RCGP Examination for Membership
Revised Oral Examiners' Guide 2002/2003

SUMMARY: KEY POINTS

- **Every candidate** who enters the examination **is eligible to take the orals** when/as he/she wishes, within the constraints of the examination regulations

- **The aim of the Orals is to test candidates' decision-making skills in defined areas**

- **Within each 20-minute oral, examiners' topics should cover three "areas of competence"** (*communication, professional values*, and *personal and professional growth*) **within four "contexts"** - *the care of patients*, specifically: *working with colleagues* (PHCT and others beyond); *society as a whole*; and *taking personal responsibility* (for care, decisions, outcomes)

- **Over a day's (or sometimes a half day's) examining**, when examiner pairings are normally maintained, **the topics examined should normally be, so far as is possible, the same**

- **Each question must be asked of candidates in a consistent fashion.** The phrasing of the *initial* question should be in a standard form. Depending upon the quality of the candidate's response to initial questioning, supplementary questions should be available (again, in standard form) which address *basic*, *high level* or *low level attributes*, so that the examiner can make the most precise judgment possible

- **In order to conduct fair orals, Examiners should be mindful of difficulties posed by particular candidates** (eg candidate with a speech problem, ethnic minority candidate, non-native English speaker). In particular - and for all candidates - the intention/s of questions always needs to be made explicit. Examiners should not change discourse mode (eg from professional to personal) when faced with a challenging candidate

- **Examiners should use the Oral Grade Criteria** ("word pictures") **to help them make their decisions** on a candidate, by question and overall. They should be clear as to what constitutes an outstanding, excellent, etc, answer - and especially around the pass/fail divide

- **The Oral constitutes a separate pass/fail/merit module of the MRCGP examination.** Each candidate is reviewed by the four oral examiners together to confirm the result of the module. They may adjudicate a marginal candidate in either direction (1-2 "points" only). **The four examiners thus determine the pass/fail decision explicitly.** Merit is determined proportionately by the examination analysis system

- **Examiners record their judgments, with other data, on a computer-readable card.** This provides for written comments for possible transmission to candidates, with a codification of commonly-made observations

- **A day comprises six oral slots** (so 4 examiners examine a total of 12 candidates). **The 65 minute oral slot is organised as follows:**

  - 5 minutes preparation for the first oral
  - 20 minute *oral examination 1* in examiner pairs
  - 10 minute reflect/discuss/changeover/preparation for the second oral
  - 20 minute *oral examination 2* in examiner pairs
  - 10 minute discussion of both candidates in foursome

CONTENTS

Daily Timetable of the Orals

Paperwork

Educational Background

"Blueprinting"

The aim and function of the orals in the MRCGP

Examiners' tasks

Problems in running orals

Strategies

- planning the oral
- starting the oral
- questioning on individual topics
- avoiding and dealing with problems
- grading ("marking") the topic
- ending the oral; the overall grade

General advice

Attachments:

1. Oral Planning Sheet
2. Examiners' Marking sheet
3. Examiners' Quartet and Summary Sheet
4. Oral Grade Criteria
5. Oral Question Card (old version as well as current one)
6. List of coded feedback comments
7. Guidance for examiners

DAILY TIMETABLE OF THE ORALS

The daily arrangements are as follows:

08.45 - 09.00	Plenary: announcements, orientation
09.00 - 09.30	Planning of morning's orals in fours
09.30 - 10.35	Oral Slot 1
10.35 - 10.55	Coffee
10.55 - 12.00	Oral Slot 2
12.00 - 13.05	Oral Slot 3
13.05 - 13.45	Lunch
13.45 - 14.00	Planning of afternoon's orals in fours
14.00 - 15.05	Oral Slot 4
15.05 - 16.10	Oral Slot 5
16.10 - 16.30	Tea
16.30 - 17.35	Oral Slot 6
17.35 - 18.00	Evening meeting; grogs

Examiner pairs are consistent only over a half day, though many continue for the whole day.

