The Faculty of
Intensive Care Medicine

Dean
Dr Carl Waldmann

Churchill House | 35 Red Lion Square | London | WC1R 4SG
tel 020 7092 1728 | fax 020 7092 1730 | email ficm@rcoa.ac.uk | web www.ficm.ac.uk

FICM Examination Report – October 2017

Background

The tenth sitting of the Fellowship of the Faculty of Intensive Care Medicine Final examination took place in July and October 2017. The oral exams took place over two days where candidates were exposed to a range of assessments covering a wide area of the curriculum.

The FFICM MCQ

The MCQ was held on 11 July 2017. 86 candidates sat the exam, of whom 51 passed (59.30%). The MCQ pass mark was 70.64%. This was reached by Angoff referencing, which was carried out by a dedicated MCQ Angoff group. The Angoff score was further adjusted by the use of Standard Error of Measurement (SEM) to allow for borderline candidates. The reliability for this exam was 0.7211, which was calculated using KR20. The pass rate on this occasion represented a fall from previous sittings of the exam. Variability of this nature is within the range seen in other college exams and is consistent with the criterion referenced standard setting used in the FFICM.

The FFICM OSCE/SOE

Candidates

82 candidates attended the exam, of these 26 had a previous pass in either the Structured Oral Exam (16) or the OSCE (10).

SOE

The Borderline Regression (BR) and Hofstee methods were used in the standard setting of the SOEs, with Hofstee being used to cross reference the result achieved from the BR method. All statistical analysis available was discussed by the Board of Examiners. The final pass mark of 27 out of 32 was reached through a combination of statistical analysis and expert judgement after consideration of borderline candidates. 66 candidates sat the SOE. Of the 66, 48 (73%) passed the SOE component. 10 candidates sat the SOE with a previous pass in the OSCE. 9 from 10 passed giving a 90% pass rate for SOE only applicants.

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OSCE

Standard setting was performed using modified Angoff referencing by the OSCE working party in advance and a cumulative pass mark of 158/240, 160/240 and 158/240 was reached for the 3 questions sets used over the two days of the exam. 72 candidates sat the OSCE. Of the 72, 56 (78%) passed this component. 16 candidates sat the OSCE with a previous pass in the SOE. 11 candidates passed, giving a 68.75% pass rate for OSCE only candidates.

Overall

55 candidates from 82 (67%) passed the exam overall and achieved the Fellowship in Intensive Care Medicine. This compares with 66% in March 2017. Examiners commented upon a number of candidates who had attended the exam with a fail in one component who on this occasion achieved full marks in the SOE or high scores in the OSCE. There are many possible explanations for this. One would be the ability to concentrate on one part of the exam in isolation but an alternative suggestion is that able candidates who had previously presented to the exam inadequately prepared performed well following an adequate amount of study. An overview of results are set out in the table below:

All candidates	**SOE**	**Total**	**66**
		PASS (N)	**48**
		PASS (%)	**72.72**
	OSCE	**Total**	**72**
		PASS (N)	**56**
		PASS (%)	**77.77**
	Overall	**Total**	**82**
		PASS(N)	**55**
		PASS (%)	**67.07**

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Over the two days of examining 11 visitors attended the exam. There is a limit to the number of places available to visitors and it is unfortunate that on both days visitors fail to attend without warning denying others the opportunity to see how the exam runs and increasing the time applicants have to wait to visit the exam. All visitors attending the exam on this occasion were involved in organising training and assessment. The feedback during this exam was similar to previous sittings. Visitors appreciated seeing the standard of candidates and the expectations of the examiners. The standard expected was seen as fair and it was recognized that questions seen as difficult for practicing clinicians were within the syllabus and often dealt with surprisingly well by candidates who would have done the expected bookwork prior to attending. When discussing the standard with visitors it was noted that the FFICM Final examination can be taken at any point during Stage 2 of the new training programme prior to entering ST7. The earlier candidates chose to take the exam the greater chance that they may not have seen all aspects of intensive care. Candidates should understand the need to put in the required amount of study to compensate for this before taking the exam.

Discussion amongst the visitors about the way in which a communication station ran revealed that what some visitors witnessed in the station was different to others. This is due to the station being designed to simulate a real life encounter where the simulated individual (actor) would only reveal information to the candidate if appropriately prompted.

Visitors commented upon how worthwhile and well organized the simulation station was. Interestingly some candidates lost marks because despite mentioning diagnoses in discussion they failed to follow them up. This was generally because they opted for an alternative, incorrect, diagnosis rather than keeping an open mind as they should clinically.

Examiners understand that candidates often find the exam situation stressful. On occasion examiners feed back to the board of examiners at call-over that some candidates appear debilitated by stress. There is only so much examiners can do to ally anxiety during the exam. Occasionally they request that concern is fed back to tutors. One strategy that may help these candidates is extra exam practice to try to normalize the exam environment.

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Topics that were raised as not being well done by candidates include a question on calcium. Yet again the issue of ECG and radiology needs mentioning. It seems the concept of examiners asking for a structured description of the findings in some artifacts but just the obvious findings in others is now understood by candidates. There still remains a need to improve both interpretation and presentation of findings. A systematic review of an ECG for example includes rate, rhythm and axis. Visitors and examiners were surprised that candidates failed to recognize obvious abnormalities like atrial flutter. On occasion it is surprising that the candidate does not expect certain diagnoses from the clinical scenario. One would expect widespread T wave inversion across the chest leads in a patient without signs or history of acute myocardial injury to prompt a candidate to consider left ventricular hypertrophy both in real life and the exam.

The smooth running of the exam relies upon efficient support from the Faculty Examinations Department and the hard work of the board of examiners who have many responsibilities to the exam outside of examining the oral exam. The senior examiners have additional responsibilities so as usual I would also like to thank Dr Vickie Robson (Deputy Chair), the Chairs of the various parts of the exam – Jerome Cockings (Audit), Gary Mills (SOE), Jeremy Cordingly (OSCE) and Jeremy Bewley (MCQ) – as well their deputy chairs and all of the Board of Examiners – for all their hard work in setting and running this examination again.

Andrew T Cohen – Chairman, FFICM Board of Examiners

October 2017