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A BEHIND-THE-SCENES LOOK AT THE MEQ EXAMINATION

A DAY IN THE LIFE OF AN EXAMINER, *WITH APOLOGIES TO A. SOLZHENITZYN*

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ACKNOWLEDGEMENT

We acknowledge Aboriginal and Torres Strait Islander Peoples as the First Nations and the traditional custodians of the lands and waters now known as Australia, and Māori as tangata whenua in Aotearoa, also known as New Zealand.

We recognise and value the traditional knowledge held by Aboriginal and Torres Strait Islander Peoples and Māori. We honour and respect the Elders past and present, who weave their wisdom into all realms of life— spiritual, cultural, social, emotional, and physical.

We wish to acknowledge this workshop is being conducted on the lands of the Wajuk people of the Nyoongar nation in Boorloo (Perth), on the banks of the Derbal Yerrigan.

ACKNOWLEDGEMENT

We recognise those with lived and living experience of a mental health condition, including community members and College members. We affirm their ongoing contribution to the improvement of mental healthcare for all people.
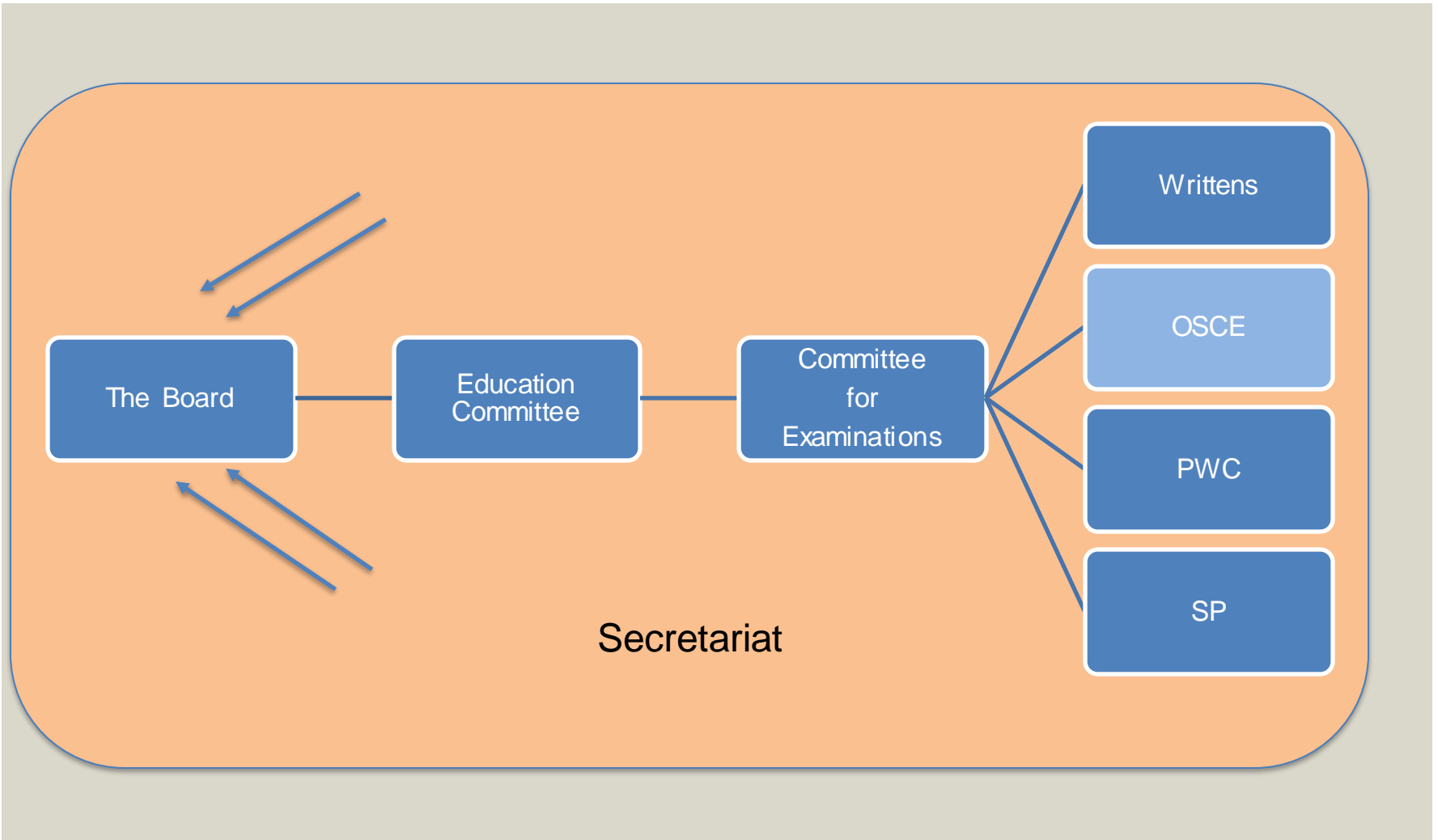
- The assessments' organisational structure

- The MEQ

- Question Setting & Vetting

- Standard setting & Exercise

- Marking & results analyses

- Tips & Strategies

- A pen and paper exercise

- Some general comments

- Q&A session

ORGANISATIONAL STRUCTURE

WHO MAKE UP THE CFE AND WRITTENS SUBCOMMITTEE?

MEMBERSHIP OF THE CFE* & WRITTENS SUBCOMMITTEE

- Chair, Deputy Chair, & Co-chairs of the Subcommittees.

- Nominations of Fellows by Fellows

- To be Subcommittee member, Fellows must have three years post nominals.

