Thoughts about the Membership and Fellowship Examinations for COSECSA 28 and 29 November 2005

These examinations were held at Muhimbili Hospital. The local organising team were Drs L Lema and L Museru.

The examinations were coordinated by:

Dr M Cotton for the MCS
Dr Jani for the FCS Gen Surg
Prof C Lavy for the FCS Orth

MCS Clinical

The bays [6] had one, or at the most two, cases which means that they are not clinical bays but almost OSCE. This led to a certain amount of boredom for the examiners doing the same case for six consecutive candidates. This was due to the small number of patients as the medical staff were on strike! The local organisers are to be congratulated for holding the exams in such circumstances.

We must make sure each examiner examines for half the allocated time and the examiners need to be there all the time, not wandering off in order to mark with another examiner.

The history taking bay is difficult and slow with interpreters. In future, it may be better to use actors [?nurses] who have been scripted in English. What happened to the information giving bay?

If we are going to use single cases, we need marking/tick sheets to make sure all information and clinical findings are obtained as in any OSCE exam. There were too many interruptions by some of the examiners trying to impose their personalities; interruption makes the candidate lose their train of thought or concentration and doesn't give the candidate the best chance of success.

MCS Oral

Should we try three parts of 20 mins each. At present we have:

- Critical care and surgical pathology 15 mins for each examiner [30 mins]
- Preparation for surgery and operative surgery plus review of logbooks at the same time. Why not do more of basic sciences. There is not enough emphasis on anatomy and physiology; 10 min each examiner [20 mins] ?
    - Anatomy and operative surgery
    - Physiology and critical care
    - Pathology and principles of surgery [which includes pre and post op care wound healing, radiotherapy, chemo, lasers etc]

With the 5-minute change-over and marking time, this would take about 10 mins longer only in all.

We need syllabus sheets in each exam room so that the examiners know what subjects are to be covered.

I would suggest we train six to 10 examiners of different specialities as surgical anatomy examiners. We could hold a day course at one of the COSECSA meetings and get hold of plastinated specimens [these are expensive, but I am working on Ethicon], bones, X-rays, CT and MRI scans.

These could be held in the secretariat for safe keeping. In Edinburgh, the examiners are given 24 topics for the week-long exams and 10 different for each day - we are trusted not to tell the candidates the topics. This gives us a chance to read up ahead of time in those areas where we are a little rusty!

General

- Candidates need, numbers
- Examiners need name badges
- Document what you have talked about in the oral for the candidate to carry that information to the next table so that topics are not repeated
- Examiners need hard covered files with uniform paper designed for marking the clinicals and orals
- The marking system is cumbersome what about bad fail, bare fail, pass, good pass, distinction Any bad fail in one part is irredeemable,

one with two bare fails in clinicals is also irredeemable, despite the other marks.

- The bell must be loud and rung at the beginning, end and half-way for change of examiners
- Patients should be undressed and covered with a sheet - time is wasted getting off outdoor clothes
- Clinicals, except for the history taking bay, must concentrate on examination of the patient to elicit the signs in an orderly and structured manner, although some communication is necessary.
- Logbooks must be asked about in the operative part of the exam; if not, they should be marked separately
- Examiners who know candidates i.e. they have worked for them, should inform the organisers prior to the exam and timetables organised
- Refreshments mid-morning at least at the venue close by.

Fellowship

If we are going to have clinicals, short cases needed as well. I think clinicals are needed for general surgery and orthopaedics but not so sure about urology when it comes in.

The candidates were almost indistinguishable from the membership candidates, so we need harder questions, also knowledge of recent/seminal literature. This is available electronically. The examiners must be up to date as well. In fact, I would advise different cases from the Membership exam so comparisons cannot be made. A different venue, I think, would be difficult.

In the orals, up-to-date examining techniques using laptops with clinical photos, X-rays and histology should be used; most people have laptops. We must make sure NOW that there is a 3-year gap between MCS and FCS as this former has been running for three years so the more experienced MCS candidates have been examined. FCS examiners should have examined for MCS at least once first

The examiners training session is compulsory for all examiners and should be at least half a day prior to the exams. However, we thought the standard of both examiners and candidates was high, examiners were fair throughout,

the standard was consistent, and everyone should be congratulated under difficult circumstances.

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