PAPERWORK

There are three forms, copies attached:

(1) An ***"Oral Planning Sheet"***: on this, the two pairs of examiners plan a day's or half a day's orals, depending upon how long pairings last. This planning is undertaken during the 30 minute morning or 15 minute afternoon planning session. The examiners should agree what topics each pair may use in any oral and which *contexts* and *areas of competence* each topic would cover. This carbonised list should be completed by the lead examiner of the four: one copy is kept by each examiner pair for reference.

(2) The ***"Examiners' Marking Sheet"***. This is a computer-readable form: on it, the examiner records the progress of a single oral examination. Each topic discussed is listed, together with a record of who is the lead examiner (for evaluation purposes), and which contexts and areas are addressed. A grade must be given for each topic and notes (of a helpful and repeatable nature) recorded. An overall grade should then be adduced and comments for feedback to the candidate (please include positive recommendations) always noted. A space for written comments is available, and codes given for commonly-made observations.

(3) An ***"Examiners' Quartet Summary and Review Form"***: This records the four examiners' aggregate pass/fail result, computed from the four examiners grades. Following the foursome discussion, it offers the possibility of altering this result *up or down* in marginal cases, as long as detailed justification is given. Justification is also expected of failing grades, generally. Examiners' signatures attesting to the result are then required. Please collate the examiners' coded comments to a maximum of four (for feedback to the candidate), again ensuring that constructive recommendations are included.

It is important that examiners fill in the documentation *completely. This means you!* This is not just to satisfy the Oral SS: it is to permit appropriate analysis and (hopefully) the demonstration of reliability, etc.

Three further *job aids* are provided to assist oral examiners:

(1) The current list of ***"Oral Grade Criteria"*** or "word pictures". Note that the detail of these is developed from time to time by the Oral Development Group (ODG).

(2) New, improved, larger ***Question Cards*** for examiners to write their questions etc on. We strongly recommend that Examiners use the electronic version of these "forms", for use in MS Word, which expand as you type into them. This facilitates question updating. For a copy, email smackenzie@rcgp.org.uk with "question card, please!" as the subject field

(3) A list of codes for the ***frequently-used feedback comments***, associated with the computer-readable examiners' marking sheet

A copy of each of these is appended.

EDUCATIONAL BACKGROUND

One of the problems in conducting oral exams at the level of the MRCGP is that there is little direct guidance available from the scientific literature as to how to do it well or better. One has to look for related areas, and probably the only relevant one is that of the selection interview which forms a focus in occupational psychology research.

The notes which follow thus draw where appropriate on such literature, on studies of the MRCGP, but most of all on the experience of examiners over recent years. (References to three important papers on the examination are given below. They include the Definitive Guide[1] - well, it was definitive in 1995, a paper on transcultural issues[2], and a paper reporting on an investigation into possible ethnic bias in the examination[3].) The Guide also incorporates Management's current recommendations for oral examiner behaviour, as agreed in the Oral Development Group (and even sometimes as advised by our consultants).

---

[1] Wakeford R, Southgate L, Wass V (1995). Improving oral examinations: selecting, training and monitoring examiners for the MRCGP. British Medical Journal 311, 931-935.

[2] Roberts C, Sarangi S, Southgate L, Wakeford R, Wass V (2000). Oral examinations, equal opportunities and ethnicity: fairness issues in the MRCGP. British Medical Journal *320*, 370-374

[3] Wakeford R, Farooqi A, Rashid A, Southgate L (1992). Does the MRCGP examination discriminate against Asian doctors? British Medical Journal 305, 92-94.

There are many issues here: attempting to deliver a fair examination is a key one, "blueprinting" an oral examination so as to achieve this is another.

"BLUEPRINTING"

From the psychometric point of view it is vital that five topics are covered in each oral. This is partly because of what is termed the "high case specificity of performance" (ie people are good at some things and bad at others — your job is to take a reasonable sample and assess the balance). Also, because examiners vary somewhat in their classification of question "areas of competence" (one's "professional values" may be another's "personal and professional growth"), we need you to cover what you define as all three areas of competence and four contexts in *each* oral. The implication of this is for substantial oral pre-planning and *blueprinting*.

