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Learning in practice

The objective structured public health examination (OSPHE): work-based learning for a new exam

Ayesha Ali MRCPCH MSc MFPH
Specialist Registrar in Public Health, London/KSS Deanery, currently based at The Department of Epidemiology and Public Health, University College London, UK

Introduction

Postgraduate education for all healthcare professionals is shifting from traditional knowledge-based models towards competency-based training and assessment.[1] Norcini's 2003 paper on work based assessment outline's George Miller's pyramid framework for assessing competence (see Figure 1) – with knowledge at the base ('knows'), competence at the next level ('knows how'), performance above this ('shows how') and action ('does') at the top. Action is what actually occurs in day-to-day practice, while the lower levels are what are more commonly assessed in an artificial examination environment.[2]

The Faculty of Public Health (FPH), the standard-setting body for specialists in public health, has addressed the move towards competency-based training in two ways. The first is the development of a new and more detailed curriculum. This links competencies, training outcomes and their assessment to specific stages in training. The second is the the introduction of the new objective structured public health examination (OSPHE), which will be discussed in this paper. The OSPHE targets the 'shows how' level of the pyramid – measuring performance in an examination setting.

The OSPHE

Membership of the faculty was previously obtained by passing the Part 1 and 2 components. Part 1 was a series of written examinations testing a wide range of public health knowledge. The Part 2 consisted of candidates presenting several

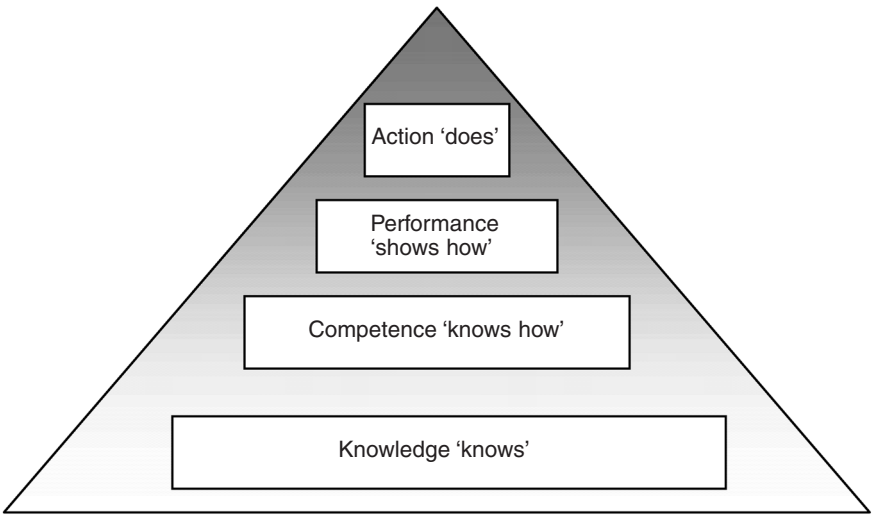

Figure 1 Miller's pyramid for assessing clinical competence

projects to address four specific competencies. Candidates were then given a viva on each of the projects as well as a general oral on a wide range of public health issues.

The Part 1 examination was replaced by the broadly similar Part A. However, the Part B exam, or the OSPHE, that has replaced the Part 2 is a radically different 'show how' assessment that requires candidates to show that they can integrate the theoretical and practical aspects of public health practice.

The OSPHE takes the form of six scenarios or 'stations', each lasting 16 minutes. Candidates are expected to make a verbal presentation and respond to questioning based on a scenario such as being interviewed by a journalist or meeting with a member of a special interest group. Information relevant to the scenario is also provided. Candidates have 8 minutes to read, assimilate, process and prepare the information given at a 'preparation' station. They are then taken into the exam room where they role-play the scenario with an examiner or actor for a further 8 minutes. The examiner and actor have a copy of the candidate's briefing materials as well as their own instructions.

The examiner marks the candidate against the same competency areas at each station – communication skills, using information from a public health perspective, giving a balanced view and dealing with conflict/uncertainty. The examiner decides on a grade between A and E for each competency. If a candidate is awarded a C on average for each competency at all six stations, they pass.[3]

This new combination of assessments – the Part A testing competence or 'know how' and the Part B testing performance or 'show how' – requires public health trainees to make full use of the daily learning opportunities when they work as members of a public health team. The 'signing off' of competencies is

done in partnership with the individuals' service trainer, but in order to prepare for the OSPHE exam trainees have developed new ways of learning from their work experiences.

Developing work-based learning resources

It is assumed that candidates will have some experience working in primary care organisations (PCO) before attempting the Part B examination. This exposure is likely to equip them with the necessary skills to pass the exam. However this will be highly dependent on the nature of the work at the PCO, the trainee and their trainer. The exam also requires large amounts of information to be assimilated and presented in timescales that do not reflect everyday working conditions. When the Part B was introduced, the FPH published a limited number of mock questions on its website. Although helpful, the small numbers and lack of question development left a gap in the learning needs of early cohorts of potential candidates. As a result trainees became highly innovative in developing their own learning resources.

Work based study groups have been set up in training locations across the country. These are run by trainees for trainees and allow convenient, accessible peer-led learning that can be structured to fit around work commitments. Trainees use the opportunity to share daily work experiences as potential exam topics, and practise questions under timed conditions. Some groups have developed their own questions using real-life work scenarios shaped to fit the format of the exam. Many of these questions have been shared via trainees web-based e-groups.

Public health training programmes are the responsibility of regional deaneries. Public health training programme directors have developed mock questions that are available on their deanery websites and have arranged local training sessions. Others have set up mock exams that mirror the timing and conditions of the actual Part B. However these arrangements vary across the country.

Commercial revision courses have also been developed. These courses, which are expensive, offer sessions on specific topics, e.g. dealing with conflict, as well as hosting mock exams.

Outcomes

In January 2006 the first cohort of candidates sat the Part B. Passing the exam leads to the award of the Membership of the Faculty of Public Health (MFPH) qualification, which is a mandatory requirement of the UK public health training programme.

At present the only formal indicator of the success of the OSPHE is its pass rate. A second indicator which is in progress is an immediate post-OSPHE questionnaire administered to all candiadates. This assessment of exam satisfaction is being undertaken by an academic institution on behalf of the FPH. It will report back in 2007.

Thus far the new approaches to learning appear to be paying off. The average pass rate in the eight sittings of the exam (January 2006 to November 2006) has been 82.5%, with an average mark of 7 out of 10. This is a considerable improvement on previous Part 2 exam results. The high rate may reflect the success of revision resources developed. It may also be because changes in the examination system required senior trainees to be given priority to sit the first few OPSHEs. These trainees will have had more work-based experience in dealing with scenarios similar to those presented in the examination. However, by far the most important reason for its success might be that at last we have an exam that tests real-life performance in the workplace.

Whatever the reasons for its success, the OSPHE exam will remain in its present format for the forseeable future, and trainees will have to take responsibility to ensure that their work environments provide not only the experience to demonstrate public health competency but also the techniques to pass the exam.

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ADDRESS FOR CORRESPONDENCE

Dr Ayesha Ali
25 Havers Avenue
Hersham
Surrey KT12 4ND
UK
Tel: +44 (0)7976 713880
Fax: +44 (0)1206 561670
Email: ahmad2@supanet.com