- 3-year terms (max of 2).

- Volunteers

* CFE: Committee For Examinations

THE MEQ

"The MEQ will have a clinical focus and will assess capacity for critical thinking about clinical practice and the application of clinical knowledge, as well as the capacity for critical thinking about issues relevant to the practice of psychiatry including sociocultural, models of illness, ethical and complex service issues."

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- Paper-based examination assesses knowledge application.

- A series of vignettes of situations most psychiatrists will face in their day-to-day practice.

- Capacity for critical thinking including sociocultural, models of illness, ethical, and complex service issues.

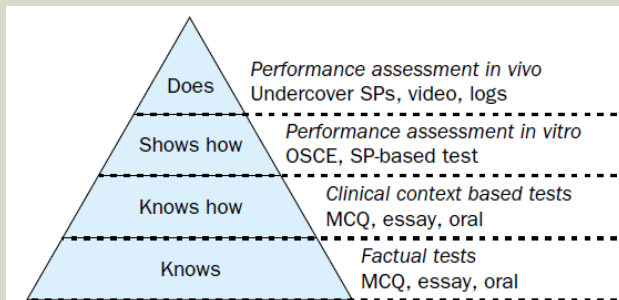- Theoretical basis, basic sciences, CPGs

- Position statements

Figure 2: **Miller's pyramid of competence**
SP=simulated patients; OSCE=objective structured clinical examination; HCQ=multiple-choice questions.

THE LANCET • Vol 357 • March 24, 2001

PURPOSE OF THE MEQ

- Assessment of clinical competence and problem solving.

- Understanding and describing the management of complex but common psychiatric situations – high face validity.

- Capacity to think broadly and include bio psychosocial aspects in assessment and treatment planning.

- Requires some clinical maturity.

QUESTION SETTING & VETTING

WHO ARE THE QUESTION WRITERS AND MARKERS?

- RANZCP Fellows

- Binational representation

- Passionate about training and teaching in psychiatry

- Question Writing Workshop (annually in November)

- Vetting, a continual process

- To be a marker, Fellows are to have two years post nominals

QUESTION GENERATION & VETTING PROCESS

- A range of sources, most commonly from real-life experiences of Fellows in the workplace, from journal articles/guidelines/peer review.

- All are relevant to psychiatry

- Strong face validity,

  – situations likely to be seen as a trainee or a consultant.

- Syllabus / blueprinting matched

- Repeat reviews

- We are reviewing our processes to improve the vetting of MEQs.

THE MEQ EXPLORES…

- Clinical assessment,

- Management & treatment,

- Staff & professionalism issues,

- Ethics, &

- Some of the areas previously examined in consultancy vivas.

- Start with an area of clinical practice that is relevant to trainees at *this stage of training and is included in the curriculum.

*Trainees must have completed Stage 1 and minimum of 6 months in Stage 2 (18 months+ of training) to undertake the MEQs and the CEQs.

DEFINE ASPECTS THAT ARE RELEVANT TO CURRICULUM

- Advocacy
- Assessment
- Basic Sciences, medical knowledge
- Epidemiology, Diagnosis & Classification and public health
- Ethics (including professionalism)
- History of psychiatry
- Leadership, governance and relevant legal frameworks

- Phenomenology
- Professional communication liaison
- Psychology, philosophy and psychodynamic principles
- Scholarship
- Sociocultural awareness

- **Specific Areas of practice**

- **Specific Disorders**

- **Treatments in psychiatry**

There are five parts to the Modified Essay Question:

1. Theme
2. Main vignette
3. A series of between 3 to 5 questions
4. Additional vignettes may precede subsequent questions.
5. Marking Guide

- **List …**

Means you want a list without anything extra, the list doesn't have to be explained or justified.

- **Outline (list and justify) …**

Means a list with something extra that indicates a reason for its inclusion.

- **Describe (list and explain) …**

Provides more detail than Outline and might resemble the Short Answer format of past written exams, i.e., some elaboration for the answer's inclusion.

- **Discuss (list and debate) …**

Means a substantial answer, covering a number of points with some analysis about its inclusion in the answer.

- Model answers in a rubric are divided into 'domains' and each domain of knowledge could be worth any number of marks - candidates can score any number of marks within that range depending on depth and breadth of cover.

Domains

| A.	**RECENT HISTORY**	
	• Precipitant for current presentation.	⓪
	• Issues around primary or secondary gain: is he genuinely worried, suicidal or is he trying to avoid court and consequences.	①
	• Explore possible symptoms of current mental illness: depression; mania.	②
	• Current functioning, coping style/personality.	③
	• History of substance use and current intoxication.	④
	• Some details re charge.	⑤
		⑥
		⑦
B.	**RISK ASSESSMENT**	
	• TO SELF - plan, intent, imminent, past history, means.	⓪
	• OTHERS - threats to victim, others, intent, plan, past history.	①
	• REPUTATION - possible impact of alleged offence (suspended from work; family and friends' reactions; publicity; content about him on social media).	②
		③
C.	**MENTAL STATE EXAMINATION**	
	• Level of engagement and rapport.	⓪
	• Looking for signs of depression, mania and current intoxication.	①
	• Shame and anger.	②
D.	**EXTERNAL SUPPORTS**	
	• Nature and quality of supports; family, friends, colleagues.	⓪
	• Living alone?	①
	• Fear of consequences for employment.	②
	• Legal support and cost.	
E.	**COLLATERAL INFORMATION**	
	• GP, family, next-of-kin.	⓪
		①