The notion of blueprinting the oral is an important one. Each oral comprises a number of "items" (or, as we call them, topics). By picking a sample of items whose position on three conceptual dimensions is selected by the examiner, we produce a controlled oral examination which contains what approximates to a representative sample of the total "population" of possible items. The three dimensions are the list of all content or subject-area *topics*, the three *areas of competence* identified by the panel of examiners, and the four *contexts* in which the topics are to be discussed. Each oral has to cover each area and each context, not all possible combinations.

THE AIM AND FUNCTION OF THE ORALS IN THE MRCGP

The aim of the orals is TO EXPLORE CANDIDATES' DECISION-MAKING SKILLS IN GENERAL PRACTICE: the extent to which, when confronted by a problem, issue or dilemma, they can see a variety of options or strategies, evaluate the implications, advantages and disadvantages of each, and reach a defensible decision, coherent with other decisions about other problems, issues and dilemmas presented to them.

The ***areas of competence*** in which these skills are to be tested in the orals are limited to the following:

1. Communication:

    Principles of verbal and non-verbal communication, generally
    Consultation models
    Effective information transfer; motivation
    Empathy; listening

2. Professional values:

    Moral and ethical principles

Patient autonomy
Medico-legal issues
Flexibility & tolerance
Implications of styles of practice
Roles of health professionals
Cultural & social factors

3. Personal and professional growth:

Continuing professional development
Self-appraisal and evaluation
Stress awareness and management; burnout
Change and change management

The ***contexts*** in which the topics are to be discussed are:

1. The care of patients, specifically

2. Working with colleagues (PHCT and others beyond)

3. Society as a whole: its expectations and the GP's role

4. Taking personal responsibility (for care, decisions, outcomes)

EXAMINERS' TASKS

1. To bring to the orals *at least twelve* prepared and calibrated questions, with follow-up questions, each to be asked in a standard form;
2. To cover to a markable level five topics per 20 minute oral;
3. By appropriate planning, to include adequate exploration of candidates' *DECISION-MAKING SKILLS* in all of the three *Areas of Competence* and four *Contexts* in each oral;
4. To explore the candidate's approach to practice—searching for coherence, rationality and consistency;
5. To obtain justification of reported behaviours, approaches, opinions and attitudes;
6. To grade the candidate on each topic (and record this, together with appropiate comments);
7. At the end of the 20 minutes, to make an overall judgement, to record the appropriate letter grade, and to comment in writing about the candidate's overall performance, especially providing feedback for weaker candidates;
8. To conduct the whole with friendliness, decorum and informality (mindful also of equal opportunity considerations);

9. At the end of a pair of orals, to review candidates in consultation with the other pair of examiners to confirm the pass/fail result of the module; and
10. To complete the paperwork carefully and comprehensively, bearing mind the requirements of the Data Protection Acts.

PROBLEMS IN RUNNING ORALS

There are two sorts of problems in conducting orals: those you may recognise and those you don't. First of all, those you may recognise:

1. A dysfunctional start to the oral
2. Covering the ground fast enough
3. The problem candidate (eg slow, slow-witted, garrulous)
4. Being led where the candidate wants to go, not where you do
5. Being given lots of facts (perfectly relevant ones) by the candidate, often about their own/training practice
6. Your co-examiner taking too long on a topic (it's always the co-examiner)
7. Communication difficulties with groups of candidates (eg those for whom English is not their mother tongue, people from ethnic minorities)
8. A dysfunctional end to the oral
9. Disagreeing with your co-examiner about the grade

Some of those which you may not be aware of (this is where the selection literature comes in):

1. First impressions are likely to be overly influential on your final judgment
2. The appearance of a candidate will influence you (un/attractiveness, particularly)
3. The contrast with previous examinees may affect your judgment (after two disastrous ones, a moderate candidate may seem wonderful)
4. You are likely to treat people like you preferentially (like you = sort of person, values, etc), also people whom you like (as oppose to dislike)
5. You may find yourself being especially critical of faults which you know you have, when you spot them in others
6. It is necessary, in an examination, to make unidimensional judgments of people (eg "good"); in practice, of course, most candidates will combine good and bad aspects

STRATEGIES

A) PLANNING THE ORAL

We plan each oral in advance in an attempt to give a good sample of topics to each examinee, regardless of what may transpire to be his/her quality. It follows that each oral question used by an examiner needs to be developed so that it can be used to test at all levels of candidate ability.

