Royal Australasian College of Surgeons

Notes to Candidates
General Surgery Fellowship Examination 2024

The following information is provided to help candidates prepare for the final Fellowship Examination in General Surgery. It is hoped that after reading this, candidates will have a better understanding of the structure of the examination and the level of knowledge and expertise expected of them. If candidates come to the examination adequately prepared their likelihood of success will be maximised.

It is important to stress that the benchmark for the examination is to assess whether the candidate is performing at a level of competency equivalent to that of a specialist in General Surgery in his or her first year of independent practice. Implicit in this assessment is the expectation that a successful candidate will not only have sound knowledge of the range of conditions that General Surgeons commonly encounter, but also they will be able to appropriately assess, investigate and manage patients with these conditions

1 SUMMARY OF CHANGES

Live patients will not be used in 2024 in the Clinical 1 and Clinical 2 segments.

All eight questions in the Clinical Imaging and Applied Anatomy exam will be still images. A DICOM viewer will no longer be used in this segment of the exam. The relevant images of cross-sectional image series will be presented as a still image.

Please note that the content of the exam remains the same and as usual will assess higher level thinking across the curriculum.

2 THE EXAM CONTENT

The content of the exams is defined by the Curriculum as developed by the Board in General Surgery. The Non-technical and Technical Modules of the Curriculum are available on both the GSA website and the NZAGS website:

https://www.surgeons.org/Trainees/surgical-specialties/general-surgery

The questions, scenarios or cases in each segment may refer to each of the levels of cognitive function (i.e., knowledge/comprehension, application/analysis or synthesis/evaluation) or, where appropriate, may be a global assessment.

Wherever possible, evaluation of the ten surgical competencies is taken into consideration throughout the assessment process. The relevant areas are the following:

MEDICAL EXPERTISE

- Relevant basic sciences outlined.
- Significance of symptoms/features identified and addressed.
- Potential pathologies identified.

JUDGEMENT – CLINICAL DECISION MAKING

History taking and examination:

- Exploration of the patient and condition.
- Description of physical examination.
- Demonstration of appropriate patient interaction.

Investigations:

- Identification of appropriate investigations.
- Justification for selection of investigations.
- Analysis of data from investigations.

Differential diagnosis:

- Possible alternatives identified and considered.
- Justification of possible alternatives from evidence.
- Clinical implications of the alternatives considered.

Treatment and Management:

- Appropriately selected treatment.
- Safe and appropriate management plan that takes into account patient's needs.
- Consideration of on-going management requirements.
- Consideration of other required professional support.

TECHNICAL EXPERTISE

Description of Procedure:

- Surgical procedure appropriate for the condition and diagnosis.
- Significant potential risk factors identified.
- Attention to safety of patient, self and others.

COMMUNICATION

- Clear, complete, and appropriate information for the patient.
- Appropriate communication of risks, advantages and alternatives of any management alternatives advocated.
- Prognosis reflecting the most likely outcomes.

LEADERSHIP AND MANAGEMENT

- Reasons for selection of investigations and treatment indicating consideration of patient needs and system constraints.

PROFESSIONALISM AND ETHICS

- Clear understanding of medico-legal and ethical issues in relation to the patient and their management.

COLLABORATION

- Understanding of other healthcare professionals involvement and roles in patient management.
- Demonstrated ability to initiate involvement and assess input of other healthcare workers in the patient's management.

3 THE MARKING SYSTEM

Examiners are paired for the duration of each examination; candidates will be assessed by a number of pairs of examiners. Each segment of the examination is marked separately without reference to other segments already completed. The results in each segment are collated by the senior examiner and the progress or final result of each candidate remains unknown to individual examiners until the meeting of the Specialty Court at the conclusion of the examination.

A candidate's performance is independently assessed by two examiners in each segment. Within each segment there is a pre-determined number of marking points.

The exam is marked using the Expanded Close Marking System (ECMS). Each marking point is scored according to the ECMS grades:

4	=	Well above the required standard.
3	=	At or above the required standard.
2	=	Below the required standard.
1	=	Well below the required standard.

The grades achieved in these marking points are used by each examiner to conclude their individual final mark and also used by the examining pair to determine a final consensus of Pass or Fail for that segment. Although each exam segment contains different numbers of Marking Points, all segments have equal weighting in determining if a candidate's overall performance is satisfactory.

At the conclusion of all segments, the Specialty Court in General Surgery (comprising the Senior Examiner and all examiners participating in that exam) meets to discuss the candidates' results. Candidates who have been successful in all segments of the exam will pass the Examination. Candidates who have not passed all 7 segments of the exam may still pass the Examination if the Specialty Court considers that their overall performance throughout the exam was satisfactory and if their deficiencies were compensated for in other segments of the exam. The overall performance is based on consideration of the distribution of all the marking point grades through all seven segments of the Examination.

