Clinical MD In Plastic And Reconstructive Surgery.

Report For Sudan Medical Specialization Board On The Clinical Examination Of 5th December 2017.

Reports by Mr David Bell and Mr Wee Lam

Introduction

Mr. David Bell and Mr Wee Lam are two consultant hand and plastic surgeons from Liverpool and Edinburgh, UK, respectively. We were invited by Dr. Osama Murtada Ahmed, Chair of Training Board and Abdelsamie Abdallal Mohamed, Head of Examination to attend as external examiners for the Sudanese Plastic Surgery exit examination. The examinations have been ongoing for 5 years as part of the National Plastic Surgery training, which takes a dedicated path of 5 years, or 3 years following general surgery training.

Examination Briefings

We received a short briefing the evening before, with an outline of the overall structure of the exam and our responsibilities. We were also given the written papers. On the day of the examination, there was further discussion and briefing and we were then taken to meet the candidates. Mr Bell and Professsor Yagi undertook the long case examinations, while Mr Lam and Associate Professor Abdul Samir Abdalla Mohamed undertook the short case exams. Both then participated in separate viva sessions. There were other observers, including Mohamed Abdelrahman who was observing the Viva examination in particular, as preparation for his role as a future examiner.

Organisation

The exams took place in the Omdurman Military hospital. The candidates were given their own waiting area but after the examinations began were kept apart and unable to confer. There was a timekeeper for each session with preprinted score sheets for each long case and short case, but the scoring for the viva was less clear.

Examination

Long cases

Two patients had been brought for evaluation, but in the interest of fairness and consistency one patient was examined by all candidates. The case was complex and challenging with scope for demonstration of academic knowledge as well as higher order thinking with application of clinical principles to the specific case. The case incorporated genetics, specific features in the history, clinical examination and site specific examination. There was enough pathology and critical areas of management to allow for examination of two tumours, a failed flap, a discussion of nasal reconstruction, special considerations - the only seeing eye potentially affected after one eye required exenteration. The room was small but adequate with enough privacy.

There were gloves provided for the candidates, but there should have been a pen torch and tongue depressor to facilitate intra-oral examination.

Short cases

The short cases were conducted in a spacious room with several patients whom had been brought in as subjects. We agreed beforehand on the pool of patients which included the following: burnt contracture involving both hands, ulnar nerve palsy secondary to trauma, congenital hand differences with ulnar longitudinal aplasia and clashed thumb, a sickle cell ankle ulcer and an extensive squamous cell carcinoma that had eroded the upper lip and oral commissure of the mouth.

Each candidate was asked a series of similar questions and observed while they took a short history and performed a short examination. Special emphasis was placed on functional reconstruction. Reconstructive options were discussed in general, although it was interesting to note that some of the answers were influenced by the reality of limited local resources; for example, the use of local flaps rather than microsurgical free flaps (not routinely available in Sudan, as far as I could understand).

Vivas

This was set up as four clinical images in a PowerPoint presentation on a computer screen. The questions for each case was given on a sheet and related to the image. Mr Bell felt that a fuller briefing with the question setter would have been helpful to further clarify the questions being asked in relation to the clinical image, but in the event his two candidates demonstrated sufficient knowledge and understanding of the conditions that it wasn't an issue.

The topics were wide ranging and included a mixture of breast reconstruction, aesthetic surgery and skin oncology. Efforts were made to include cases not previously seen in the long and short cases so as to test the breadth of the candidates' knowledge.

Scoring evaluation

After each candidate was tested, the two examiners would sit down and discuss the marks to be awarded. A mark was given for each case and the sheets then handed to Abdelsamie Mohamed Abdalla- Head of Examination committee.

Finally, the whole group of senior surgeons gathered at the end of the day with the score sheets for all the papers (written and clinical), and this was followed by a robust discussion of all candidates. In particular, each borderline candidate was discussed. This process ensured that a single rogue mark didn't affect the overall outcome.

Outcome

The final decision was to pass three and fail two of the candidates. The deliberation was long and measured, and marks for the two failed candidates discussed repeatedly. The candidates who passed were then brought into the room to be congratulated while the other two were informed personally.