- We recommend that you write your questions on cards (provided by the College, no expense spared; electronic version available, see above) and classify them by question area and context; this facilitates planning, and allows you to take effective evasive action when things *don't* go to plan

- On your card, note the precise way in which each initial question is to be phrased. Note also the follow-on questions which you are going use to tighten or slacken the topic, to cater for varying candidate ability. Record indications for "O", "E", "G", etc.

- Review your question:

  - Is it in the right "box"?
  - It the opening stem brief and clear? (Especially important for candidates from different backgrounds and/or for whom English is not their mother tongue)
  - Are pass/borderline/fail criteria clear and appropriate? Do they fit with the grade descriptors?
  - How can the question be tightened to O/E level? How low can it discriminate?
  - And how well does it address decision-making and professional judgement? (Most important!)

- In the half (or quarter) hour planning period, share your questions with your co-examiners. Explain your grading strategy and what would constitute a minimal passing response from a candidate.

- ***Please make a second copy of the completed card*** to help your co-examiner see exactly what you're getting at and to understand your grading

- Every examiner should have available a short-stem emergency question for use when things go wrong, when your co-examiner finishes before you've thought about your next question, etc

B) STARTING THE ORAL

There may appear to be a degree of chaos at the beginning of orals, especially if you're in one of the large examination rooms. But trust the administration, it's organised. Even the Marshals know what they're doing. It may nevertheless be unsettling to candidates who will then need to be settled again. So in order to maintain the exam's reputation for courteousness, we recommend that:

- Examiners should greet candidates, shake their hands, invite them to remove jacket etc as appropriate, and invite an initial comment about transport, weather, etc, before commencing questioning. (This may seem trivial and/or obvious. But not everyone does it and it's important and really very effective.)

C) QUESTIONING ON INDIVIDUAL TOPICS

- Introduce each topic and indicate its area (eg "I want to ask you about how we explain things to patients, and we'll take diabetes as an example"). Using plain English like this is probably better than saying the name of the area: ok, so "communication" is probably alright, but "personal and professional growth" is

baffling unless you know the code.

- Remember that the focus of the orals is to test candidates' decision-making skills

- Remember also, no more than 4 minutes per topic; so

- Go in deep quickly, use short question stems (no scenarios longer than a sentence), and make frequent use of the question "Why?" If you find a question is taking too long, think what you're "really getting at" with it, and go straight there.

- Use the first, main question (possibly accompanied by brief additional questions such as Why) as a form of triage. Decide which of your follow-on questions you're going to opt for (high, basic, or low level attributes) and then question further towards making your final judgment on the candidate about performance on the topic.

- Avoid factual and unmarkable questions. There are two issues here:

  a) "Factual knowledge" about GP/medicine has been comprehensively and reliably tested within the written papers. Trust them! In any case, you really cannot reliably test knowledge in an oral, so use it for the things that it does best, *even* if you're worried about factual knowledge. If you're right, there'll be low written paper marks.

  (b) Questions which result in a different sort of factual information, ie information about a candidate's practice, are producing what is known as "unmarkable stuff" and should be dropped or modified, and rapidly followed by a re-direction.

- A few examiners have in the past made use of what we term "props" - letters, pictures, ECG traces, etc. We frankly don't think that their use is helpful, and believe from experience that they waste time and add nothing. Please don't use them.

- Think how your questions are likely to be interpreted (especially by candidates from other cultures).

  - Ask questions in the kind of discourse that you want their answers to be in (institutional, professional, personal)
  - Be explicit, say how you expect the question to be answered
  - Remember that some candidates may be unused to argumentation with those senior to them. Make it clear that this is ok here!

- Remember that you are the examiner and are in charge (it's not a consultation!). You must in particular take overt control when faced by a problem candidate (see below) or time problems. Also, note that the longer candidates can prevaricate, spout facts, natter about uncontestable matters or their journey to the exam, the more they deflect the examiner from her/his task. So take control from the start, and do not nod and smile if you are really dissatisfied.