Performance review
Analyses:
- Quantative & qualitative
- Placement in the paper
- Judgement about the quality of the question
- Feedback from markers

Published or stored
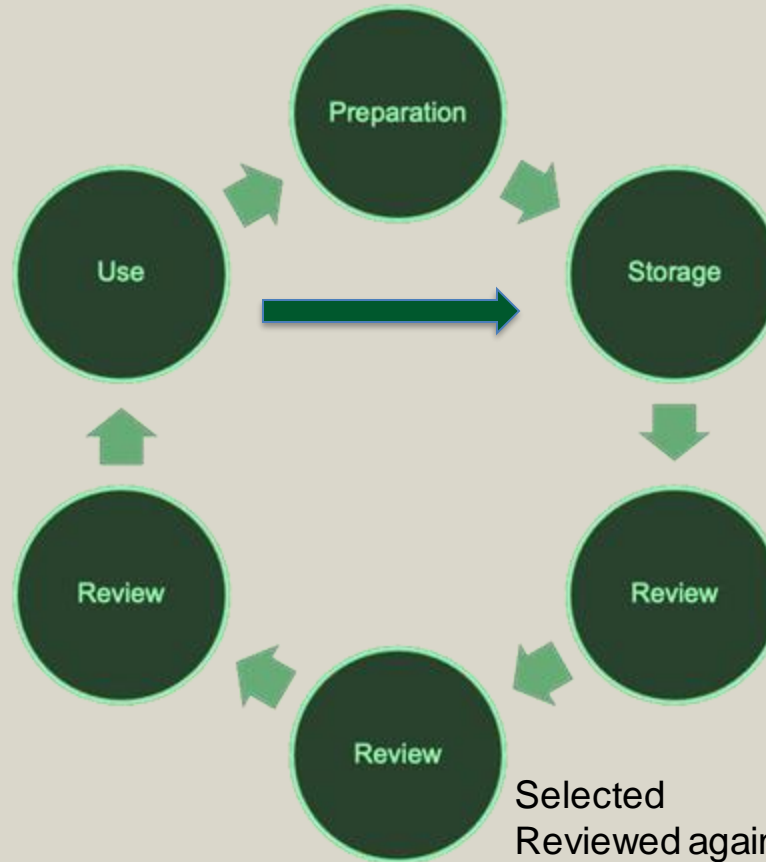
Inspiration
Dreams
Nightmares
Researched
Drafted

Content vetting
Checking
Blueprinting
Storage

Selected
Reviewed again
Edited
Standard setting

Preparation

Storage

Use

Review

Review

Review

STANDARD SETTING
& EXERCISE

STANDARD SETTING

- This is an integral part of any assessment system.

- The aim of standard setting is to define the pass score.

- Most standard setting processes require the conceptualisation of the borderline candidate.

- Involves a range of stakeholders incl examiners, policy makers, test developers, and measurement specialists.

- Standard setting is an imprecise art yet has significant implications for candidates and further afield.

STANDARD SETTING

- We want to work out that point, that cut score that separates those who know from those who do not know.

- The candidate who is most impacted by this dichotomous process is the minimally competent (***in this exam***) candidate.

- Operationalising the definition of the minimally competent candidate is actually hard.

- Examiners need an explicit definition of the concept of the minimally competent candidate. Yet, being explicit raises all sorts of problems as healthcare is complex.

STANDARD SETTING

- However, clinical performance is context-specific. We cannot be expected to assess each task that a candidate is expected to be competent in.

- Of course, there are implications for getting this wrong i.e. patient safety.

THE STANDARD SETTING PROBLEM

STANDARD SETTING : MEQ

- Follows EB-procedures

- Reflects the final outcome of a learning process.

- 'How good is good enough?".

- A cut-score from this is derived and thus will differ for each examination.

STANDARD SETTING: FIVE STEPS

- Select the judges (experts)

- Define "just good enough" knowledge and skills

- Train the judges in the chosen method

- Collect the judgements

- Combine the judgements to choose a passing score

STANDARD SETTING: FINDING THE PASS MARK

- Options:
  - **<u>Norm referenced</u>:** Used when a pre-determined proportion of examinees are required to pass e.g. 55% – not what we do

  - **<u>Criterion referenced</u>:** Used when a desirable competency level is required which each candidate should achieve

