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Psychiatric Bulletin (2003), **27**, 390–393

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The new MRCPsych Part II exam – golden tips on how to pass

"Examinations are formidable even to the best prepared, for the greatest fool may ask more than the wisest man can answer!" (Charles Kaleb Cotton)

The MRCPsych Part II examination remains an important milestone (or barrier) for those wishing to pursue higher specialist training in psychiatry. There have been significant changes to the structure of this complex exam, with modification of the multiple choice question (MCQ) and essay papers and the introduction of the critical review paper. With pass rates varying from 39–49% over recent years, it clearly represents a significant hurdle for psychiatric trainees. This article aims to provide specific advice on how best to approach and tackle each of the components of the exam.

As with any examination, successful preparation requires an early start, systematic planning and efficient learning (Asbury & Brown, 1991). Ten months is probably the minimum time needed to prepare for this examination.

Ten months before the exam

Candidates should send off for an up-to-date syllabus and available specimen question papers from the College Examinations Department to guide them on the breadth and depth of knowledge required in the exam. They should select and book a revision course, planning to attend at least 6 months before the exam. A knowledge of the marking scheme can guide candidates in the planning of a revision programme.

Candidates should aim to choose a series of revision-focused textbooks during the preparation phase. Those texts specifically following the Part II exam syllabus are likely to be of greatest help, as they help point out readily examinable facts. A recent survey of successful Part II candidates from the St George's Scheme identified a core list of nine books that were considered universally helpful and of a realistic length for trainees to use while doing potentially busy Senior House Officer posts (see Box 1).

Setting up a small study group (of between two and four equally committed trainees) creates a more pleasant and productive work environment compared with solitary learning. It allows the burden of work to be spread when looking at MCQ and critical review papers, and in producing essay plans. Computerised packages of multiple choice questions and patient management problems (PMPs), available from pharmaceutical companies, are best looked at in such groups as this allows problem areas to be discussed. Group work enables trainees to broaden their perspective and monitor their performance against that of their peers. They should also discuss with their college tutor for practice clinical exams to be incorporated into their regional academic programme.

Box 1. Revision-oriented books

Brown, T. & Wilkinson, G. (2000) *Critical Reviews in Psychiatry* (2nd edn). London: Gaskell.

Cohen, R. M. (1995) *Patient Management Problems for the MRCPsych*. Salisbury: Mark Allen Publishing.

Green, B. (2000) *The MRCPsych Study Manual* (2nd edn). Newbury: Petroc Press.

Leung, W. (2000) *Revision for the MRCPsych Part II: The Critical Review Paper*. Newbury: Petroc Press.

Malhi, G. S. & Mitchell, A. (1999) *Examination Notes in Psychiatry: Basic Sciences. A Postgraduate Text*. Oxford: Butterworth-Heinemann.

Puri, B. K. & Hall, A. D. (1998) *Revision Notes in Psychiatry*. London: Arnold.

Sackett, D. L., Strauss, S. E., Richardson, W. S., *et al* (2000) *Evidence-Based Medicine – How to Practice and Teach EBM* (2nd edn). Edinburgh: Churchill Livingstone.

Taylor, D., McConnell, H., McConnell, D., *et al* (2001) *The Maudsley 2001 Prescribing Guidelines* (6th edn). London: Martin Dunitz.

Williams, C., Trigwell, P. & Yeomans, D. (2000) *Pass the MRCPsych Parts I & II – All the Techniques You Need* (2nd edn). London: Harcourt Publishers.

Six months before the exam

Candidates should start to specifically revise and practise for each section of the written exam.

https://doi.org/10.1192/pb.27.10.390 Published online by Cambridge University Press

Multiple choice question papers

From Autumn 2003, the two MCQ papers (basic sciences and clinical topics) will each contain a mixture of single statement true/false questions and extended matching items (EMIs). Ninety minutes will be allowed for each paper. Candidates should practise identifying 'word cues' in MCQs and develop an ability to access 'hidden' knowledge. The latter takes time and practice to master. For example, a single-statement MCQ of 'disulfiram (Antabuse) inhibits alcohol dehydrogenase' may potentially alarm candidates with the 'smallprints' of neurochemistry, but could be correctly answered using basic knowledge. Most trainees would know that disulfiram acts as an enzyme inhibitor, and that the naming system of enzymes is such that the first part of the name represents the substance that would accumulate if the enzyme was inhibited – in this case, 'alcohol'. Most candidates would also know that it is the accumulation of a by-product of alcohol (and not alcohol itself) that leads to the side-effects patients experience if they drink alcohol while on this drug. Hence, the statement would correctly be marked as false (disulfiram inhibits aldehyde dehydrogenase). As the range of scores in the MCQ papers remains small (since the removal of negative marking in Spring 1999), candidates who can access their 'hidden' knowledge of facts are likely to score higher in these papers.