- There are of course frequently no clear-cut right and wrong answers in general practice. Because of this, you may find it helpful to use an explicit model when presenting a question of choice (eg what are the options open to you now? what are the implications of each? what would you decide and why?)

- In any case, ask about justification of decisions and opinions (eg "Why?"). The written papers have looked at reading, of course, but this does not preclude your occasionally asking questions of the form "What papers have you read recently to support that view?"

- Think about strategies when the candidate gives an unimpressive response:

  - Do not lower your discourse level
  - Be explicit about what kind of response you want - metacommunicate and frame more - and do not convey dissatisfaction indirectly, eg via intonation
  - Do not assume pauses or hesistancy are necessarily markers of incompetence. And do not ask more questions, more quickly!

- When you can give a grade, do so—and finish. Don't feel you've got to use up your time. It is better that more areas should be covered in the oral.

- Concentrate upon the S/B/N decision for each topic. Remember that, depending of course on you co-examiners' decisions, someone who you think has not justified a passing grade needs to be given N or below.

D) AVOIDING AND DEALING WITH PROBLEMS

Some of the problems listed above are covered in other parts of this Guide. As regards the remainder:

- Examine candidates from other cultures sensitively, bearing in mind the need to offer equal opportunities to all. Because of the difficulty that it can cause to such candidates, quasi-roleplay (e.g. "Show me how you might tell her the bad news, what sort of words would you use?") are best avoided (for all candidates).

- *"Hybrid discourse is dangerous"* we are told, and can be particularly confusing in transcultural encounters (see paper in the BMJ). So keep the nature of the *discourse* about a topic consistent. Much of your questioning will use *institutional discourse.* Just because, for example, a candidate doesn't immediately respond to the question "What does "patient-centredness" mean to you?", don't change down the discourse level to talk about experience with a particular patient, even though this may be meant helpfully. Stick with your intention, explain and rephrase.

- Recognise candidate types (eg slow, timid, garrulous, overbearing/bulldozing, etc) and have strategies planned for each. Some tips:

  Slow candidates: Cut short, ask for lists, do not ask philosophical questions, maybe gently ask them to speed up.

  Garrulous candidates: You have to listen extra carefully to hear the message; slow them down; ask for clarification; use body language to control or interrupt.

  Timid or anxious candidates: Handle gently to start with and go for depth without obvious pressurization (iron fist in velvet glove).

  Overbearing/bulldozing candidate: "Why?" questions are helpful, as are: give me some alternatives, yes but tell me what you would *do*, give me two disadvantages of that.

- Beware that a very poor candidate may, by coming up with an unexpected bit of apparently medical knowledge, make you think they aren't so awful. They are!

- When trying to encourage a poor candidate, avoid using value judgment words (eg "good") which could be interpreted as meaning that the candidate was going to get a good grade. Rather, use non-verbal encouragement.

- Arrange a code with your co-examiner for if he/she over-runs. Kicking is good.

E) GRADING ("MARKING") THE TOPIC

- Grade the topic immediately it is finished. Don't wait until the end of the oral. Use the current list of grades and descriptions, copy attached. Be clear about the S/B/N decision.

- The candidate has to earn a pass by giving the examiners what they are looking for. Just "not saying anything awful" is insufficient for a pass!

- Use questions regularly for calibration purposes. Design your subsidiary questions so that your record card records characteristics of answers at each of the levels.

- If you are giving a high-ish (or low-ish) grade, think, what would the candidate have to have done better (or worse) to get an even better grade. (We find that in this way, examiners may extend their use of the marking scale.)

F) ENDING THE ORAL; THE OVERALL GRADE

- When the bell goes, let the candidate finish his/her sentence before saying that will be all, thank you. Sometimes examiners can seem quite abrupt in stopping candidates at the bell.

- Review your list of grades given to each topic. Refer to the list of grades and descriptions: which fits the candidate best?

  - when considering your overall grade, review the list of "hidden problems" (above). Would these on balance be tending to push your mark inappropriately high or low?

  - when giving the overall grade, other things being equal, make this the average grade of those which you have given to the individual topics. 5 G's don't make an O!

  - beware of the common experience of feeling that the candidate was "getting better towards the end", and thus raising a mark. This is more likely to reflect true variations in candidate ability amongst the topics discussed than "getting to the candidates's true ability".