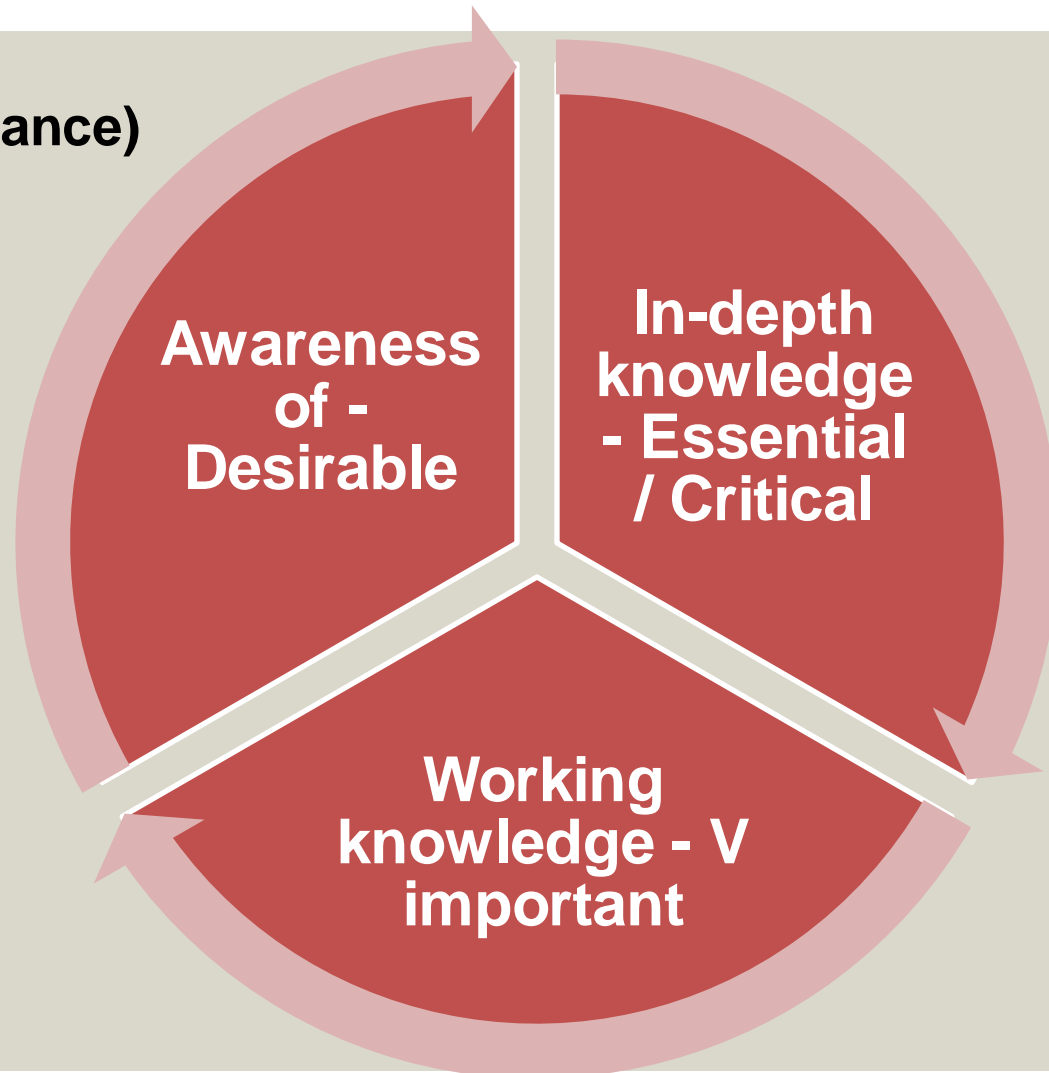- RANZCP uses "modified Ebel method"

MODIFIED EBEL METHOD

- A recognised process to determine the pass mark.

- Recognises also that all methods of assessment will involve some element of expert judgement.

- There is no universally recognised 'gold standard' method.

- Acceptance there is no completely objective, mathematical calculation that will deliver the pass mark.

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Importance (Relevance)

Peer determined

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Importance (Relevance)

Peer determined

CAP MEQ

Awareness of - Desirable

In-depth knowledge - Essential / Critical

Working knowledge - V important

MODIFIED EBEL METHOD:
TWO STAGES: 2

Difficulty (peer determined)