The lack of practice examples of EMIs poses a problem for trainees. They should create their own examples by thinking of an examinable theme (e.g. neurophysiology), a list of 10–12 options (e.g. list of disorders and drugs) and a set of scenarios (e.g. electroencephalogram changes) following on from an introductory statement. Examples could be swapped and practised in the trainees' study groups.

The essay paper

This tests the candidate's ability to synthesise information and communicate it in written format (Oyebode, 2002). Since Autumn 2001, only one essay out of a choice of three needs to be produced in 90 minutes. Although this has reduced the time pressure candidates previously had, it also poses new challenges as candidates need to be able to fully expand the question tackled. Examples would include incorporating relevant age/sex/cultural differences, other sub-specialities (e.g. learning disability, old age psychiatry), problems with research and 'non-medical' factors (e.g. carers, politics, finance). In quoting references, it is better to quote a small number and critically appraise them, rather than write long lists of unappraised references. A maximum that would be required in any reference quote would be the lead author's name, year and journal name. Evidence-based journal clubs provide a rich source of such information.

A good study group can help reduce the burden in preparing for this paper by giving each member a different topic-related essay plan to prepare and discuss weekly. Concentrating on broad essay plans allows a range of potential essay titles to be tackled in the actual exam. The past 12–15 months of the *British Journal of Psychiatry* (especially the editorials), *Advances in Psychiatric Treatment* and the *BMJ* provide productive sources of information in preparing such plans. Trainees should also write some complete essays under exam conditions, as most will not have done so for several years.

The critical review paper

This paper, first introduced in 1999, requires candidates to tackle a total of 10 questions, under two sections, in 90 minutes. The questions relate to an amended journal article/study and cover concepts of methodology, statistics and interpretation of results. Although the initial papers set were mainly based around studies done using randomised controlled trials, more complex study types are now starting to appear. Hence, candidates should practise looking at meta-analyses, systematic reviews and 'nested' case–control studies. It is likely that qualitative research findings will start to appear more frequently in these papers, and candidates should ensure that they understand terms such as triangulation and respondent validation with regard to these studies. In preparing for this exam, much benefit can be derived from looking at journal papers 'cold' in the context of an evidence-based journal club (Dhar & O'Brien, 2001).

Four months before the exam

Candidates should start to incorporate preparation for the clinical exam into their revision programme.

The individual patient assessment (IPA)

The patient seen might come from any branch of psychiatry. Candidates have 60 minutes with the patient and 40 minutes being examined by two examiners (including the observed patient interview). They should practise obtaining a basic history within 25 minutes, do a brief physical relevant to the patient and then ask the patient to sit quietly beside them. They should then draw up a diagnosis (including differential) and check that they have sufficient information to discuss aetiology. At least 10 minutes should be spent planning management and considering prognosis. When thinking of management, candidates should imagine no financial constraints and should not be restricted by the patient's current treatment plan. Therefore, a symptomatic in-patient on depot, with schizophrenia and drug misuse, could potentially have clozapine, live in supported accommodation with 24-hour staffing, have daily visits from the community team, input from a substance misuse service, advice on risk management from a forensic team, a second opinion from a rehabilitation service, family therapy, motivational therapy, cognitive–behavioural therapy and relapse prevention!

Key words to mention are care programme approach (CPA), key-worker, primary care liaison, carer's assessment and the use of self-help/voluntary services.

https://doi.org/10.1192/pb.27.10.390 Published online by Cambridge University Press

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All plans must include thoughts on risk assessment. Management plans should be based around the biological–psychological–social model used in considering aetiological issues. This model can be adapted into a 3 × 3 grid by incorporating short-, medium- and long-term interventions on the other axis.