- We want two independent judgments, so *don't* let your co-examiner browbeat you into changing your grade. Unless it transpires that you have slept through some catastrophic or brilliant answer, maintain your judgment!

- At the end of the oral, note on the marking sheet any comments for possible feedback to the candidate. Hopefully, most of these will be catered for by our coding system. Mark any of these which apply, and write any further comments down in longhand in the space provided; include some positive recommendations, if you can.

- In the foursome, note on the "Quartet Summary & Review Form" the grades given by each examiner. Then, using the guidance given to you on the form, work out whether the candidate has passed or failed according to a simple aggregation of the grades given. Zero points or less is a fail; one point or more is a pass.

    - If the foursome is content with the result, proceed as under.
    - But marginally passing or failing candidates - those with "zero" to plus two points - may, respectively, be lowered or raised, if this is the consensus of the examiners. If you do this, fill in the "Final Result (if different)" space on the form appropriately, and *change the individual examiners' grades on the form and on the Opscan marksheets*. Please justify the change in overall result clearly on the form.

- Please write down comments on the form about a failing candidate's performance—preferably with concrete examples—in such a form as they can be transmitted *verbatim* to the candidate by the Convenor of the Panel. Use the coded comments, but limit these to four to avoid overload. And include some positive recommendations.

- Members of the Oral Development Group who act as Marshals have instructions to inspect the forms at the end of each examination session to ensure that examiners' comments are transmissible. Make sure that your comments are full and legible so that your coffee/lunch/tea break is uninterrupted!

GENERAL ADVICE

- Try to recognise what your fellow examiners do well (and badly). Learn from this.

- Don't be afraid to experiment with new techniques and questions but preferably only one experiment per oral!

- Remember to be clear about the focus of your questions, and what constitute excellent, good, etc, and - especially - passing and failing responses. Determining the S/B/N decision for each question is the challenge.

Oral Development Group
May 2001

Oral Planning Sheet

Pair A: Ex 1 .... Ex 2 .... Pair B: Ex 3 .... Ex 4 ....

Date: / / am/pm	Area of Competence		
Context	Communication	Profl Values	Per/pro Gr'th
Care of Patients	Examiner 1[] 2[] 3[] 4[]	Examiner 1[] 2[] 3[] 4[]	Examiner 1[] 2[] 3[] 4[]
Working with Colleagues	Examiner 1[] 2[] 3[] 4[]	Examiner 1[] 2[] 3[] 4[]	Examiner 1[] 2[] 3[] 4[]
Society	Examiner 1[] 2[] 3[] 4[]	Examiner 1[] 2[] 3[] 4[]	Examiner 1[] 2[] 3[] 4[]
Personal Responsibility	Examiner 1[] 2[] 3[] 4[]	Examiner 1[] 2[] 3[] 4[]	Examiner 1[] 2[] 3[] 4[]

MRCGP Oral Examination Mark Sheet

Examiner's Name:

Candidate's Name:

Exr. No. | CAND No.

0	0	0		0	0	0	0
1	1	1		1	1	1	1
2	2	2		2	2	2	2
3	3	3		3	3	3	3
4	4	4		4	4	4	4
5	5	5		5	5	5	5
6	6	6		6	6	6	6
7	7	7		7	7	7	7
8	8	8		8	8	8	8
9	9	9		9	9	9	9

- ◆ Use pencil only ◆ Make heavy marks that fill the lozenge completely.
- ◆ Write the candidate number and your examiner number in the top row of the boxes to the right AND fill in the appropriate lozenge under each digit
- ◆ Ensure that you fill in one lozenge in every shaded area of this form