MCQ paper

- % providing the correct response*

MEQ paper

- Marks achieved*
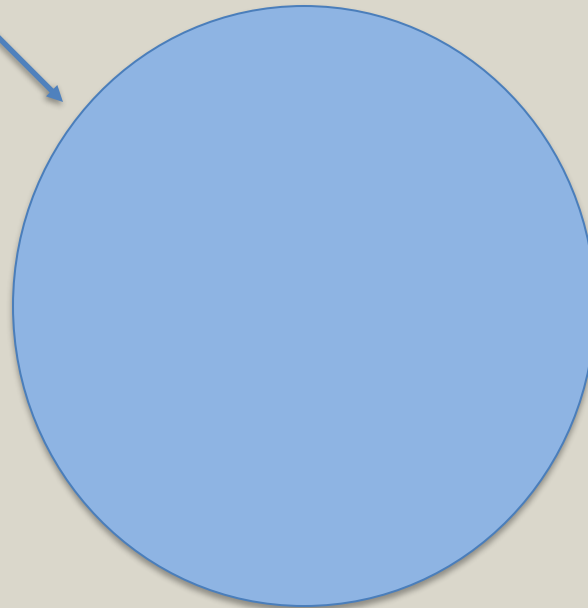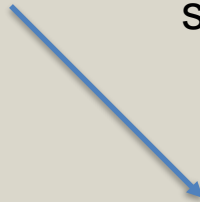
* Minimally competent junior psychiatrist
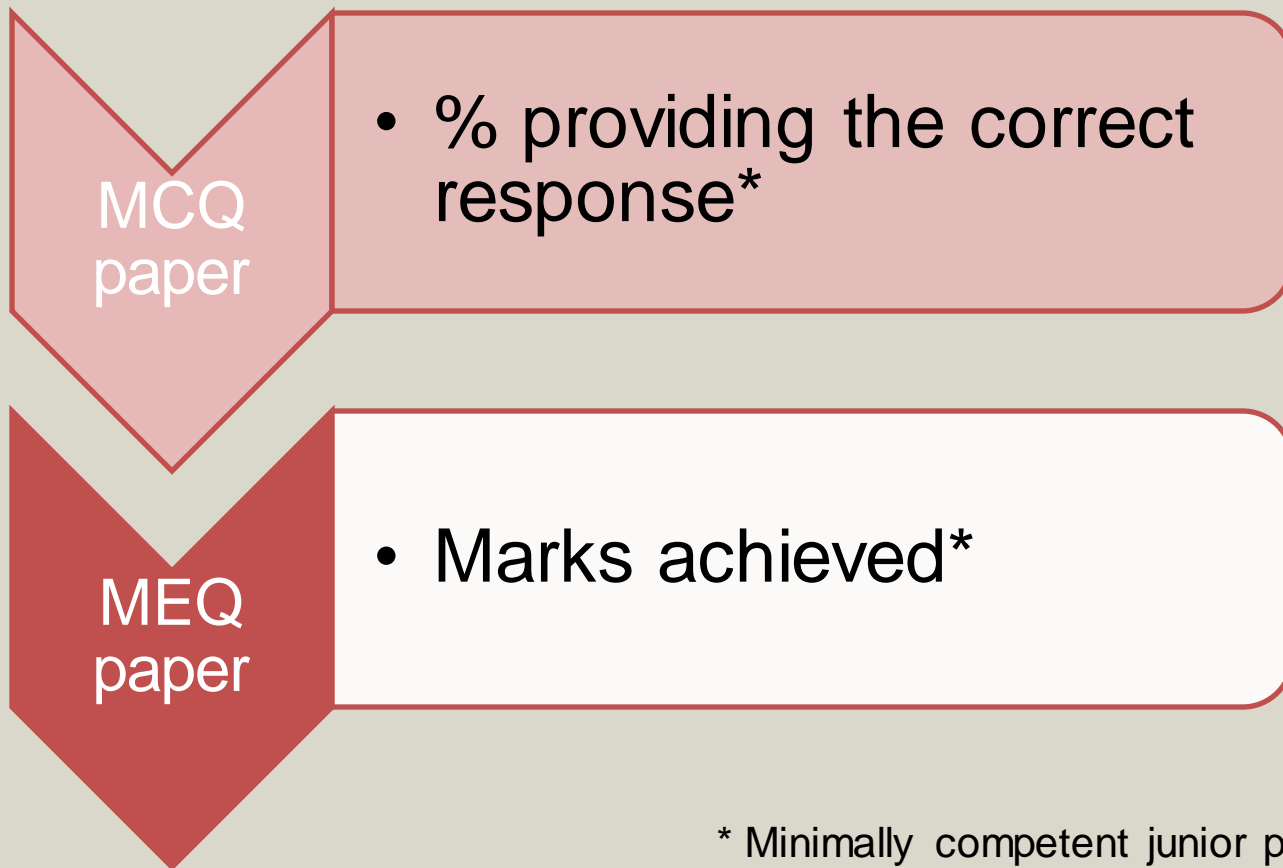
Cohort

For which group are we setting the standard?

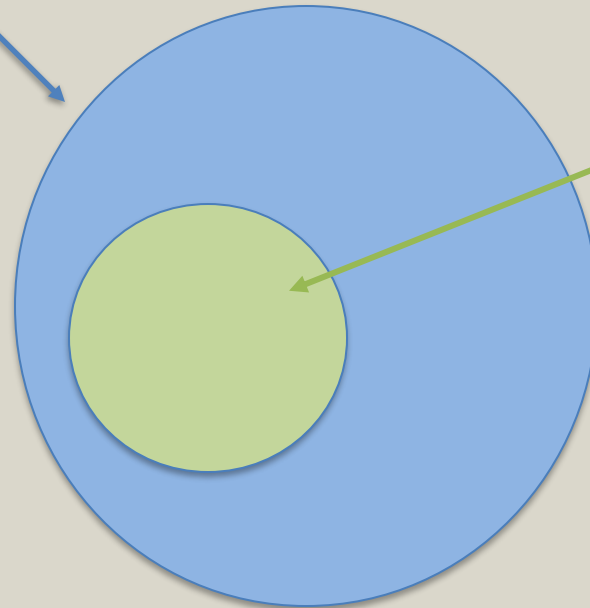# THE STANDARD SETTING PROBLEM CONT.

Cohort

For which group are we setting the standard?

Minimally-competent Junior Consultants

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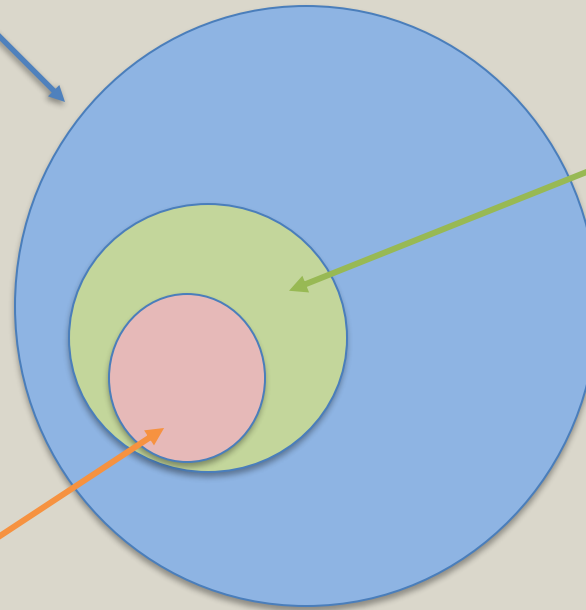New Zealand
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Psychiatrists

Cohort

For which group are we setting the standard?

Minimally-competent Junior Consultants

The proportion that will pass a question, or achieve a mark.

They set the standard.