4 THE STRUCTURE OF THE EXAMINATION

There are seven components (segments) consisting of two written and five clinical/viva examinations.

The written segments are completed approximately a month prior to the clinical/viva segments (in April and August). Candidates nominate which venue they wish to attend; venues are available in Adelaide, Brisbane, Hobart, Melbourne, Sydney, Perth, in Australia and in Auckland and Wellington in Aotearoa New Zealand.

The face-to-face vivas occur from Friday to Sunday for examinations held in Australia however, due to smaller candidate numbers in Aotearoa New Zealand, the exam only runs on Friday and Saturday with the three computer-based vivas usually on the Friday and the two clinical vivas usually on the Saturday.

The exact timetable may vary, depending on the resources available in each examination venue.

The dates for the 2024 Fellowship Examinations can be found on the RACS website at the following address:

https://www.surgeons.org/examinations/dates-locations-and-deadlines

5 WRITTEN EXAMINATION

This examination consists of two separate segments. The main objective of the Examination One (Spots) is to test the breadth of the candidate's knowledge acquired during their training whereas Examination Two (Short Answer Questions) is designed to test the depth of knowledge. The questions cover many aspects of the syllabus/curriculum. The questions evaluate clinical management and decision-making; aspects of pathophysiology, pathology, surgical anatomy and operative surgery may be included.

Neither examination has a specified 'reading time' period at the start of the examination. The ten minutes reading time will be added onto the two hours examination time for candidates to use as they see fit, meaning a total examination time of 130 minutes.

EXAMINATION ONE – 130 MINUTES

This exam consists of 25 'spot' questions. Each question typically consists of an image or photo that acts as a prompt for usually 3 questions. There are approximately 5 minutes per question in this paper and time management is critical. An unanswered question can only be a fail.

Great care should be taken to reading the questions properly and answering the questions posed. An answer that does not relate to the question posed will fail even if the content is correct. Each question in this exam is marked as pass or fail. A clear pass for this component of the exam is 18/25 questions.

EXAMINATION TWO – 130 MINUTES

This exam consists of 8 'short answer' questions (i.e., approx. 15 minutes should be allocated to each). These questions expect greater detail than the spot questions and may include one anatomy question. Candidates should also be familiar with the college 'Training Standards framework' as short answer questions may also pertain to the 9 core competencies.

One of the eight questions is a generic question which explores the nontechnical competencies and will be based on a theme across all specialties. Each of the specialties will have their own question relevant to their curriculum. It will count as an equal part of the eight questions in written examination two.

Answers are expected to convey advanced clinical reasoning and demonstrate that the candidate has the required knowledge with an in-depth understanding of current ideas and controversies surrounding the topic.

As with Examination One, it is important to read the questions properly and answer the questions posed. Diagrams can be acceptable as part of the answer. Each question in this exam is marked as a Pass or Fail. A clear pass is 6/8 questions.

Candidates are encouraged to view the Demonstration version of the electronic format available at (log-in required):

https://www.surgeons.org/examinations/fellowship-examination-fex/preparing-for-the-fellowship-examination/preparing-for-the-written-component

The General Surgery written examination will be delivered electronically and paper based.

Important Information (for candidates sitting computer-based version)
1. *Answers are typed in the text box provided for each question. The amount of space provided for essay questions is unlimited.* 2. *Answers are auto-saved every 60 seconds and whenever the 'Next' button is clicked.* 3. *If a candidate runs out of time, all answers will be submitted automatically, and the examination will close.*
Important Information (for candidates sitting paper-based version)
1. *The papers are identified only by candidate examination number.* 2. *The written papers are scanned and sent to the examiners once the examination is completed. Candidates are asked to avoid using coloured highlighters, pens or pencils as colour distinction may be lost during the scanning process.* 3. *Writing clearly and legibly, using either a black or blue pen is important. Only the lined side of the paper should be used for writing.*

6 CLINICAL/VIVAS

This component consists of five separate segments. Candidates will be assessed by several pairs of examiners. An observer may be present for the examination and discussion of the candidate. The observer may be present via a Video Conferencing platform or in person.

OPERATIVE SURGERY VIVA

This 30-minute viva consists of a 10-minute structured operative scenario prompted by a short PowerPoint presentation and 5 mini-scenarios prompted by a single clinical image. This viva is designed to assess the candidates' knowledge of common surgical procedures and manoeuvres and their ability to choose safe options when things 'are not going to plan'. Operative knowledge and decision-making are assessed.

The operative scenario is allocated 3 defined marking points; 1 for knowledge, 1 for application of that knowledge and 1 for global synthesis and evaluation of the scenario. The 5 mini-scenarios are allocated 1 marking point each.