WHICH ORAL ① ②

TOPIC AND NOTES

WHOSE Q? OWN CoEx

COMPETENCE /CONTEXT: C PV PPG

GRADE

1 ______________________________ O C

	C	PV	PPG	GRADE		
CP	○	○	○	O	S	U
WC	○	○	○	E	B	P
S	○	○	○	G	N	D
PR	○	○	○			

2 ______________________________ O C

	C	PV	PPG	GRADE		
CP	○	○	○	O	S	U
WC	○	○	○	E	B	P
S	○	○	○	G	N	D
PR	○	○	○			

3 ______________________________ O C

	C	PV	PPG	GRADE		
CP	○	○	○	O	S	U
WC	○	○	○	E	B	P
S	○	○	○	G	N	D
PR	○	○	○			

4 ______________________________ O C

	C	PV	PPG	GRADE		
CP	○	○	○	O	S	U
WC	○	○	○	E	B	P
S	○	○	○	G	N	D
PR	○	○	○			

5 ______________________________ O C

	C	PV	PPG	GRADE		
CP	○	○	○	O	S	U
WC	○	○	○	E	B	P
S	○	○	○	G	N	D
PR	○	○	○			

6 ______________________________ O C

	C	PV	PPG	GRADE		
CP	○	○	○	O	S	U
WC	○	○	○	E	B	P
S	○	○	○	G	N	D
PR	○	○	○			

COMMENTS FOR FEEDBACK

1	2	3	4	5
6	7	8	9	10
11	12	13	14	15
16	17	18	19	20

OVERALL GRADE

O	S	U
E	B	P
G	N	D

MRCGP EXAMINATION: ORAL EXAMINATION   QUARTET SUMMARY & REVIEW FORM (Revd. 4/2001)

TO BE COMPLETED and SIGNED in INK PLEASE, NOT PENCIL

[sticky label: cand name/no]

Date ....   Time of Quartet ....

---------- FIRST ORAL ----------

Examiner 1 ..../........ Name/No.
GRADE .....

Examiner 2 ..../........ Name/No.
GRADE .....

---------- SECOND ORAL ----------

Examiner 3 ..../........ Name/No.
GRADE .....

Examiner 4 ..../........ Name/No.
GRADE .....

Result

AGGREGATED RESULT P/F .... (Merit will be computed)

FINAL RESULT P/F .... (if different)

Computing the aggregated result

"B" = borderline: "all B's" = just fail, anything more = pass. "B" counts zero in the aggregation stakes

"S" = + 1 point	"G" = + 2 points	"E" = + 3 points	"O" = + 4 points
"N" = - 1 point	"U" = - 2 points	"P" = - 3 points	"D" = - 4 points

- Calculate the total points, with "B" counting as zero
- One or more on aggregate is a pass, zero or less is a fail
- If aggregate result is between 0 and +2 the quartet is empowered to move scores up or down after discussion
- It is crucial that reasons for changing the initial aggregate result are documented

- IT IS ALSO CRUCIAL THAT THE FINAL GRADES ON THE MACHINE-MARKABLE SHEET ARE AMENDED

Justification of any "raised" result or failing result given, in the latter case suitable for passing on to candidate *verbatim*. Include up to four "coded" comments, and positive recommendations for action

....

....

....

....

....

Signatures of Examiners attesting to Result

....	....	....	....
Examiner 1	Examiner 2	Examiner 3	Examiner 4

Oral Grade Criteria (rev. 10.01)

O Outstanding
Very well informed, coherent, rational, consistent, critical. Stretches the examiner. Supports arguments by reference to the evidence, both published and topical. Can reconcile conflicting views and data. Very robust justification of proposed actions. Impressive exploration of ethical issues.

E Excellent
Confident and fluent candidate. Rational, consistent. Impressive range of options/implications. Well informed, uses rigorous and well-substantiated arguments. Integrates understanding of the topic into their reasoning when justifying decisions. Relevant ethical issues explored in depth.

G Good
Definitely passing candidate. Generally rational, consistent and fluent. Good options/implications. Sound evidence base, makes acceptable rather than robust or rigorous arguments. Can analyse their understanding of essential issues when justifying decisions. Important ethical issues recognised and explored.

S Satisfactory
Examiner is comfortable with candidate's adequacy at MRCGP level. Main options and implications seen and understood, but no sophistication of approach. He/she is solid and can apply their understanding of the essential issues when decision making. Informed by some evidence. Some ethical issues recognised.

B Borderline Examiner not comfortable with candidate's adequacy for Membership. Not enough justification of decisions. Can understand the relevance of the topic but decision making skills are, on balance, not quite acceptable. Superficial appreciation of ethical aspects.