THE "MINIMALLY COMPETENT JUNIOR PSYCHIATRIST"

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A junior psychiatrist:

- Some knowledge gaps

- Some difficulty applying knowledge to more complex clinical situations

- Seeks advice more often than a senior colleague

- Can lack sophistication

But…

- A good grasp of basic knowledge

- Able to practice independently or in private practice

- Is "safe" enough to be on an after-hours roster or to cover a colleague's leave

- "Forgivable errors"

- Represents the point at which a candidate is 'good enough'

  = pass mark

- Can be conceptualized as the 'point of separation' between

  pass and fail categories

- This 'point of separation' can be translated into a cut score

- Fairness

STANDARD SETTING GROUPS

- CFE

- Satellite groups across Australia and New Zealand

- Your peers set the standard

- Each question is set to a standard

- Candidates are under examination conditions and under time pressure.

- Candidates will not structure their responses in the way that the marking guide is set up.

- Often minimally competent candidates may write a lot about a couple of points therefore missing out on rest of the points expected in the answer.

MEQ STANDARD SETTING EXERCISE

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Modified Essay 2

The information that is presented in italics in this question is a repetition of the earlier sections of the case vignette.

You are a junior consultant psychiatrist in a community mental health service in a regional city. Jacinta, a 39-year-old unemployed woman living alone on a disability pension for a longstanding diagnosis of schizoaffective disorder. She is prescribed clozapine 300mg daily and lithium 750mg daily which provide good control of her psychotic and mood symptoms. She was last admitted to an inpatient unit three years ago. Jacinta is adherent with her medication and does not abuse illicit substances. She has a BMI of 35 but is physically healthy.

Jacinta wants to have a baby and asks for your advice.

Jacinta attends a fertility clinic and becomes pregnant. Following the birth of a healthy infant three weeks ago, the maternal child health nurse contacts you worried about Jacinta's deteriorating mental health. She reports that Jacinta has verbalised hearing God speaking to her, telling her the baby is from the devil. Jacinta has refused to comply with a request to present to the hospital.

Question 2.3

Outline (list and justify) your response to the maternal child health nurse's contact.
Please note: a list with no justification will not receive any marks. **(9 marks)**

Review the question and consider how you might respond

MEQ STANDARD SETTING EXERCISE II

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INDIVIDUALLY estimate the MARK a minimally competent junior psychiatrist (candidates) WILL ACHIEVE FOR THE QUESTION based on the marking guide for the question

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A.	**Clinical Assessment:** Requires urgent outreach assessment. Mental state examination, medication adherence, attitude to treatment, substance use, serum clozapine/lithium levels. Remain collaborative and recovery-focussed as much as possible.	⓪ ① ② ③
B.	**Risk Assessment - mother:** Relapsed psychosis, suicide, physical health, reputational damage, further isolation, self-stigma	⓪ ① ②
C.	**Risk Assessment - infant:** Risk of infanticide driven by delusions, risk of failure to thrive, neglect, harm/abuse, impaired attachment.	⓪ ① ②
D.	**Management:** Likely to require admission, preferably to mother-baby unit with assertive post-discharge follow-up (assertive outreach team). If involuntary, what happens to the baby? Consider mandatory reporting requirements.	⓪ ① ② ③
E.	**Supports:** Information and support for mother, partner, family. Consider whether someone can stay with the patient to provide additional supports. Offer support to maternal child health nurse.	⓪ ① ②

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Outline (list and justify) your response to the maternal child health nurse's contact.
Please note: a list with no justification will not receive any marks. **(9 marks)**

GROUP PROVIDES CONSENSUS on the mark a minimally competent junior psychiatrist (candidate) will achieve for the question after discussion.

MARKING & ANALYSES OF RESULTS

MEQ MARKING

- MEQ Marking Teams

- Team Leader

- Volunteers

CALIBRATION

- Calibration for the MEQ is conducted by each team and usually via discussion with follow-up conversations.

- Consensus - standardised evidence-based processes.

- Additional marks may be awarded from time to time.

POST-EXAM ANALYSES

POST-EXAM RESULTS ANALYSIS

- All results are analysed and validated from the raw data
  - Multiple methods; independent checking
  - This gives us the confidence that the results being used are as accurate as possible.
- Analyses are performed to identify inconsistencies
  - Candidate performance
  - Response options
  - Marker feedback
  - Marker performance
- Any unexpected result is reviewed.
- Cohort comparisons
- Within-cohort comparisons (e.g SIMG & Trainees)

EXAMPLE: MEQ

MEQ	Name	Issue / Dx	Blue-printing	Total Mark	Avg. Mark (sd)	Avg. (%)
1.1					4.79 (1.9)	47.9
1.2					5.78 (2.2)	48.17
1.3					4.75 (1.3)	79.17
1.4					2.93 (1.6)	29.3
Total					18.25 (4.4)	48.0

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1.3					4.75 (1.3)	79.17
1.4					2.93 (1.6)	29.3
Total					18.25 (4.4)	48.0

WE GET IT RIGHT, MOST OF THE TIME

Marker A/B	No of candidates marked	Average mark	Average %	Std Dev	
Marker A	98	6.0	49.7%	1.6	
Marker B	92	3.8	31.6%	2.1	
Marker C	91	3.5	29.6%	1.4	
	281	4.4	37.0%		

No of candidates marked	Average mark	Average %	Std Dev	
98	4.4	43.9%	1.6	
92	4.7	47.4%	2.0	
91	4.3	43.1%	1.3	
281	4.5	44.8%		

Marker A/B	No of candidates marked	Average mark	Average %	Std Dev	
Marker A	98	3.7	30.7%	2.1	
Marker B	92	3.1	26.0%	1.6	
Marker C	91	4.2	35.3%	2.3	
	281	3.7	30.7%		