Prognosis should always be short and long term. Short-term prognosis reflects the immediate management plan and should be positive. In the long-term prognosis, an acceptable word is 'guarded'. Be prepared to quote statistics and then relate them to the patient. For example, the overall 10% suicide risk in depressed patients may be increased in the exam patient who also misuses alcohol.

Trainees should approach each patient clerking as a potential exam case, preparing management plans that can be presented to their consultant. They should practise clerking a broad range of patients, including those from the sub-specialities (e.g. learning disability and substance misuse).

Patient management problems

The use of PMPs provides the examiners with an opportunity to explore the candidates' skills in applying clinical knowledge in a wider and more practical setting. They will be asked about three different PMPs, over 30 minutes, with a varied content and from any branch of psychiatry. Questions on the sub-specialities are particularly common in this section. Usually, a small group of examiners will have gathered together to collect, refine and re-edit an ever-increasing bank of clinical vignettes. From Spring 2003, every candidate, being examined at the same time across the UK, will be read out and given a copy of the same clinical vignette (McCreadie, 2002). They will then be given identical probe questions and will be expected to answer with an agreed number of facts in order to pass.

Candidates should aim to answer the question posed and the management of cases should be structured around the clinical setting in which they are set. It is never easy to read old notes and speak to relatives when asked to assess an aggressive, potentially psychotic patient in a police station at 1 a.m.! Generally, answers must include thoughts on risk assessment and be related to working in a multi-disciplinary environment, making use of the CPA. Trainees should approach each problem encountered in their ward work or ward round as a possible vignette, and generate practical and real solutions to them. The use of active thought and reason, by reflecting on actual clinical experiences, provides the ideal framework for answering PMPs.

The exam days

The written exams are exhausting, as four papers are sat in one day. Take a supply of sugary refreshments to help maintain concentration, especially for the afternoon MCQ papers. On the day of the clinical exam, ensure that you are in the area the evening before. All candidates should dress conservatively – a potentially disinhibited patient may totally unnerve a flamboyantly-dressed candidate! During the IPA, the first few minutes should be spent putting the potentially-nervous patient at ease. Write the headings of the history on separate pieces of paper and number them.

The future

The changes in the MRCPsych Part II exam continue to make it an intellectually challenging and broad-based hurdle for psychiatric trainees (see Box 2 for some final tips). The increase in the IPA exam time (from 30 to 40 minutes) from Spring 2003 is designed to put a greater emphasis on the exploration of psychodynamic aetiological factors, differential diagnosis and management. The use of structured/standardised PMPs should also reduce

Box 2. Ten golden tips

1. Obtain the MCQ paper breakdown from the College to guide revision.
2. Use websites for sample essay plans, key journal articles to read and MCQs (e.g. www.rcpsych.ac.uk, www.mrcpsych.com, www.superego-cafe.com).
3. Reduce the effect of state-dependent (contextual) learning by practising MCQs in a range of settings, such as your own home, the on-call room or out-patient clinics. It will help aid the recall of particularly difficult facts, such as electroencephalogram banding frequencies.
4. Write an essay outline at the front of the answer booklet to show the structure in case you don't complete the essay.
5. In quoting a drug trial reference, outline the advantages (e.g. randomised controlled trial, double-blind, intention-to-treat analysis done) and disadvantages (e.g. short trial, no NNT data) of that study.
6. Write 'note form' answers for the critical review paper and check the marks available per sub-question as a guide.
7. Practise the observed patient interview (5–10 minutes) as much as history taking and presenting. Get comfortable with demonstrating cognitive tests. You will not then be unnerved by being asked to test frontal lobe function in the exam. If possible, video-tape practice consultations.
8. Remember that a sub-speciality PMP may be asked by a psychiatrist from another field (e.g. an old age psychiatrist asking a child psychiatry vignette).
9. On the exam day, avoid looking at factual information before each paper, as it may distort 'older' information learnt.
10. Tell the patient that interruptions may be necessary in the IPA.

MCQ=multiple choice question
NNT=number needed to treat
PMP=patient management problem
IPA=individual patient assessment

https://doi.org/10.1192/pb.27.10.390 Published online by Cambridge University Press

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the undue influence of more maverick examiners. Many of the skills learnt in preparing for the exam (e.g. updating knowledge) need not be restricted to just the exam, but will be of help to doctors throughout their professional careers.

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https://doi.org/10.1192/pb.27.10.390 Published online by Cambridge University Press