N Not adequate
Cannot discuss topic in a depth appropriate for a Member of the College. Can recognise essential issues but examiner not satisfied with candidate's decision-making skills. Inflexible, superficial and needs prompting. Limited range of options seen. Very limited use of evidence. Unable to apply ethical principles.

U Unsatisfactory
Cannot discuss topic in a depth appropriate for a doctor entering general practice. Cannot recognise essential issues Poor decision-making skills. Almost no evidence for approaches. Options rarely seen. Is unaware of ethical dimension.

P Poor
Cannot discuss topic in a depth appropriate for a medically-qualified person. Inconsistent. Cannot recognise essential issues and unable to see range of options. No evidence of rational decision-making or ethical considerations.

D Dreadful
Candidate worse than poor, adopts such arbitrary approaches as to affect patient care adversely.

MRCGP Orals: Question Card (Old version) Examiner ....

TOPIC ....

AREA OF COMPETENCE			CONTEXT			
communic'n :	professional : values	personal + prof'l growth	care of pts. :	working with collgs.	society :	personal respons'ty
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

Question

Follow-ons

O

E

G

S

B

N

U

P

D

Examiner

MRCGP Orals: Question Card (3.02 v2)

TOPIC

	Communication	AREA OF COMPETENCE Professional Values	Personal/professional Growth
CONTEXT			
Care of patients	☐	☐	☐
Working with colleagues	☐	☐	☐
Society	☐	☐	☐
Personal responsibility	☐	☐	☐

Question

Supplementary questions seeking high level attributes

Supplementary questions seeking basic level attributes

Supplementary questions seeking low level attributes

High level attributes (O, E, G)
Basic level attributes (S, B)
Low level attributes (N, U, P, D)

Record of Grades Given

O	
E	
G	
S	
B	
N	
U	
P	
D	

Notes, References, etc

Question first used:	Date of this update:

MRCGP Orals: Classified Comments on Candidates for use with Opscan form

(with "translated" feedback as transmitted to candidates)

1. **Disorganised / inconsistent**
   There was some evidence of inconsistency and a disorganised approach to problem solving and decision making.
2. **Slow, had to be led**
   The candidate needed to be led and demonstrated a slow and slightly ponderous approach.
3. **Garrulous and verbose**
   The candidate was somewhat garrulous and needed to be guided and interrupted in order to be allowed the opportunity to score marks.
4. **Superficial and shallow / lack of justification**
   There appeared to be a shallow and superficial appreciation of some of the questions and there was a lack of justification for decisions that were made.
5. **Difficulty understanding candidate**
   The examiners found it very difficult to understand the points that the candidate was trying to convey.
6. **Difficulty recognising dilemma**
   There appeared to be some difficulty in recognising dilemmas that the candidate was confronted with.
7. **Failure to see a sufficient range of options**
   The candidate found it difficult to contemplate the range of options that needed to be considered in order to justify a rational approach to decision making.
8. **Inability to apply knowledge**
   The candidate was hesitant in applying knowledge to a given situation.
9. **Rigid and inflexible**
   The candidate appeared to take a somewhat rigid and inflexible approach to some of the dilemmas with which he/she was confronted.
10. **Unable to apply an ethical framework effectively**
    There was not much evidence of being able to apply ethical frameworks to assist in decision making.
11. **Lack of self-awareness**
    There appeared to be little or no evidence of self-awareness.
12. **Insufficient evidence of patient-centredness**
    There was little or no evidence of a patient centred approach to problem solving and/or decision-making.
13. **Reluctant to take personal responsibility**
    There appeared to be an unwillingness to take personal responsibility for decision making.
14. **Insufficient evidence of empathy & caring**
    There was insufficient evidence of empathy & caring demonstrated.
15. **Insufficient evidence of decision-making skills**
    The candidate appeared to have difficulty in making decisions.
16. **Lack of evidence to support decision-making**
    There appeared to be a lack of evidence supporting decisions that were made.
17. **Failed to see issue**
    The candidate failed to appreciate the issues he/she was confronted with
18. **Extremely nervous**
    The candidate's performance was inhibited by extreme nervousness