PATHOPHYSIOLOGY, CRITICAL CARE & CLINICAL REASONING VIVA

This 40-minute viva consists of two 10-minute scenarios and usually 4 mini-scenarios. The longer scenarios typically contain a trauma or acute care component requiring knowledge of resuscitation, transfusion, shock and/or a complex clinical reasoning problem. The shorter scenarios are more likely to focus on the pathology or pathophysiology of a particular condition.

Each of the 10-minute scenarios is allocated 3 defined Marking Points: 1 for knowledge, 1 for application of that knowledge and 1 for global synthesis and evaluation of the scenario. The 4 mini-scenarios are allocated 1 marking point each.

CLINICAL IMAGING AND APPLIED ANATOMY VIVA

The duration of the viva will be 30 minutes and the format will consist of 8 images. These will be of either anatomical or operative specimens, clinical pictures or radiological images including multi-slice scans. These images will be used as a prompt to discuss applied anatomy. It is important that candidates are familiar with both operative anatomy as well as radiological anatomy for this exam. A DICOM viewer will no longer be used for the exam and appropriate still images from cross sectional imaging series will be presented.

Each of the anatomy images is allocated 1 marking point.

CLINICAL 1 VIVA (MEDIUM CASES)

The Clinical 1 viva will be delivered electronically and not involve live patients. Recorded videos, photos, results from investigations, and referral letters may be used as stimuli for discussion. The candidate and a pair of examiners spend 40 minutes discussing 2 medium clinical cases. The candidate is expected to:

- Interpret relevant information from the clinical presentation.
- Succinctly define the problems and findings.
- Propose investigations, review imaging and discuss the patient's problem.
- Formulate and justify an appropriate plan of management.

The candidate needs to demonstrate a high level of knowledge of the clinical problem and show an ability to apply that knowledge in synthesizing an appropriate management plan. Each long case is allocated 4 marking points: 1 knowledge of clinical presentation, 1 for theoretical knowledge, 1 for application of that knowledge and 1 for global synthesis and evaluation of the clinical case.

CLINICAL 2 VIVA (SHORT CASES)

The Clinical 2 viva will be delivered electronically and not involve live patients. In this 40-minute viva the candidate will be examined on 5 short clinical cases delivered electronically. Recorded videos, photos, results from investigations, and referral letters may be used as stimuli for discussion.

The nature of the clinical problems that present in this viva can involve conditions that present in an elective or emergency setting. The candidate is expected to

- Have adequate knowledge of the clinical presentation.
- Knowledge of appropriate history and examination that is required.
- Propose investigations, review imaging and discuss the patient's problem.
- Formulate and justify an appropriate plan of management.

Each short case is allocated 2 marking points: 1 for knowledge of the clinical presentation and 1 for global synthesis and evaluation of the clinical case.

At each viva the candidate is examined by a pair of examiners. The examiners will introduce themselves and will also wear name badges. They will introduce any observer and their role, indicating that they are observing the Examiners and not taking part in the examination of the candidate.

7 COPING WITH THE EXAMINATION

It is acknowledged that the Fellowship examination is a challenging experience for candidates, but day to day surgical practice is also challenging. Members of the Court of Examiners have been carefully selected to have not only good knowledge of the training requirements and the curriculum for General Surgery but also strong interest in the well-being of International Medical Graduates and Trainees and a demonstrated capacity for balanced and fair assessment of candidates.

Preparation, both physically and mentally is the key to a successful exam. Practice in completing written papers is essential, answering both spot-style questions and short question components is important, including getting the timing right. Practice in answering written questions is an excellent learning tool.

Undoubtedly a lot of time needs to be spent revising the theory that underpins our specialty in the lead up to the written papers and computer-based vivas. It is important to maintain continuous contact and involvement with the clinical environment in the lead up to the exam. Treating every patient seen in the clinical setting in the lead up to the exam as a potential exam case and discussing the case with training supervisors will undoubtedly improve the performance in the exam.

Vivas should be treated as an interaction with colleagues rather than an interrogation by the examiners.

Candidates who find they struggle to answer any component of a viva should ask for clarification. The examiners will give the clarification or may move forward to another area. If the examiner suggests a candidate reconsider an answer – they should be trusted, and the prompts followed. Examiners are trying to help candidates, not trick them.

For unsuccessful candidates a composite written report will be provided by the Senior Examiner to the Board Chair, the current Supervisor and candidate through the Examinations Department. This report will be emailed within three to four weeks of the Fellowship Examination. Candidates should liaise with the Board Chair and Supervisor to arrange an interview within four weeks of the Fellowship Examination. A regional Examiner should not be approached directly.

For any queries prior to the examination, please contact the Examinations Department by email: examinations@surgeons.org.

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