Overall Impressions

The exit examination for the Plastic and Reconstructive syllabus followed a similar format to the exit examination for the Intercollegiate FRCS (Plastic Surgery) in the UK and that was our standard for comparison. There are written components with multiple choice questions (held a week before) and clinical components with long and short cases and Viva examinations. The length of examination is slightly shorter than the UK version with fewer cases tested.

Our understanding was that the syllabus for the Sudanese examination was similar to the UK syllabus, and covered the entire scope of plastic, reconstructive and aesthetic surgery. In the UK, it has been noted that no single deanery can cover all the training that are required for the entire syllabus during training, and candidates are sometimes at a disadvantage when they are tested on a topic they have not seen. For example, there are sub-specialties, such as maxillofacial surgery, where a plastic surgery trainee would not have experienced but still expected to have a working knowledge of fixing facial fractures. However, it is expected that the examination should focus on principles and broad management and not specific details.

In Sudan, this may be evident for topics such as aesthetic surgery. As long as the examination focused on principles and broad discussion, we are of the opinion that the examination would continue to be fair. Testing a wide ranging list of topics is characteristic of the very nature of plastic surgery itself. This would also ensure that the examination can continue to progress towards an internationally recognized standard such as the FRCS (Plastic Surgery) or the EBOPRAS. As mentioned, that was our standard for comparison but we are not certain if this was the eventual aim of the Sudanese examination.

We wondered about the possibility of the examination being more focused on conditions seen in the country, and whether an answer should be more focused on the resources available, such as the use of local flaps, rather than a 'textbook correct' answer such as free flaps. This pose a particular challenge to a Sudanese candidate, who would need to have a good working knowledge of both, as compared to a UK candidate who might be spared discussions related to specific reconstructive options where free flaps are not available. However, such a ‘relevant’ examination in Sudan, and therefore the preparation towards it, may therefore ensure a candidate who would be better equipped in dealing with the particular challenges of conditions seen locally, and to work within the resources available.

Conclusions and Recommendations

Overall, both David Bell and Wee Lam enjoyed the examination tremendously. It was a valuable snapshot of the training in Sudan and also a chance to interact with the local candidates as well as senior experienced professors.

We both felt that the examination was fair, structured and comprehensive. The following are our recommendations:

1. We were informed that the examination was the 'final finishing line' for the candidates. If they passed, they would be certified competent to practice independently with immediate effect. Although that was the intention of an exit examination and therefore standards set accordingly, we felt that a Certificate of Completion of Training (CCT) be kept separate from examination success, as in the UK. The CCT takes into account other information such as the logbook, and all deficiencies are addressed (including targeted training in deficient areas) before a trainee is allowed to complete his training (whether he has passed his examination or not). Perhaps the CCT in Sudan can be kept separate and the candidates be allowed to practice for a final six months in a senior position after passing the examination.
2. We would recommend reducing the time for each short case and and seeing more cases. The time allocated was 10 minutes per case, and we often ran out of questions by 8 minutes.
3. We would recommend a structured marking scheme for the Viva examinations.
4. We would recommend having examination tools available for the long and short cases, e.g., torch and tongue depressors.
5. We were informed that the candidates practise among themselves but no examination course was available. As the examination has been ongoing for 5 years, there would be a pool of consultants by now who could conduct examination preparation courses. We felt this would be extremely helpful for future candidates. The examination is not only a test of knowledge but also of technique, and often candidates failed because of the latter. Knowledge can be improved with more studious preparation but technique may need specific coaching. A preparation course is also a good way to improve the 'higher order thinking' of plastic trainees, which is after all what this examination is all about.
6. Finally, we are impressed by the efforts that went into the organization of this examination. The involvement of senior professors was clearly evident and reflect a desire to raise the standard of Plastic Surgery in the country. In order to improve examination preparation especially in areas where trainees are not routinely exposed to during training, a long distance learning course might be useful, for example, a ChM in Plastic Surgery where online tutorials can be conducted with overseas Consultants. Such courses are not yet routinely available but we would be keen to find out if this is an area that would be helpful for future candidates and also Plastic Surgery training in general in Sudan.