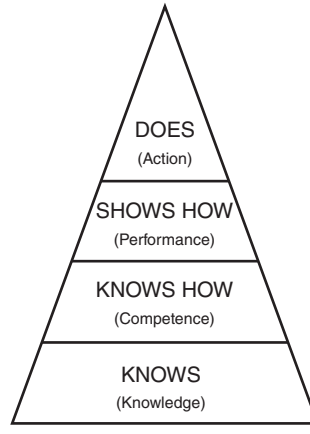

Figure 1. Millers Pyramid (see Miller, 1990)

There are therefore two variations of SBAs: single 'best' answer where one of the answer stems is clearly more appropriate or better than the rest, although the other answer stems are plausible, and the single 'correct' or single 'only' type of question where only one stem is correct and the remaining are incorrect.

Where SBAs are used for basic science questions in medical examinations the single 'correct' type of question tends to predominate, since the answers are generally very clear-cut. However, when SBAs are used to assess clinical knowledge, the single 'best' type of question predominates since clinical scenarios and their management tend to be more open to interpretation, or, indeed, there may be more than one type of management that is perfectly reasonable.

A good SBA question should pass the 'cover test', meaning that in a properly constructed question a good candidate should be able to cover the answer options and deduce the answer merely from the information in the stem and the lead-in question. In practice this can be difficult, and question writers often resort to a 'which of the following … ' style of questioning. However, this is not a true SBA and is really a true-false question in the guise of an SBA.

Our advice would be always to apply the cover test. In other words, read the question with the five options covered. If you feel you know the answer and it appears in the list of options, your answer is almost certainly correct. A well-constructed question will have plausible 'distractors' that could make you doubt yourself. Therefore, it is best to try and answer the question without initially looking at all the options.

There are a number of potential flaws in SBA questions, which the well-prepared candidate could possibly use to their advantage. Many of these (with examples) are summarised in Hayes and McCrorie (2010). In addition to these, numerical questions will have a preponderance of answer 'C' being correct. This is because it is more common to spread the 'distractors' around the correct answer. However, the wily question writer can use this phenomenon to his advantage and place the correct numerical answer at either end of the spectrum.

We hope that our 400 questions give a broad coverage of the syllabus and that you will find the different styles of question writing useful. However, as Obstetrics & Gynaecology is such a vast subject, it is impossible to cover everything unless the questions run into several volumes.

We have not included questions in core modules 1, 2, 4 and 19 as we do not feel these subjects lend themselves to the SBA format and can be better assessed by other assessment tools. The number of questions in the included core modules represent what we consider to be an appropriate weighting.

We hope you find this book helpful as part of your exam preparation.

References

Hayes, K and McCrorie P (2010) The principles and best practice of question writing for postgraduate examinations. Best practice & research Clinical Obstetrics and Gynaecology, 24, 783–794.

Miller, GE (1990) The assessment of clinical skills/competence/performance. Academic Medicine, 65, S63–S67.

Questions

Module 3

IT, Governance and Research

1 If involved in a serious incident requiring investigation (SIRI), initial steps would involve completing an incident form, ensuring completion of notes accurately and participating in team debrief.
If a trainee is involved in an SIRI, what action should be taken as soon as possible?
A. Discuss with the medical defence organisation
B. Engage fully with the investigation
C. Meet with the educational supervisor to discuss the case
D. Write a formal statement
E. Write a reflection of the vent

2 In surrogacy arrangement, the commissioning couple need to obtain parental orders. Within what time frame after delivery must these be made?
A. 6 months
B. 12 months
C. 18 months
D. 24 months
E. 36 months

3 When managing a patient with surrogate pregnancy, who decides about the treatment required for any clinical situation that may affect the pregnancy?
A. The binding agreement
B. The commissioning father
C. The commissioning mother
D. The surrogate mother
E. The unborn child

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4 A primigravida at 24 weeks gestation has come to the antenatal clinic with a fear of childbirth and is asking for elective caesarean section as a mode of delivery.
What would be the recommended management?
A. Adequate exploration of the fears with counselling by trained personnel
B. Discharging the patient to midwife care with advise for vaginal delivery
C. Enlisting the patient for elective caesarean section
D. Referral to another obstetrician for second opinion
E. Referral to the supervisor of midwife

5 Women requesting caesarean section on maternal request might have posttraumatic stress disorder (PTSD) after previous childbirth. What is the incidence of PTSD after childbirth?
A. 0–1%
B. 6–7%
C. 12–13%
D. 24–25%
E. 36–37%

6 Among those receiving gynaecological treatment, what is the reported incidence of domestic violence in the United Kingdom?
A. 11%
B. 21%
C. 31%
D. 41%
E. 51%

7 When obtaining consent for a procedure, a doctor should take reasonable care in communicating with the patients, as their inability to recall from such discussion is often evident.
What percentage of the information that is discussed during the process of obtaining consent before surgery is retained at 6 months?
A. 10%
B. 20%
C. 30%
D. 40%
E. 50%

8 One of the main challenges faced by clinical trials is a lower than expected rate of recruitment.
What is the key to successful recruitment?
A. Collaboration and collective effort in multicentric trials
B. Do nothing, as clinical trials are not important
C. Provide incentives for participation in medical studies
D. Wait for colleagues to publish clinical trials
E. Withhold care to patients if they do not agree to participate in clinical trials

9 Improved outcomes are often observed in women participating in a clinical trial.
What is the reason behind this improved outcome, irrespective of study findings?
A. Positive change in the behaviour of clinicians and participants along with improved delivery of care
B. There is no difference in the outcome of care
C. Treatment is provided in a new hospital with latest technology
D. Treatment is provided in a tertiary hospital
E. Treatment is usually based on postal delivery of medication

10 On completing a consent form with a patient for a diagnostic laparoscopy, you mention that the chance of suffering a bowel injury is 'uncommon'.
How would you define 'uncommon' in this context in numerical terms?
A. 1/1–1/10
B. 1/10–1/100
C. 1/100–1/1000
D. 1/1000–1/10,000
E. <1/10,000

Core Surgical Skills

11 A medical student asks you how to measure blood pressure.
What maximum pressure should you inflate the cuff to measure systolic blood pressure in pregnancy?
A. Always initially inflate to 200 mmHg then deflate
B. Patient's palpated diastolic blood pressure
C. Patient's palpated systolic blood pressure
D. Patients palpated systolic blood pressure + 20–30 mmHg
E. Patients palpated systolic blood pressure + 5 mmHg

12 A healthy 39-year-old woman with no significant past medical history attends a preoperative assessment clinic.
She is due to undergo a total abdominal hysterectomy for heavy menstrual bleeding following a local anaesthetic endometrial ablation that was unsuccessful.
She is fit and well.
What preoperative investigation is required?
A. Chest X-ray
B. Coagulation screen
C. Electrocardiogram
D. Full blood count
E. Renal function tests

13 On deciding where to place your secondary lateral ports at laparoscopy, care should be taken to avoid the inferior epigastric vessels.
Where can these be found?
A. ~2 cm from the midline
B. Lateral to the lateral umbilical ligaments
C. Lateral to the medial umbilical ligaments
D. Medial to the lateral umbilical ligaments
E. Medial to the medial umbilical ligaments

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