Marker A/B	No of candidates marked	Average mark	Average %	Std Dev	
Marker A	145	1.0	25.0%	1.1	
Marker B	136	0.4	9.2%	0.6	
	281	0.7	17.1%		

WE GET IT RIGHT, MOST OF THE TIME

- Question worth: 10
- Standard set: 8 marks
- Avg marks achieved: 7.5

Marker A/B	No of candidates marked	Average mark	Average %	Std Dev
Marker A	98	9.1	91.3%	1.2
Marker B	92	4.4	44.2%	2.5
Marker C	91	9.1	90.5%	1.5
	281	7.5	75.4%	

WE GET IT RIGHT, MOST OF THE TIME

- Question worth: 7
- Standard set: 4 marks
- Average marks achieved: 3.6

Marker A/B	No of candidates marked	Average mark	Average %	Std Dev	
Marker A	98	4.5	64.0%	1.3	
Marker B	92	2.7	39.0%	1.1	
Marker C	91	4.2	60.3%	1.5	
	281	3.6	51.5%		

MARKER FEEDBACK

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The strengths of the cohort:	The weaknesses of the cohort:	The strengths of the question:	The weaknesses of the question:
Most considered trauma factors and affective syndrome	Quite a few missed the intent of the question, some were disorganized, some others were generic	Required reflection and critical thinking	Answers noted suggest that the question was in the majority not clear to the candidates.
This was a very easy Work-based place assessment question without any extra academic knowledge or preparation required. Most candidates included the relevant basic answers.	Some candidates discussed substance misuse disorders despite being advised that this had been excluded. Then most frequent omission was to mention therapeutic alliance, consent from & involvement of family. Of concern, some candidates recommended ECT for this patient.	Testing every-day work-place based knowledge - this type of patient would be seen very frequently within mental health treatment settings.	No extra academic knowledge required to answer this question apart from explaining the various psychotherapies but it would be expected that this information would be provided to the patient, in their consultation.

TIPS & STRATEGIES

Eligibility

You are eligible to apply for the MEQ exam after you have completed 18 months FTE training.

The RANZCP recommends that you take the exam in Stage 3, as it is set at the standard expected at the end of Stage 3.

You should have successfully completed the exam by 60 months FTE training.

I. STRATEGIES TO IMPROVE CANDIDATE PERFORMANCE IN THE ESE

- This is the responsibility of all stakeholders, including the CFE.

- Compared to MCQ and the OSCEs?

  The MCQ and OSCEs measure different competencies. They are/were both good examples of evidence-based assessment methods however they are limited in the depth of knowledge which can be assessed.

- We have implemented a number of changes in the ESE, some pre-ACER.

- CEQ: 40 marks (unchanged) but over 50 minutes and, those 50 minutes can be used by a candidate as they choose.

- MEQ: 125 marks in a 150-minute examination

III STRATEGIES

- Reading extensively and broadly

- Podcasts which are broad in topic.

- Practice, practice, practice

- MEQs: PRETEND to be a consultant; walk like a duck, talk like a duck, look like a duck; ask your supervisor to d/w as if you

  are a consultant. Ask to lead the team meeting/ward round – ask for feedback.

- Podcasts

  – Preparation for the CEQ and MEQ papers.

  – Hosted by current examiners and trainees who have recently sat the exams.

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- The patient
- The family
- Occupation, Social, Educ
- The care system
- Institutions, Covenants,
- The HCP
- Etc

Interconnected with the CANMEDS Competencies

Image By dzm1try

With thanks to Dr Dom Baetens

TIMING	• ~1mk/min • 125mk/150min
READING	• Application of knowledge in clinical situations.
STRATEGY	• Answer each sub-question as a standalone item. • Short Answer technique

- Practice, practice, practice

- Read College Feedback

  – Often, there are recurring themes

- Commonly, marker feedback is about a failure to follow the instruction.

- Follow the instruction. Provide a list if that is the direction.

- Use supervision to think like a psychiatrist.

TIPS FOR THE MEQ II

- Use bullet points if that works for you.

- Ensure you provide a justification/description/for-&-against arguments.

- Draw on your clinical experience when responding to the MEQ.

PREPARING FOR THE MEQ I

1. Don't underestimate the time required for preparation.

2. Consider your commitments e.g. family, children, placement, etc.

3. Don't sit too early

4. Sitting at the right time

   o This is very individual

   o More experience under your belt esp CAP, CL

   o Do some committee work; leadership opportunities in your workplace

   o Some may want to consider fractionating your work

   o Ensure you know what supports will be required.

   o Ensure you can have study time

PREPARING FOR THE MEQ II

5. Practice, practice, practice

6. Develop a mind map/grid / onion layers

7. Stick to the timing from the get-go. Time management is a problem for many.

8. Technique

   o Be succinct in your responses

   o Consider using bullet points vs narrative style

   o Use headings e.g. risk assessment

9. Use different writing tools until you find one which fits your hand comfortably

10. Develop muscle memory

11. Think of your handwriting

12. Choose a pen that feels comfortable and allows you to write larger if handwriting is a problem. Or, apply for special consids to type your responses.

13. On the day – have enough pens; dress comfortably

14. Use double spacing – makes for better legibility, allows for corrections, insertions, etc

15. If you think you need to type the essay, apply for special consids

16. Group practice vs solo practice vs study buddy

17. Mark each other's submissions

18. Be kind but not nice when marking; be critical.

19. Know the basics – ethical principles, recovery, patient centered care, BPS model of care, position statements, CANMEDS

20. CANMEDS

- The College website provides tips on how broad the consultant's roles are

- Not all the CANMED roles will be applicable in each MEQ.

21. Use your experience, cultural background

22. Think like a consultant, walk like a consultant, talk like a consultant

23. Ask to be able to lead team meetings, clinical reviews

24. Ask for feedback from consultants

25. Think out loud; demonstrate clinical reasoning

26. Listen to those with a lived experience

27. Listen to your patients

28. Listen to the multidisciplinary team

29. Talk to your colleagues and ask for feedback; give feedback

- A taster

- Read the scenario, address the task BEFORE looking the marking guide. As per standard setting procedure.

- Work in groups

YOUR QUESTIONS ANSWERED

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- Being addressed.

- Elements of papers to highlight a particularly relevant competency

  – well-written prose, how ethical principles are woven into an essay.

- The risk :

  – Becomes a focal point for candidates,

  – Formulaic responses.

WHY ARE SO FEW PRACTICE MEQ QUESTIONS RELEASED FOR AN EXAM WITH SUCH LOW PASS RATES?

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- Small bank of questions,

- > 12 months' gestation

- Recycling and upcycling

WHY IS THE CUT SCORE NOT PUBLISHED?

- There is a risk that candidates will focus on the cut score and work

  towards that.

- The cut score changes

  - standard setting, which relies on the expertise of Fellows determining

    the cut score and on the questions set for that exam.

INDIVIDUALISED FEEDBACK?

- This is not possible at this particular time.

- Remember, the committees are peopled by volunteer Fellows who are passionate about teaching, training and development.

SOME GENERAL COMMENTS

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26. Review and benchmark the content and role of the Clinical Essay Question and Modified Essay Question examinations to ensure utility and fitness for purpose, including relevance of each to contemporary practice. (Standard 5.2)

REVIEW OF THE MEQ 2023

- Final report due Winter 2023.
- Is there an alternative way to assess candidates?
- The MEQ is an important assessment for the College.
- We are conducting a QI exercise given the low pass rates. How can we improve the pass rate?
- Decoupling has revealed the extent of the poor performance in MEQ exams
- The MEQ has strong face validity. It comprises scenarios, clinical or otherwise, that an early-career psychiatrist can be expected to face as part of their routine work.
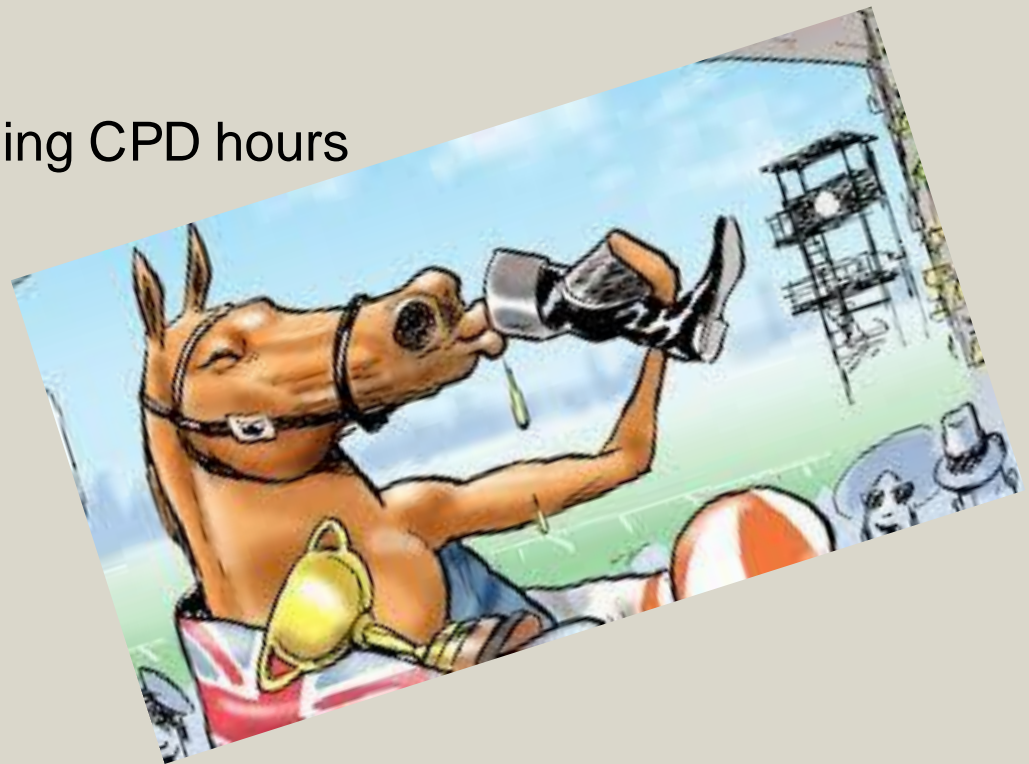
MEREDITH'S HOUSEKEEPING CEQ & MEQ

- Application dates – NO LATE APPLICATIONS
- Online ONLY applications
- Special consids
  - At the time of application
  - Long term ailments, learning difficulties
  - Acute (usually medical issues)
  - Adequate documentation, recency
- Incident reports
- Results release
- Review requests
- Contingency planning
- etc

QWW 2023 INVITE

The Royal
Australian &
New Zealand
College of
Psychiatrists

- 2nd and 3rd November 2023

- Melbourne

- Easy and fun way of gaining CPD hours

MEQ FEEDBACK SURVEY

Q&A